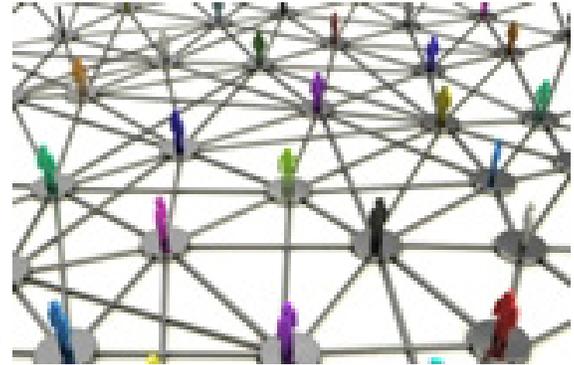


From Patient to Partner — Engaging Patients in the Paradigm Shift to Population Health Management

This is the first in a series of three articles about engaging patients in population health management, exploring the ways in which providers can foster collaboration with patients in care management and the questions this work raises for the identity of providers in the future.



From Sickness to Health — Getting Everyone to Pitch In The US must transform its costly, fragmented healthcare system to a new delivery paradigm — one that is integrated, takes accountability not just for illness but also for wellness, and one that provides better value for patients, providers, and payers. A recent study of chronic care patients in the US showed that, while regions ranked in the highest fifth of spending provided as much as 60% more care than regions in the lowest fifth of spending, the increased outlay resulted in negligible improvement of outcomes or patient satisfaction.ⁱ

Care providers of all types are already working to redesign care models, improve quality, and slow the rise in costs in their centers of care. However, the kind of transformation we are talking about will require changes beyond what is happening in the provider realm alone — it requires changes in how patients and their caregivers *participate* in their care (when sick) and in their overall well-being (when healthy).

As healthcare moves toward population health management, it is becoming increasingly apparent that patients will be key partners in achieving the Triple Aim — improving the health of populations and the patient experience while reducing costs. Health systems joining this movement now can reap the benefits with payers' pilot programs, and will win business and better manage their margins as the payment model evolves.

Defining the Goal — From Patient to Partner

As one of our clients has said, “This population health management stuff is great, but how can we get enough of our patients to do the right thing — especially when so many of those choices are deeply entrenched in their culture?” Building out robust, coordinated systems of care will require substantial work. However, population health management can only go so far without enabling patients to more actively engage in their own health.

Patient Behavior and Lifestyle Choices Drive Cost

We are slowly taking to heart that social factors are significant determinants of health and illness. In fact, McGinnis et. al. find traditional healthcare delivery determines as little as 10% of a person's overall health.ⁱⁱ

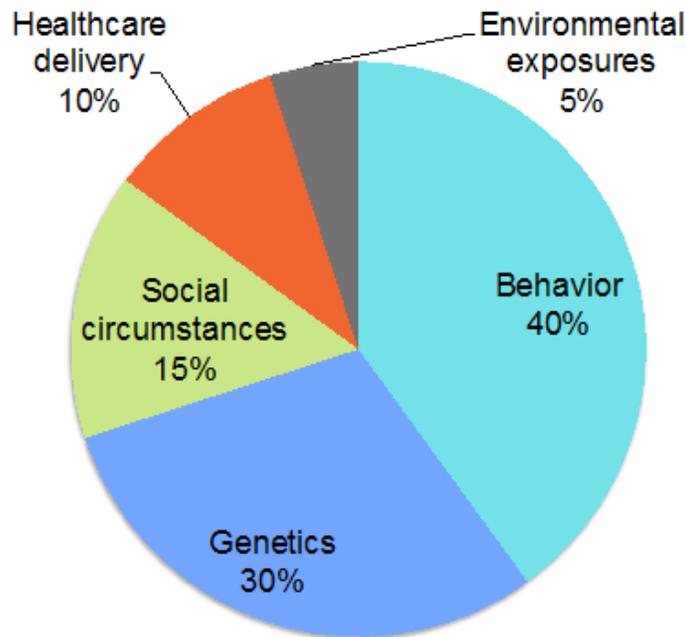
Excerpted from:
THE WHARTON HEALTHCARE QUARTERLY
SUMMER 2013, VOLUME 2, NUMBER 3

Contributors:
Jennifer Tomasik and Carey
Huntington Gallagher
To learn more about
Jennifer and Carey, [click here](#).

From Patient to Partner — Engaging Patients in the Paradigm Shift to Population Health Management

continued

Determinants of Individuals' Overall Health



Source: McGinnis et.al. 2002

Numerous studies suggest more than half of health issues in the US can be attributed to lifestyle issues, from high stress and smoking to sedentary activity and improper nutrition, just to name a few.ⁱⁱⁱ We face a significant shift in bridging the gap between how healthcare works today — accounting for only 10% of the “overall health” pie — and a system that can reliably deliver comprehensive health.

We know changing individual behavior isn't easy, so we set out to answer the question, “*What might make it easier for people to take greater ownership of their health so they can successfully transform from passive patients to active partners?*”

Change = Behavior + Supports

When we work with organizations, we help them spur widespread change by focusing on the level of *practice* — the different actions people will need to take to realize different outcomes. We believe practice change is based on two components, *behavior* and *supports*. Change depends on people understanding the new behaviors that need to be in place. Those behaviors require supports that make it easier for people to change their actions than to choose not to do so.

The “practice” of healthcare can be understood as a set of “behaviors” that becomes embedded in daily life, plus the “supports” that provide the appropriate resources to achieve the desired outcomes. Without those supports, new behaviors often fall flat. For instance, a home infusion agency we worked with needed to help patients administer medication on their own after several sessions with a nurse. Patients were having difficulty, and talking them through steps on the phone was coming up short. Some patients wound up going to the hospital for help, which often counted as an unnecessary

From Patient to Partner — Engaging Patients in the Paradigm Shift to Population Health Management

continued

readmission. After reviewing the problem, infusion nurses developed a diagram with large, color photographs that walked patients through the procedure. The diagram supported the new behavior change, helping patients take the reins of their own care.

Similarly, an academic medical center set a goal to schedule follow-up appointments for as many discharged patients as possible. After some time, they saw no-show rates for those appointments approached 70%. When a team dug into the underlying cause, they saw the health system was scheduling patients into slots without their input. Some patients couldn't make the appointments because they had to work, or their caregiver did, they couldn't find transportation to the doctor's office, or they didn't know where it was. The health system had met their scheduling metric but hadn't achieved better patient outcomes. Several units piloted a program where patients could advise when and where they could successfully get to a provider. Having the patient participate in setting up the appointment also reinforced the importance of the follow-up itself and, slowly, the appointment attendance rate rose.

The road to successful population management will require a paradigm shift not only for patients, who will need to be more active partners in their own care, but also for providers, as their roles change. The next two articles in this series will explore specific strategies for patient behavior change and discuss implications of the changes for providers and the nation's health system as a whole.

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200 or visit our website at <http://www.cfar.com>.

References

- i. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care." *Ann Intern Med* 2003;138(4):273-87.
- ii. McGinnis JM, Williams-Russo P, Knickman JR. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs* Mar 2002;21(2):78-93.
- iii. George B. "September Virtual HC Roundtable – Transforming Healthcare through Integrated Leadership." Harvard Business School Health Industry Alumni Association (Presentation). Online 11 Sep 2012. Accessed 1 Nov 2012.