Patient Engagement:
Competencies and Tools for Home Health and Hospice Providers

Paula Suter, BSN, MA
Beth Hennessey, BSN, MSN
Mag VanOosten, BSN

Sutter Care at Home
Sutter Health

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Learning Objectives

The learner will:

1. Define patient engagement and describe how engagement improves outcomes

2. List competencies needed to provide health literate care and facilitate shared decision-making

3. Evaluate tools for agency and staff use to promote patient health literacy and the shared decision-making process
What is Patient Engagement?

- Promoting and supporting active patient and public involvement in health and healthcare to strengthen their influence on healthcare decisions at both the individual and collective level. (Angela Coulter)

- Actions people take for their health and to benefit from health care. (Center for Advancing Health)

- One of the seven characteristics of an effective, efficient and continuously improving health system. (IOM Report: Best Care at Lower Cost)

- The holy grail of healthcare

- The blockbuster drug of the century

Why is Patient Engagement and Patient Centered Care So Important?

Associated with:

- Better health: Faster recovery, Improved clinical outcomes
- Better Care: Better care experience, More satisfaction with care
- Lower Cost: Decreased use of healthcare services, Lower annual charges
Patient Engagement and New Payment Models

Medicare Shared Savings Program

Ties reimbursement to effective patient communication and shared decision-making

Patient Engagement

Incentives based on HCAHPS scores

Medicare's Hospital Value Based Purchasing Program

Activation and Engagement

Interventions to improve self-awareness and knowledge

Low Activation (level 1)

Moderate Activation (level 2-3)

High Activation (level 4)

Interventions to improve skill and confidence

Interventions to improve problem solving, handling challenges

Engaged
The questions to ask yourself…

How can we deliver high quality care that better engages patients?

Are our clinicians equipped to do this?

Needed: A Multi-Dimensional Framework

- Too many Interventions focus only on patient factors
- Organizational and societal barriers must be addressed
- Organizations must seek to create the opportunities for engagement
A Multidimensional Framework for Patient and Family Engagement In Health and Health Care

Examples at the Organizational Level

Demonstrate patient participation and leadership is central to your organizational goals

- Care conference participation
- Open records
- Presence on committees
- Involved with new staff hires/ orientation
Prepare for the Future Now
CMS Focus on Post-Acute Care Quality

Recommendations:

- Develop a cohesive strategy to manage the patient journey post discharge in a way that reduces total cost of care
- Educate other sectors about capabilities and technologies available to assist

Source: Sg2, CMS Tightens Purse Strings. April 2nd, 2014

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Patient engagement requires knowledge, skill, and confidence

- Find a doctor and define the preferred relationship
- Articulate health issues
- Share, access, and evaluate information
- Negotiate decisions
- Develop partnership with the patient
- Identify/Review patient preferences and preferred role
- Identify choices
- Present evidence and help patient reflect

Shared decisions

Health literate tools and training

- Find a doctor and define the preferred relationship
- Articulate health issues
- Share, access, and evaluate information
- Negotiate decisions
- Develop partnership with the patient
- Identify/Review patient preferences and preferred role
- Identify choices
- Present evidence and help patient reflect

Improved satisfaction, outcomes and shared decisions

Source: E. Bernabeo and E. Holmboe (2013). Patients, providers, and systems need to acquire a specific set of competencies to achieve truly patient-centered care. Health Affairs 32, No. 2: 250-258
How is “Health Literacy” different from “Literacy”?

**Literacy**
- Having the basic skills to read, write and compute without regard to context

**Health literacy**
- Reading, writing, computing, communicating and understanding in the context of health care


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Health literacy: A matter of quality, cost and satisfaction

**Infographic:**

- 9 out of 10 adults have difficulty using health information that is routinely available.
- Patients with health literacy support:
  - Reduced costs: 5.3%
  - Reduced hospital admissions: 12.5%
- Annual healthcare costs:
  - 4x higher for low literacy compared to high literacy.
- Proficient health literacy skills: 12% of English-speaking adults in the U.S.

Patient engagement fundamentally relies on health literacy

Clear information about one’s health leads to greater patient empowerment and engagement; these, in turn, predict a desire for more health-related information.


This Approach is Appropriate for All Individuals Regardless of:

- Reading ability
- Education level
- Socio-economic status

Universal Precaution Approach

To Improve Understanding and Engagement

Use a universal precautions approach to health literacy with verbal and written materials.

Universal Precautions
Oral Communication Self Assessment

Found in AHRQ Universal Precautions Tool Kit
Enhancing Provider Competencies:
Make “the right thing to do, the easy thing to do”

Plain language cheat sheet for med list

<table>
<thead>
<tr>
<th>Avoid these:</th>
<th>Plain language alternatives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Take by mouth</td>
</tr>
<tr>
<td>Sub-lingual</td>
<td>Under the tongue</td>
</tr>
<tr>
<td>Topical</td>
<td>On the skin</td>
</tr>
<tr>
<td>Daily</td>
<td>One (1) time a day</td>
</tr>
<tr>
<td>PRN</td>
<td>Take as needed</td>
</tr>
<tr>
<td>QD</td>
<td>Every day</td>
</tr>
<tr>
<td>BID</td>
<td>Two (2) times a day</td>
</tr>
<tr>
<td>TID</td>
<td>Three (3) times a day</td>
</tr>
<tr>
<td>QID</td>
<td>Four (4) times a day</td>
</tr>
<tr>
<td>QOD</td>
<td>Every other day</td>
</tr>
<tr>
<td>Discontinue</td>
<td>Stop taking</td>
</tr>
<tr>
<td>Hypertension/HTN</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Intravenous/IV</td>
<td>In the vein</td>
</tr>
<tr>
<td>Med</td>
<td>Medicine</td>
</tr>
<tr>
<td>PO</td>
<td>By mouth</td>
</tr>
<tr>
<td>NPO</td>
<td>Nothing by mouth</td>
</tr>
<tr>
<td>UTI</td>
<td>Bladder infection</td>
</tr>
</tbody>
</table>

Verify Understanding
Teach-Back Competency Check List

Teach Back Method Competency Checklist

<table>
<thead>
<tr>
<th>NAME:</th>
<th>CRITERIA CHECKLIST</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Defines the concept and definition of Teach-Back.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Defines “plain language” and avoids technical terms.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Avoids jargon and technical terms where possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Uses open-ended questions and avoids closed-ended questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Uses plenty of writing (e.g., charts) for patients to review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Selects an appropriate experiential topic to teach the patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Maintains the locked teaching to full team prior that the patient must know in order to be</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>decreased safely. “Checks” together the information of each team.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Provides the information to the patient and their family/significant other.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Uses the patient in response to non-threatening statements, or asks a “teach-back” question related to the information that was taught to verify the patient’s understanding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Identifies any gaps in understanding and provides additional teaching until the patient is</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>able to teach-back the information that was given.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Fosters a climate where the patient feels comfortable speaking out loud. statements such as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I feel comfortable that I have achieved all the tasks…”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I just want to make sure that I have understood anything…”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I want to make sure that I have understood this material so many times…”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Demonstrates they understand the “Check for Teach” process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>tones.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional comments:

You get to hear in the patients own words:
- their understanding
- what is important
- how to best “connect” new information
Asking questions to understand persons preferences

These are some things you can work on that will help you return to gardening. Let's go over these options together.

What would you like to work on?

Use Shared Decision Making Approach to Goal Setting

My plan for controlling diabetes at home

<table>
<thead>
<tr>
<th>Things I can do</th>
<th>How I will do it:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check my blood sugar:</td>
<td>- Every day at different times of day - More often if I am sick - Before driving</td>
</tr>
<tr>
<td>Know about high blood sugar:</td>
<td>- Confused - Not like myself (change in personality)</td>
</tr>
<tr>
<td>Know about low blood sugar:</td>
<td>- Tired - Light headed or dizzy - Weakness</td>
</tr>
<tr>
<td>What would you like to work on?</td>
<td></td>
</tr>
</tbody>
</table>

I will...

Walk 15 minutes each day

Starting tomorrow

How will I do it?

Walk around my house for 15 minutes after lunch daily for the next week

What problem am I facing?

I may feel too tired to do it

How will I deal with these problems so I can do this?

Ask my husband to encourage me

How will doing this help me?

Will improve my energy level so I can work in my garden again

A member of my care team will follow up with me on March 2nd.

Your care team will work with you to set goals so you can stick to your plan.
Health Literate Care Competencies In Action

One Patient’s view on the Stoplight tool
http://bcove.me/ckmub1o1

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Evidence: Easy-to-read is Preferred!

College educated readers’ response to health information written at 5th grade level:

↑ Recall of key messages

↑ Satisfaction


Patient facing health literate tools:
Consistency across providers & settings

Sample Stoplight Topics:

1. Heart failure
2. COPD
3. Diabetes
4. Depression
5. Pneumonia
6. Falls
7. Wounds
8. Pain
9. Constipation
10. Nausea
11. Anxiety
12. Stroke
13. Shortness of breath

Provider specific instruction determined here:
• Call your nurse
• Call your doctor
• Call HH/hospice
• Call Case Manager
Moving toward Health Literate Care: Stoplight form before

- Third person
- Zones drive navigation
- Graphic does not support text
- Font, layout, graphics not consistent with health literacy principles

Stoplight after: supports patient and family engagement

- First person
- Patient daily assessment drives navigation
- Font, layout, graphics consistent with health literacy and plain language principles
- Supports patient and caregiver engagement
- Supports teach back with content ready for “chunk and check”
Universal Precautions Approach in Action: Patient Friendly Medicine List

Medication and Route | Dose | Frequency | Reason | Instructions
--- | --- | --- | --- | ---
Furosemide Oral | 20 MG | 1 Tablet = 20mg | Every Morning | Diuretic
Levethracen Oral | 106 MCG | 1 Tablet = 100mcg | Daily | Hyperthyroidism
Montelukast Oral | 10 MG | 1 Tablet = 10mg | Daily | Respiratory Therapy
Multivitamin Oral | 1 pill | As Directed | One Time Per Day | Supplement
Pantoprazole Oral | 40 MG | 1 Tablet = Every Morning | Good |

Allergies: ROSEMIDE - VIOLET

01/13/2014, EPINEPHRINE

Font size increased to 14 pt

High Alert Medication Stoplight Tools

A recent study found that four agents were responsible for 2/3 of all drug related hospitalizations:

1. Plavix
2. Coumadin
3. Insulin
4. Oral Hypoglycemics

High Risk Med: Morphine 20mg/ml

Morphine 20 mg/ml

Doctors may prescribe a medicine called morphine. It works well and is a safe treatment for shortness of breath and pain. Morphine comes mixed with a liquid. This sheet describes medicine that contains 20 mg of morphine in every 1 ml of liquid (also known as 20 mg/ml).

How to take it

Morphine can be placed under the tongue or between the cheek and the gum. It can also be added to a small amount of water or juice, or to a soft food like applesauce.

How to measure your dose

Your nurse will write down how much morphine (the dose) to take and how often to take it.

Your nurse may fill oral syringes (syringes without needles) with labeled doses of morphine. You may also be given empty oral syringes that you can fill. The chart below shows the dose of morphine in each amount of liquid and how to fill the syringe for each dose.

Dosing table for morphine 20 mg/ml

<table>
<thead>
<tr>
<th>Dose of morphine (mg)</th>
<th>Amount of liquid (ml)</th>
<th>Fill the syringe</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 mg</td>
<td>0.25 ml</td>
<td>Half way between 0.2 and 0.3</td>
</tr>
<tr>
<td>10 mg</td>
<td>0.5 ml</td>
<td>To the 5 mark</td>
</tr>
<tr>
<td>15 mg</td>
<td>0.75 ml</td>
<td>Half way between 0.7 and 0.9</td>
</tr>
<tr>
<td>20 mg</td>
<td>1.0 ml</td>
<td>To the 0 mark</td>
</tr>
</tbody>
</table>

Picture of oral syringe showing morphine doses:

```
0.1 0.2 0.3 0.4 0.5 0.6 0.7 0.8 0.9 1.0
```

Dose of morphine: 5 mg 10 mg 15 mg 20 mg

“Health Literate” SBAR for Patients in PHR

How to give your doctor a quick, clear picture of your health problem

1. Say why you are:
   - Give reason
   - If you are not the patient, say how you know the patient

2. Say what you are being treated for at this time:

   Include:
   - Names of medical problems
   - Names of health care services you have seen
   - Medical supplies you use (medication, oxygen, walker)

3. Say why you are calling:

   For example:
   - To ask a question
   - To report a problem or a change from normal
   - Because you noticed new signs or symptoms

4. Say what you need:

   For example:
   - To make an appointment
   - Have a test
   - More information

5. End the call by asking how to reach the doctor if you need more help:
Engaging Patient & Caregivers

As a person's condition changes, their needs and preferences change. Shared decision making with patient and caregivers is facilitated with health literate tools.

Quality of Life Tools

Coping with the dying process

Name: __________________________ Date: __________________________

I feel:
- Angry about ...
- Guilty about ...
- Unrewarded by ...
- Frustrated with ...
- Other: __________________________

I worry about:
- What is going to happen next
- Being able to handle death
- Taking care of ...
- Being able to live without ...
- Other: __________________________

I wish I could:
- Relax
- Take care of myself
- Feel good again
- Have more time to ...
- Talk to someone about how I feel
- Other: __________________________

Help coping with the dying process
- What gives me a sense of value?
- What gives me a sense of purpose?
- What gives me a sense of meaning?
### System Best Practice: Health literate care in ALL settings by ALL providers

#### Training
- Knowledge/Skills
  - Awareness
  - Screening
  - Intervention

#### Tools
- Disease self-monitoring tools
- Personal Health Record (PHR)
- Patient Information Booklet
- High risk medication tools
- Preventative care materials
- Access to care materials

<table>
<thead>
<tr>
<th>Across service lines</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCAH</td>
</tr>
<tr>
<td>Across care settings</td>
<td>Region</td>
</tr>
<tr>
<td>Across the system</td>
<td>Sutter Health</td>
</tr>
</tbody>
</table>

What questions do you have? We have time.