The 2013 Committee on Research report:

- Defines and explores the rationale for health care user engagement
- Provides recommendations for actions when developing initiatives to increase health care user engagement
- Highlights promising strategies that increase user engagement at different levels of the health care system
- Identifies emerging topic areas of health care user engagement
Defining Health Care User Engagement

The strategies and framework in health care consumer engagement will be built around:

“A set of behaviors by health professionals, a set of organizational policies and procedures and a set of individual and collective mindsets and cultural philosophies that foster both the inclusion of patients and family members as active members of the health care team and encourage collaborative partnerships with patients and families, providers and communities.”

Examples of Barriers to Health Care User Engagement:

• Current volume-based reimbursement system that does not offer significant funding upfront toward health engagement initiatives

• Ambiguity surrounding the definition of health care user engagement and the large number of diverse strategies that hospitals can employ to achieve desired results

• Current professional culture and norms that intimidate patients in approaching their health care providers

• Low health literacy levels among patients

• Lack of measurement tools to assess where a patient is along the engagement or activation continuum and how well an organization is doing in engaging health care users
Framework for Engaging Health Care Users

Individual
- Increase the skills, knowledge and understanding of patients and families about what to expect when receiving care

Health Care Team
- Promote shared understanding of expectations among patients and providers when seeking care

Organization
- Encourage partnerships and integrate the patient and family perspective into all aspects of hospital operations

Community
- Expand the focus beyond the hospital setting and find opportunities to improve overall community health

Demographics
- Prior Experience
- Knowledge Skills
- Attitudes

Bedside Inpatient Unit
- Emergency Department
- Clinic
- Exam Room
- Home

Hospital
- Patient-Centered Health Home (PCHH)
- Accountable Care Organization (ACO)

Schools
- Neighborhoods
- Public Health
- Faith-based Groups
- Community Groups
- Coalitions

Information Sharing... Shared Decision Making... Self-Management... Partnerships
## Strategies for Engaging Health Care Users

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<thead>
<tr>
<th>Health Care System</th>
<th>Description</th>
<th>Examples of Engagement Strategies</th>
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| Community          | Communities have an important role to play in supporting residents living with chronic disease. A growing number of hospitals and health systems are partnering with community health centers and public health agencies to involve the community in engaging in healthier behaviors and self-management activities. | • Providing health education and health literacy classes  
• Providing healthy cooking and physical education classes  
• Using patient navigators and peers to provide support  
• Making local policy changes that promote healthier lifestyles (e.g., eliminating sugary drinks from school cafeterias) |
| Organization       | Health care organizations can implement many programs and changes in care delivery to engage patients throughout the continuum of care and involve them in improving quality and the patient experience. | • Using volunteers or patient advocates to support care  
• Involving patients and families in patient and family advisory councils, governance and other committees  
• Removing restrictions on visiting policies for families  
• Opening access to medical records  
• Using email and social media technology (e.g., Facebook, Twitter) |
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| **Health Care Team**        | The growing incidence of chronic disease combined with an expanded patient base has placed more responsibility onto clinicians practicing both inside and outside the hospital. Clinicians must work with each other and with patients to design individual care plans to achieve better outcomes. | • Using bedside change-of-shift reports  
• Involving patients and families in multidisciplinary rounds  
• Using patient- and family-activated rapid response  
• Providing shared decision-making tools  
• Using patient teach-back  
• Using clinic-based multidisciplinary care teams |
| **Individual (Patients and Families)** | Clinical advances have the ability to improve the quality of life for the majority of patients. To receive the full benefit, patients must actively manage their conditions to help prevent complications. For example, new HIV/AIDS drugs extend life, but patients must maintain the necessary regimens for success. | • Seeking health information and knowledge  
• Adhering to treatment plans and medication regimens  
• Participating in shared decision making  
• Using online personal health records  
• Engaging in wellness activities |
Background
This customer-owned system of care, called the SCF Nuka System of Care, provides a range of medical, dental, behavioral and complementary medicine, traditional healing, home-based services and education. At SCF, a multidisciplinary team follows each patient and gives customer-owners access to providers’ direct phone numbers and encourages email communication.

Results
Since the implementation of this model, positive results have been achieved in utilization, customer-owner and employee satisfaction and clinical quality outcomes.
Background
Methodist Le Bonheur Healthcare partnered with faith-based groups such as the Congregational Health Network (CHN) to improve and maintain a smooth care transition from inpatient hospital admission to home.

Results
An analysis of 473 CHN participants found that the mortality rate was nearly one-half of the rate for nonenrolled patients with similar characteristics. The same study also found that CHN members had lower health care charges than nonparticipants, lower inpatient utilization and higher patient satisfaction with the health care system overall.

Background
Griffin Hospital determined there were too many readmissions for patients with congestive heart failure. To reduce this number, Griffin Hospital began partnering with long-term care organizations such as nursing homes and home health agencies to standardize protocols and patient education materials.

Results
CHF readmissions at Griffin Hospital fell from 15 percent to 7 percent during the course of the project. From 2010 through 2011 alone, the internal heart to heart failure readmissions decreased from 13.2 percent to 8.6 percent, and heart failure to any readmission decreased from 30.2 percent to 23 percent.
Background
CHA implemented several public health community programs to address pediatric asthma, obesity and chronic disease management. The Children’s Asthma Program developed a web-based registry for pediatric patients that tracks treatments and outcomes and provides decision support prompts. The centralized complex care management program provides a multidisciplinary team that engages patients and helps them with a variety of clinically and nonclinically related tasks. The Institute for Community Health and the Cambridge Health Department partnered to prevent obesity by developing programs, supporting policy changes and utilizing volunteer health advisors to provide education on diabetes prevention at community events and local churches.

Results
Over five years, CHA admissions for pediatric asthma fell by 45 percent and pediatric emergency department visits fell by 50 percent. Over six months of operation, the centralized complex care management program generated a 5:1 return of investment. From 2004 to 2007, 40 percent of children who were overweight moved into the healthy weight category.
Background
Kaiser Permanente supports all aspects of a person’s well-being and examines every aspect of the organization to determine how it contributes in a positive way to total health. Kaiser Permanente created programs in both the clinic and the community to support the full continuum of health for members.

Results
The Community Health Initiatives have expanded from just three communities eight years ago to more than 40 locales. In addition, Kaiser Permanente has been a partner for high-profile health initiatives such as “The Weight of the Nation” documentary and other programs targeting obesity in America.
Background
Georgia Health Sciences Health System partnered with patients and families in all aspects of the health care system’s operations. Patient and family advisors were instrumental in providing input into key operational and strategic decisions including anesthesia staffing, medication dispensing, patient handoffs, patient and family rounding, patient safety and the design of new services.

Results
In a three-year period, patient satisfaction scores increased and medication errors declined.
Background
To slow the rise of annual health care spending, Bellin Health System searched for innovative ways to reduce costs, while still improving the availability and quality of care. Bellin developed and established employee health and wellness programs that offer comprehensive resources to help employees make sustainable lifestyle and behavior changes, customized work solutions and a comprehensive navigation platform to guide patients and ensure they receive the appropriate level of care.

Results
Since 2002, the cost of employee health coverage at Bellin has not increased. An estimated $10 million savings in employee health costs was also projected over a five-year period.

Background
Sentara Healthcare found that 20 percent of its employees were responsible for 80 percent of the organization’s health care costs. To cut costs, Sentara established a wellness program, Mission: Health, that provides monetary incentives to encourage employees to actively manage their health. For example, employees identified as low-risk receive more than $500 in annual premium reductions while those considered high-risk are given an opportunity to earn the award by partnering with a health coach.

Results
During the first year, 85 percent of participants who were identified as high-risk and monitored in the program maintained or improved their critical health risks. In 2010, Sentara Healthcare also saved $3.4 million in health care costs.
Health Care User Engagement at the Organization Level: Saint Elizabeth’s Medical Center (SEMC)

Background
SEMC built a robust program, WellnessWorks, to create a culture of wellness, address high claims of utilization and serve as an example to its community. WellnessWorks encouraged employee participation in activities that promoted physical exertion and improved nutrition. For example, employees receive a $50 reward for completing an annual physical, a yearly dental checkup, a flu shot and a biometric screening/consultation and earn up to $200 for completing tiered exercise and nutritional requirements.

Results
In 2011, more than 60 percent of employees were participating in on-site wellness programs and activities. Over a five-year period, participants experienced 67 percent reduction in high-risk total cholesterol, 36 percent reduction in high-risk LDL cholesterol and 56 percent reduction in pre-diabetes.
Background
CCHMC focused on patients, families and the health care team when designating and implementing an approach for patient- and family-centered rounds. CCHMC instituted a patient and family experience committee to address unsolicited patient and family concerns. The goal was to address concerns as they happened while the family was still in the hospital so that staff could strengthen the lines of communication and mitigate negative perceptions and feedback as much as possible.

Results
CCHMC monitored feedback from nurses, residents, attending physicians and the families. The process evolved based on this feedback. Within one year, family-focused teaching rounds were standard throughout the organization. CCHMC also monitored patient and family satisfaction scores as well as anecdotal information from providers participating in the rounds to see where changes could be made.
Background
Helen DeVos Children’s Hospital revised its procedure for rounding and wanted the multidisciplinary team to involve the family and the patient in the decision-making process as well as participate in clinical readiness for discharge. The multidisciplinary team utilizes the families’ input, values the information that they provide and asks them to actively participate in making the care plan.

Results
Since implementing family-centered rounds, nursing units have raised their patient satisfaction scores from below the 50th percentile to greater than the 90th percentile on a consistent basis. Although the family-centered rounds may not be the only reason for these higher scores, families have responded positively about their involvement in rounds and feel better prepared for discharge.
Background

IMDF supports research projects on shared decision making at both primary and specialty care demonstration sites across the country. IMDF facilitates a learning community, provides patient surveys to help evaluate decision aids and their impacts, provides access to a secure online data warehouse to capture patient survey data and performs data analyses on survey process measures.

Results

From 86 trials in six countries of 34 different types of decisions, a study found that decision aids led to greater knowledge, higher accuracy in risk perceptions, lower decisional conflicts, higher participation in the decision making and fewer individuals that were undecided about their care.

Health Care User Engagement at the Health Care Team Level: Emory Healthcare

**Background**
Emory Healthcare had patient and family advisors contribute to the development of protocols for conducting bedside change-of-shift reports and serve as instructors in training front-line staff.

**Results**
Patient satisfaction increased with overall nursing care augmenting from the 41st to 78th percentile in Press Ganey satisfaction scores. Quality outcomes also improved, Hospital-acquired pressure ulcers decreased from 8.15 percent to 2.5 percent, and patient falls from 3.24 to 2.85 falls per 1,000 patient days.
Background
Visiting hour restrictions were eliminated at three New Jersey hospitals in the Atlantic Health System to further encourage patient and family engagement. The open visitation policy was established with input from administration, nursing, medical staff, trustees, security, and patients and families.

Results
Patient satisfaction scores at the hospital increased and an internal staff survey showed strong support for continuing the open visitation policy.

(As of January 2013, a peer-reviewed journal article about Atlantic Health System’s flexible visiting hours is pending.)
Background
Geisinger Health System established a medical home model, ProvenHealth Navigator, designed to reduce “downstream” costs from the highest acuity by moving resources “upstream.” More services are rendered in primary care as the starting point of the chain of care delivery.

Results
ProvenHealth Navigator improved health coordination, enhanced patient access to primary care providers and provided more effective and efficient disease and case management. Over time, the program also reduced costs. Geisinger’s estimated total cumulative savings was 7.1 percent (based on the model that accounts for the prescription drug coverage interaction effects) and 4.3 percent (based on the model that does not account for the interaction effects) from November 2007 to December 2010.

Background
Howard University Hospital provided patients in its diabetes program access to personal health records to assist them in monitoring a range of clinical indicators pertinent to diabetic health. Through this initiative, clinicians are able to check how their patients are doing and follow up with them between visits. Patients are invited to enroll in the program and get assistance setting up the public health record and receive training and ongoing support.

Results
Hemoglobin A1c levels fell by approximately 13 percent for patients participating in the program compared to an increase in levels for those not participating.
**Background**
Ryhov Hospital transitioned more than 52 percent of its traditional peritoneal and hemodialysis patients to a self-management program, training patients interested in managing their own dialysis.

**Results**
The 52 percent of dialysis patients who are on self-dialysis had fewer side effects and lower infection rates.
Many promising technologies and practices are being tested and many are yet to be discovered. Topic areas that are likely to have some significance in the future of health care user engagement include:

- Consideration and integration of behavioral health and mental health as they relate to engagement at all four levels—community, organization, team and individual
- Role of health plans as significant stakeholders in the engagement process
- Role of employers as drivers for creating a culture of health
- Emergence of new technologies that will facilitate patient, family and provider interactions; health education; treatments and overall engagement
- Role of social media as a means to enhance communication and networking with individuals and communities
Resources to Improve Health Care User Engagement

AHA Resources

Hospitals in Pursuit of Excellence

AHA Guides

Caring for Vulnerable Populations
A Call To Action: Creating a Culture of Health
Patient-Centered Medical Home
Accountable Care Organizations: An AHA Research Synthesis Report

Other Resources

Informed Medical Decisions Foundation
Guide to Patient and Family Engagement
Crossing the Quality Chasm: A New Health Care System for the 21st Century