Partnering with Patients: The Role of the Home Care Agency in Promoting Patient Engagement

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Objectives:

1. Compare the concepts of patient empowerment and the impact these definitions have on identification of successful outcomes.

2. Identify the importance of patient empowerment being supported by the home health agency.

3. Identify 3 competencies needed within agency to improve patient engagement (PE) outcomes.
Definitions:

- **Patient Engagement**
  “promote and support active patient and public involvement in health and healthcare and to strengthen their influence on healthcare decisions” (Coulter, 2011)

- **Patient Empowerment**
  Process of personal transformation. Empowerment may be a personal internal process, that is “created” within someone or created through interaction between 2 or more people. (Aujoulat et al., 2006).

- **Patient Activation**
  4 Stages: (1) believing the patient role is important, (2) having the confidence and knowledge necessary to take action, (3) actually taking action to maintain and improve one’s health, and (4) staying the course even under stress. (Hibbard et al, 2009)

- **Patient Self-Management**
  Personal management of health and illness. Includes medical management, role management and emotional management. (Lorig et al, 2003)

Commonalities

- philosophy of practice
- collaborative relationships
- focus on patient as decision maker
What makes this an imperative in home care today?

- Changing Demographics
- Computer Savvy patients
- Expectation of Inclusion
- Critical to successful outcomes

What changes are ahead?

- Patients
  - Aging in place
  - Diversity
  - Computer Savvy
  - Increased chronic illness
  - Self-Management

- Environment
  - Participatory medicine
  - Minimally disruptive medicine
  - Health Policy
  - Social Media

- Home Health Care Agencies
  - Learning Organizations
  - Nimble Leaders
  - Data driven
  - Collaborate
  - APN's
  - Social Media

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Percentage Increase of Oldest of Old (85+) 1995 to 2020

Source: U.S. Bureau of the Census

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Change in Race and Origin 2010, 2050

![Graph showing population age 65 and over, by race and Hispanic origin, 2010 and projected 2050.]

NOTE: These projections are based on Census 2010 and are not consistent with the 2010 Census results. Projections based on the 2010 census will be released in the 2012 "Population and Housing Characteristics of the United States". The term "Non-Hispanic White alone" is used in table to refer to people who reported being White and no other race. The "All other races alone or in combination" includes American Indian and Alaska Native alone, Native Hawaiian and Other Pacific Islander alone, and all people who reported two or more races.

SOURCE: U.S. Census Bureau, 2010 Census Summary File 1: U.S. Census Bureau, Table 4: Projections of the population by sex, race, and Hispanic origin for the United States: 2010 to 2050 (IP2006-4).

Computer Use Among Older Adults

- In 2010.....
  - 56% adults > 65 reported use of a internet or email
  - 46.2% reported using computer to search for health care information
  - 34% report using social media

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Seniors and Social Media

Facebook for Centenarians: Senior Citizens Learn Social Media

Assisted and independent living residents struggling with boredom are learning how to use email, Facebook, and Twitter to reconnect with old friends.

Dealing with the “Quantified Self”
Wireless Future of Medicine

Chronic Illness

Occurrence:
- 7 out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer and stroke account for more than 50% of all deaths each year.
- In 2005, 133 million Americans – almost 1 out of every 2 adults – had at least one chronic illness.
- About one-fourth of people with chronic conditions have one or more daily activity limitations.
- Polypharmacy often occurs with patients with chronic illnesses.

Life Style Diseases:
- Obesity has become a major health concern. 1 in every 3 adults is obese and almost 1 in 5 youth between the ages of 6 and 19 is obese (BMI ≥ 95th percentile of the CDC growth chart).
- Arthritis is the most common cause of disability, with nearly 19 million Americans reporting activity limitations.
- Excessive alcohol consumption is the third leading preventable cause of death in the U.S., behind diet and physical activity and tobacco.

http://www.cdc.gov/chronicdisease/overview/index.htm
Patient Activation is...

- Understanding that one must take charge of one’s health and that personal actions determine health outcomes.
- A process of gaining skills, knowledge, and behaviors to manage health
- Confidence to make needed changes

*Increased activation results in improved health behaviors.* (Hibbard, 2004)

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The Questions (PAM-13)

1. When all is said and done, I am the person who is responsible for managing my health condition.
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function.
3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.
4. I know what each of my prescribed medications do.
5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.
6. I am confident that I can tell a doctor concerns I have even when he or she does not ask.
7. I am confident that I can follow through on medical treatments I need to do at home.
8. I understand the nature and causes of my health condition(s).
9. I know the different medical treatment options available for my health condition.
10. I have been able to maintain the lifestyle changes for my health condition that I have made.
11. I know how to prevent further problems with my health condition.
12. I know how to prevent further problems when new situations or problems arise with my health condition.
13. I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.
Conviction Readiness Ruler

On a scale of 1 to 10, how important is it for you to make a change?

Example, If you are a 5, why are you a 5 and not a 3?
Or if you are a 5, what needs to happen for you to go to a 7?
How could I assist you in getting to a 7?

Confidence Ruler

On a scale of 1 to 10, how confident are you that you could make a change if you wanted to?

Example, If you are a 5, why are you a 5 and not a 3?
Or if you are a 5, what needs to happen for you to go to a 7?
How could I assist you in getting to a 7?
What the Ruler Measures

• Importance (Conviction)
  • Willingness to change
• Confidence
  • In one’s ability to change
• Readiness
  • A matter of priorities

(Miller & Rollick, 1994)

Confidence + Importance = Readiness
Building Confidence

- Review past successes
- Define small steps that can lead to success
- Problem solve to address barriers
- Provide tools strategies, resources, teach skills
- Note progress and use slips as occasions to further problem solve rather than failure

Patient Expectations of Self-Management

- Access to information
- Involved in decision making
- Identify own goals
- Dialogue in care plan development
Access to Information

Patients who had access to their medical records reported:

• Positives:
  • Better communication with providers
  • enhanced knowledge of health and improved self care
  • greater participation in and improved decision making
  • improved quality such as f/u on abnormal tests
  • Identified errors or inconsistencies and had corrected

• Negatives:
  • seeing previously undisclosed information
  • derogatory language (SOB?)

(Woods et al, 2013)

Current Participants:

the door is wide open, the room is filled, and we’re ready to design new ways to give consumers/patients their own health information in the most meaningful way.

Susan Woods, 2013
Patients who had access to their medical records reported:

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A Patient-Centric Definition of Participatory Medicine:
Participatory Medicine is a movement in which networked patients shift from being mere passengers to responsible drivers of their health, and in which providers encourage and value them as full partners.

The Society for Participatory Medicine is a 501(c) 3 devoted to promoting the concept of participatory medicine, a movement in which networked patients shift from being mere passengers to responsible drivers of their health, and in which providers encourage and value them as full partners.
Statin Decision Aide

**People at higher risk of CV events (17% over 10 years)**

- Imagine 100 people at the level of a healthy 50-year-old. About 17% of them will have a CV event.

However, if none of the 100 people were to take a drug for 10 years:
- *Outcomes:*
  - 100 people will not have a CV event.
  - About 170 people will have a CV event.

**Dialogue in care plan development**

**SHEAR Communication Technique for Patients & Advocates**

- **S (Statement):** What are your goals or concerns about your care? Please share your thoughts.
- **H (Hypothesis):** Based on our conversation, what might be the cause of your concerns?
- **E (Evidence):** What evidence or data supports your hypothesis? Can we gather additional information?
- **A (Action):** What steps can we take to address your concerns? How can we work together to improve your care?
- **R (Review):** Let’s review our discussion and actions. How does this plan sound to you? Is there anything else you would like to add?
Minimally Disruptive Medicine

Shared decision making enables patients and clinicians to share the best available research evidence and make decisions that better reflect the patient's values and preferences. Minimally disruptive medicine focuses on pursuing the patient's goals (preventing premature death, feeling better, and living without hindrance from complications of disease or treatment) while reducing the treatment burden.

What Can Your Agency Do?

• Become a Learning Organization
  • Look to future
  • Walk the talk
  • Value your most precious asset: employees

• Coaching/SMART Goals/MI (Motivational Interviewing)/ Teachback
Learning Organizations are....

organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together.

Peter Senge

“In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

— Eric Hoffer
Learning Organizations have mastered:

- Building shared vision
- Development of Mental models
- Systems thinking
- Personal mastery
- Team learning

Building shared vision

Vision

Sharing.
Mental Models

• Front Line is where the answer is
• Team approach
• Respect for all individuals on team
• Power of the individual
• Share the vision: walk the talk
• Cut waste!

IOM Workgroup

*Values and Principles of High Functioning Health Care Teams*

- Clear roles
- Mutual trust
- Effective Communication
- Shared Goals
- Measurable processes and outcomes

- Expectations, responsibilities and accountabilities
- Trust leads to shared achievement
- Continually refine communication skills
- Reflects patient priorities and are understood by all members
- Reliable feedback on overall functioning of the team and achievement of specific goals
Personal mastery

• **Learning.** An emphasis on learning and development is necessary so that people can share, understand and contribute to what’s going on.
• **Empower** your employees
• **Provide** the skills, tools and expertise needed to do the job
• Learn to work in a **team:** rules, expectations, outcomes

Building Blocks of a Learning Organization

1. A supportive learning environment
   • Differences in opinion are welcome
   • Unless an opinion is consistent with what most people believe, it won’t be valued
   • People value new ideas.
   • Unless an idea has been around for a long time, no one wants to hear it.
   • Despite the workload, people find time to review how the work is going.
Building Blocks to Learning Organization

2. Concrete learning processes and practices
   • Experiments frequently with new ways of working.
   • Have a formal process for conducting and evaluating experiments or new ideas.
   • Team systematically collects information on
     • competitors
     • customers
     • economic and social trends
     • technological trends
     • best-in-class organizations
   • Newly hired employees receive adequate training.

Building Blocks cont’d

3. Leadership that reinforces learning
   • My managers invite input from others in discussions.
   • My managers acknowledge their own limitations with respect to knowledge, information, or expertise.
   • My managers ask probing questions.
   • My managers listen attentively.
   • My managers encourage multiple points of view.
   • My managers provide time, resources, and venues for identifying problems and organizational challenges.
   • My managers provide time, resources, and venues for reflecting and improving on past performance.
   • My managers criticize views different from their own.

For complete survey, go to: los.hbs.edu
Or learning.tools.hbr.org (shortened version)
### Benchmark Scores

<table>
<thead>
<tr>
<th>Support Learning Environment</th>
<th>Scaled Scores</th>
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<tbody>
<tr>
<td></td>
<td>First quartile</td>
<td>Second quartile</td>
<td>Median</td>
<td>Fourth quartile</td>
<td>Top quartile</td>
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<tr>
<td>Appreciation of differences</td>
<td>14–50</td>
<td>15–40</td>
<td>18–60</td>
<td>20–60</td>
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<td>Openness to new ideas</td>
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<td>Time for reflection</td>
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<td>15–40</td>
<td>18–60</td>
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<td>Learning environment composite</td>
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<td>32–35</td>
<td>34–60</td>
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</tbody>
</table>

| Concrete Learning Processes and Practices                        | Scaled Scores |          |          |          |          |
|                                                                  | First quartile| Second quartile | Median | Fourth quartile | Top quartile |
| Experiential                                                     | 18–50         | 19–40    | 20–60    | 22–60    | 22–60    |
| Information collection                                            | 23–70         | 24–60    | 24–60    | 24–60    | 24–60    |
| Participation                                                     | 20–60         | 21–50    | 22–50    | 22–50    | 22–50    |
| Feedback and training                                            | 36–50         | 37–60    | 37–60    | 37–60    | 37–60    |
| Information transfer                                              | 34–60         | 35–60    | 35–60    | 35–60    | 35–60    |
| Learning processes composite                                      | 31–42         | 32–35    | 34–60    | 35–60    | 35–60    |

| Leadership that Reinforces Learning                              | Scaled Scores |          |          |          |          |
|                                                                  | First quartile| Second quartile | Median | Fourth quartile | Top quartile |
| Composite                                                        | 33–60         | 34–60    | 36–60    | 36–60    | 36–60    |

Note: The scaled scores for learning environment and learning processes were computed by multiplying each raw score on the seven-point scale by 1.2 and dividing by 170. For learning leadership, which was based on a five-point scale, the divisor was 16.

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### Barriers to a “learning organization”

- Defensive routines
- Dynamic complexity of systems
- Inadequate and ambiguous outcome feedback
- Misperceptions of the feedback
- Poor interpersonal and organizational inquiry skills
Provide Staff with Tools to Do the Job

• Access to Experts-live and on line
• Medication Reconciliation Support
• Time to implement what is expected:
  • Use of Motivational Interviewing
  • Coaching
  • Teach Back
  • Patient Activated Learning
  • Health Literacy
• Trust/Empowerment
The Staff Readiness for Future Survey

• Is your staff ready?

Motivational Interviewing (MI)

• Leads to better understanding of patient actions
• Incorporates patient into care planning
• Skills include:
  • active listening
  • SMART goal planning
  • Coaching
  • teachback
Where to start:
  Role playing in MI
  Select most problematic diagnosis, category
  Develop process expected of all staff
  Teach skills, provide tools
  Measure-process and outcomes
Create S.M.A.R.T. Goals

SPECIFIC
MEASUREABLE
ACHIEVABLE
REALISTIC
TIMELY

Smart Goal Work Sheet

SMART Goals
S: Specific
M: Measurable
A: Attainable
R: Relevant
T: Time Bound

SMART

Goal:
Active Listening

- Sensing
  - Postpone evaluation
  - Avoid interruptions
  - Maintain interest

- Active Listening

- Responding
  - Show interest
  - Clarify the message

- Evaluating
  - Empathize
  - Organize information

Coaching vs Teaching

- COACHING
  - Facilitator
  - Patient identified
    SMART goals
  - Patient/care partner
    centered
  - Improved motivation
  - Motivational interviewing/
    Active listening

- TEACHING
  - Teacher
  - Teacher identified
    goals/timelines.
  - “Expert centered”
### CHF Teach-Back Worksheet

**Patient/Resident Name:**

**Medicare:**  □ No  □ Yes

**Sending Facility Name:**

**Receiving Facility Name:**

**Auditing Agency:**

**Discharge Date:**

<table>
<thead>
<tr>
<th>Reason for Teaching</th>
<th>Patient can teach back what to do in case of an emergency.</th>
<th>Patient can teach back to family for heart failure every day.</th>
<th>Patient can teach back how to take medication as prescribed every day.</th>
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<tr>
<td><strong>Motivation</strong></td>
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<td><strong>Weight Management</strong></td>
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<td><strong>Learn Out</strong></td>
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**Total Score:**

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### Patient Activated Learning

**Patient Starts Out: Empowered**

- I have my list of questions
- I think I am ready
- This time I will say my peace

**The Medical Exam**

- Physician-Driven
- Bio-medical Focus
- Same for 80 yrs+

**Patient Leaves: Disempowered**

- What did he say?
- We didn’t agree on anything
- He ignored my questions
- I won’t share that again

**A Trip To The Doctor's Office or Medical Home From the Patient’s Perspective**

By Steve Wilkins
How to “walk the talk”: 

- What does your agency do if patient wishes to review their chart? (How complicated is it and how long does it take to comply?)
- How do you handle the “non-compliant” patient?
- How is it handled when nurse discovers patient is not taking a critical medication? (Teach vs Coach)
- How does your staff link clinical plan to patient self-identified goals?
- Do you routinely include in the clinical record:
  - Patient friendly list of medications, easily updatable
  - SMART goal planning sheets
  - Personal health record for patient (paper or electronic)
  - Teach back guides for relevant diagnosis
- Do you include these MI topics in your annual competency evaluations?
- Do you have specialists (pharmacist, advanced practice RN) available for consult?

Your Personal Readiness……

- Acknowledge the complexity of change
- Flexible
- Take care of your self
- Develop Critical competencies
- Build Personal Support system
Critical Competencies (Dye & Garmin, 2006)

1. Self Awareness
   - Living by personal conviction
   - Emotional intelligence

2. Compelling Vision
   - Visionary
   - Communicates vision
   - Earns loyalty and trust

3. Masterful Style

4. Style of Execution
   - Energize staff
   - Give feedback
   - Listen like you mean it
   - Mentor others

Role of APN

- Does your state allow you to have signed orders by APN?
  - Need to get this changed
- Increase role of APN in direct care and in-service education.
- Joint appointment with hospital and home care or MD office and your agency.
- Work with insurers to get reimbursement for APN’s
Use the tools patients now have:

I-phone
  - med reminders
  - videos of exercise program

Computer
  - electronic personal health space or
  - personal health record
  - medication lists(one true source)

Conclusion

- Steps to take:
  - What is the message from Sr. Management to front line staff?
  - Do we meet the criteria of a learning agency? If I am not sure, take the survey!
  - What are the education gaps within my staff and evaluate them using survey tool.
  - Does my agency reward the right behaviors and outcomes?
  - What 3 interventions can I select to implement in my agency when I go home?
  - What can I do to support myself?
References


References cont’d:


Questions/ Comments

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