Patient Engagement in the Population Health Management Era

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President, Population Health Services
Agenda

I. Overview of Mercy Health
II. History of patient engagement
III. Barriers to successful engagement
IV. Framework for consideration
V. Examples
VI. Lessons learned
Mercy Health

Who We Are
One system serving eight markets in Ohio and Kentucky.

8 Regions served across Ohio & Kentucky
~1,450 Mercy Health employed physicians
450 Number of Mercy Health locations
23 Number of Mercy Health hospitals
Mercy Health & Advanced Health Select ‘Network of Networks’

- Population Health Services Organization (PHSO) supports MHS and AHS
- Over 3,400 Providers are part of Advanced Health Select
MHS risk lives: Our population health patients 4 years into transformation

1. Medicare
   - Medicare Shared Savings Program (MSSP Track 3) & Bundle Payments
   - Elderly population, care management central to trend management
   - Covered lives: ~70k

2. Medicare Advantage
   - At-Risk Contracts
   - Elderly population, care management central to trend management
   - Covered lives: ~25K

3. Self Insured
   - Mercy Health
   - Commercial population, Savings accrue MHS
   - Covered lives: ~47k

Mercy Health Select currently manages roughly 140,000 lives in various accountable care relationships
MHS managed populations

140,000 Attributed lives

$1.1B Medical spend

- MSSP Track 3: $669M
- Medicare Advantage: $203M
- Commercial (MH Employees): $205M

33% MSSP Track 3
49% Medicare Advantage
18% Commercial (MH Employees)
Picker Institute “Principles of Patient-Centered Care” (1987)
Quick (modern day) history lesson: patient engagement in context

• 2001 IOM Crossing the Quality Chasm calls for “patient-centered care” as one of six aims.

• 2009 ACA mentions “patient-centered care” 43 times.
  • References patient engagement, patient experience, health literacy, shared decision making

• 2015 MACRA charges the Secretary to prioritize patient reported outcome measures, patient experience measures, and care coordination measures.
HHS incentivizes providers to engage patients (i.e. Meaningful Use)

<table>
<thead>
<tr>
<th>Eligible Professional Core Objectives</th>
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<tbody>
<tr>
<td>Computerized Physician Order Entry (CPOE) for Medication, Laboratory and Radiology Orders</td>
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<tr>
<td>D1 - Improve Quality, Safety, Efficiency</td>
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<tr>
<td>e-Prescribing (eRx)</td>
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<tr>
<td>Record Demographics</td>
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<tr>
<td>D1 - Improve Quality, Safety, Efficiency</td>
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<tr>
<td>Record Vital Signs</td>
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<tr>
<td>D1 - Improve Quality, Safety, Efficiency</td>
</tr>
<tr>
<td>Record Smoking Status</td>
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<tr>
<td>D1 - Improve Quality, Safety, Efficiency</td>
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<td>Clinical Decision Support Rule</td>
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Measurement framework (i.e. HHS and ACO)

OVERALL MEASURES

ACO Measures #1-7: Patient/Care giver experience

<table>
<thead>
<tr>
<th>Intermediate Outcomes</th>
<th>Expenditures</th>
<th>Experience</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Expenditures</td>
<td>Healthcare Expenditures</td>
<td>Patient Activation</td>
<td>Functional Health</td>
</tr>
<tr>
<td>Public Health Expenditures</td>
<td>Access to Care</td>
<td>Health Risk</td>
<td>Health Risk</td>
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<tr>
<td>Patient Expenditures</td>
<td>Communication with Healthcare</td>
<td>Disease/condition</td>
<td>Disease/condition</td>
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<tr>
<td>Enabling Service Expenditures</td>
<td>Shared Decision-making</td>
<td>Site of Care</td>
<td>Site of Care</td>
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<tr>
<td>Access to Enabling Services</td>
<td>Access to Enabling Services</td>
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Source: Office of the National Coordinator for Health Information Technology
Definitions

Engagement: Employing strategies to motivate patients to access and use services and tools to manage their illness.

Self-management: Process patients can use to look at their health behaviors and then make choices to improve their health based on their knowledge, skills, and attitudes.
Barriers to patient engagement

**System**
- Culture (Hoteling services)
- Infrastructure
- Incentives & financing

**Patient**
- Activation
- Literacy
- Diversity
- Social determinants of health & digital divide
- Incentives & financing (Employer-based)

**Provider**
- Culture (Doc knows best)
- Infrastructure
- Incentives & financing
Relative influence of major factors affecting health promotion

Factors influencing health promotion

- Lifestyle & behaviors: 50%
- Human biology: 20%
- Environment: 20%
- Medical care: 10%

Roughly 95% of all health care dollars go to direct medical care services, ~5% are allocated to population health.

Three phases to achieve value (quality/costs) in population health:

Phase 1

Primary care:
The hub for managing populations: preventive services, chronic illness, high risk

Continuity of Care:
Reduce readmissions through coordinated care

Phase 2

Specialty care:
Where a large fraction of costs are incurred, especially in commercial populations

Patient engagement:
Involving patients in better self-management of care

Phase 3

Wellness Promotion:
Programs to prevent or delay the progression of illness

Ongoing: IT, analytics and central infrastructure
### 2016 priority MHS programs: Primary & Continuity of care

<table>
<thead>
<tr>
<th>Setting</th>
<th>Initiative</th>
<th>MHS Program</th>
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<tbody>
<tr>
<td>Primary Care</td>
<td>Manage high risk population health patients</td>
<td>• Ambulatory care coordination program</td>
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<td></td>
<td>Enroll &amp; engage PHP in prevention and wellness</td>
<td>• Chronic disease management program</td>
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<td></td>
<td>Reduce unplanned readmissions</td>
<td>• Population health pharmacy program</td>
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<td>Reduce post acute variation</td>
<td>• Risk score accuracy program</td>
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<td></td>
<td></td>
<td>• Clinical decision support program</td>
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<tr>
<td>Continuity of care</td>
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<td>• Prevention and outreach program (Primary care 10 &amp; ACO measures)</td>
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<td>• Care transitions program</td>
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<tr>
<td></td>
<td></td>
<td>• Readmissions initiatives</td>
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<td></td>
<td>• SNF Coordinated Care Network</td>
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### Why these programs?

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Develop team based care</th>
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<tr>
<td></td>
<td>Manage chronic diseases and focus on prevention</td>
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<tr>
<td>Continuity of care</td>
<td>Demonstrate value in bundles/procedures</td>
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<tr>
<td></td>
<td>Reduce readmissions and post acute variation</td>
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<tr>
<td>IT &amp; Analytics</td>
<td>Information -&gt; Insight -&gt; Action</td>
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Care Model

Intensity of intervention based on risk stratification

- **Critical**
  - Care transitions
  - Pharmacy medication therapy management
  - Palliative care and End Stage Renal Disease programs

- **High**
  - Ambulatory care coordination
  - Geisinger readmission tool
  - Coordinated care network for Skilled Nursing Facilities

- **Moderate**
  - Advanced clinical decision support
  - Telesurance management by exception
  - Telehealth (Video visits, e-Visits)

- **Low**
  - Evidence based guideline adherence
  - Prevention outreach campaigns
  - Close care gaps
MHS patient engagement strategy

1. Inform patients
   - Information
     - Maps, directions, after visit summary
     - Services & Physician directory (Kyruus)
   - Wayfinding
     - Services & Physician directory (Kyruus)
   - Education
     - Care plan, informed consent, advanced directives

2. Engage patients
   - Prevention, outreach
   - Shared-decision making
   - Remote monitoring, tracking, actionable analytics
   - Patient Reported Outcomes
   - Non face-to-face access
     - Telehealth (video, e-visits)
     - Patient portal (MyChart Lab, test results, open scheduling)

3. Empower patients
   - Price transparency
   - Social communities
   - Patient portal
     - MyChart open notes, mobile access, self management
   - Incentives and behavioral economics

Broad patient engagement
Independent self management of health and wellness
Partnership-driven community engagement
Inform patients: Physician directory

The Kyruus ProviderMatch™ Suite of Products optimizes patient access across all points of service.

**ProviderMatch for Access Centers**
Customer service application for schedulers and access professionals

**ProviderMatch for Consumers**
Self-service tool for physician search and online scheduling

**ProviderMatch for Network Referrals**
Point-of-service application for office staff and referral coordinators
Inform patients: Longitudinal plan of care

The Longitudinal Plan of Care Report provides longitudinal care for patients across visits and providers. It emphasizes the importance of communication a patient's plan between providers and ensuring continuity in patient care.
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Engage patients: Prevention and outreach

What is it?
• Outreach campaigns for prevention and closing care gaps for Hypertension and Diabetes.
• Birthday letters (2016), IVR Phone

Why is it important?
• Improves health, reduces chronic disease and cancer burden.
• Permits providers to meet quality measures

Progress to date
Completed Campaigns
• 2015: Colorectal and breast cancer Screening, Pneumococcal Vaccine
• 2016: Diabetes, MyChart flu, Pneumococcal Vaccine
Outreach program to reduce ED Visits

Chronic Program Impact
2015 ED Visits Per 1000 MSSP (HF, COPD, hDM)

40% Reduction

ED Visits Per 1000

January  February  March  April  May  June  July  August  September  October

TA Chronic Enrollment  Non-TA ED Visits Per 1000  TA ED Visits Per 1000

Average Non TA APK  Average TA APK

1324  2021  1491  793
Engage patients: MyChart enrollment

Total active patients = 337,184
Total results released = 4,344,822
Total appointments scheduled = 15,653
Engage patients: Telehealth

Survey Finds Email Visits Preferred to Clinic Near Errands or Work

Preference for Location of Services

- Clinic location near work
- Clinic located near errands
- Emailing provider with symptoms
- Clinic located near the home

Increasing Consumer Preference

Stepwise Workflow Implementation

- High
- Remote Monitoring
  - eICU
  - Home monitoring
  - Personal Devices

- Synchronous Care
  - Video Visits
  - Point to Point Video Consults

- Asynchronous Care
  - Video Visits
  - Point to Point Video Consults
  - Telephone

- Patient Messaging
  - E visits
  - Tele-consults

Low

Technological Complexity

Low

High
Engage patients: Shared decision making

Current state:
- Incorporating communication tools into daily practice has proved challenging.
- Patients don’t often receive information on their personal risks for a procedure.

Patient concerns:
- What are the risks and benefits for patients like me?
Engaging patients using graphs and numbers to display personalized risks
Incorporating personalized risk information into the consent process

Based on my personal health, my risks for this procedure are:

<table>
<thead>
<tr>
<th>Specific Risks</th>
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<tbody>
<tr>
<td>Death</td>
<td>2.0%</td>
</tr>
<tr>
<td>Long Length of Stay**</td>
<td>5.9%</td>
</tr>
<tr>
<td>Permanent Stroke</td>
<td>0.3%</td>
</tr>
<tr>
<td>Long time on ventilator</td>
<td>12.1%</td>
</tr>
<tr>
<td>Chest wound infection</td>
<td>0.4%</td>
</tr>
<tr>
<td>Kidney Failure</td>
<td>0.7%</td>
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</tbody>
</table>

**Average overall risks for CABG from the Society of Thoracic Surgeons (STS) database

**More than 14 days

<table>
<thead>
<tr>
<th>Average overall risk for patients who receive heart surgery*</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td>1.9%</td>
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<tr>
<td></td>
<td>5.1%</td>
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<tr>
<td></td>
<td>1.3%</td>
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<td></td>
<td>10.1%</td>
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<td></td>
<td>0.2%</td>
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<tr>
<td></td>
<td>2.4%</td>
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Patient Reported Outcome Measures: Demonstrating value to patients

Direct collection of information from patients regarding symptoms, functional status, and mental health.

- **Tier 1: Health status achieved**
- **Tier 2: Process of Recovery**
- **Tier 3: Sustainability of Recovery**
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Price transparency: Consumerism in healthcare

Figure 1: Distribution of Total ESI Spending by Shoppable/Non-Shoppable Services, 2011

- Shoppable Outpatient/Physician Services: 34%
- Non-shoppable Inpatient Facility Services: 14%
- Non-shoppable Outpatient/Physician Services: 33%
- Shoppable Inpatient Facility Knee and Hip Replacements: 1.3%
- Shoppable Inpatient Facility Services: 7%
- Prescription Drugs: 11%

Source: HCCI, 2016. Claims data from employer-sponsored insurance (ESI) population younger than age 65 for the year 2011, data weighted to be nationally representative.
Empower patients through social communities

patientslikeme

Learn from others
Compare treatments, symptoms and experiences with people like you and take control of your health

Connect with people like you
Share your experience, give and get support to improve your life and the lives of others

disaboom
CONNECTING THE MILLIONS TOUCHED BY DISABILITY

community
Empower patients: Transparency with Epic’s open notes

Share Clinicians’ Notes with Patients in MyChart

Providing patients with access to physician-documented progress notes can have a positive impact on patient-centered care. Research studies conducted by the non-profit OpenNotes organization have shown improvements in patient compliance to the transparency provided by sharing progress notes.

You can use your After Visit Summary report in MyChart as a way for clinicians to share their progress notes and notes from Hyperspace.

When clinicians write their notes in Hyperspace, they can use the Share w/ Pt button to share the note.

Progress Notes (F3 to enlarge)

John Hess is a 65 yo male who presents for a welcome to Medicare exam. His last medical examination was approximately 2 years ago. In addition to his routine examination, he reports a 5-day history of sinus congestion, post-nasal drainage, and a non-productive cough. He has used an over-the-counter cough medicine with some improvement. He reports he has been...
Empower patients: interactive self management

Due Date Calculator
Find out your due date and get daily info about your developing baby

Everyday Health Log
Keep track of your pregnancy through daily logging

Health Insights
Personalized insights guide you through a healthy pregnancy

Appointments
Glow Nurture takes care of the planning for you!
UnitedHealthcare Motion™ provides employees enrolled in fully insured health plans with wearable devices at no additional charge to earn financial reimbursement incentives up to $1460 per year.
INCENTIVE TARGETS:

**FREQUENCY**
300 STEPS IN 5 MINUTES

✅ Achieve by¹:
- Shopping for groceries
- Mopping the floor
- Dancing
- Washing a car
- Gardening

**INTENSITY**
3,000 STEPS IN 30 MINUTES

✅ Achieve by¹:
- Taking an aerobics class
- Playing in a tennis match
- Practicing yoga
- Mowing the lawn
- Skiing

**TENACITY**
10,000 STEPS IN ONE DAY

✅ Achieve by²:
- Going for a 15-minute run
- Cycling to work
- Taking the stairs
- Cleaning the house
- Walking for 30 minutes
CONCLUSIONS AND RELEVANCE  In primary care practices, shared financial incentives for physicians and patients, but not incentives to physicians or patients alone, resulted in a statistically significant difference in reduction of LDL-C levels at 12 months. This reduction was modest, however, and further information is needed to understand whether this approach represents good value.
Effect of Financial Incentives to Physicians, Patients, or Both on Lipid Levels
A Randomized Clinical Trial

Mean LDL_C Levels by Quarter in Intervention and Control Groups

Shared incentives produce lowest LDL levels
Effect of Financial Incentives to Physicians, Patients, or Both on Lipid Levels
A Randomized Clinical Trial

Mean Weekly Medication Adherence by Intervention Group

Shared incentives produce highest adherence

Adherence was calculated by dividing the number of pill bottle openings per week by 7. Standard deviation for the shared patient-physician incentives group was 1.8%; patient incentives, 2.4%; physician incentives, 5.5%; and control, 4.4%.
Lessons learned

• Patient engagement is still nascent.
• Aligned incentives can produce greater engagement and reduce costs.
• There is no silver bullet: engagement requires a multifaceted approach.
• Empowering patients will likely require significant investment.
"We want to include you in this decision without letting you affect it."
THANK YOU

CEMilford@mercy.com