REVIEW ARTICLE

Patient Activation for Population Health: Shifting From A Fee-for-Service Model Toward A Proactive, Preventive Approach with Increased Engagement

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America's health care system is currently designed to drive up costs through inefficiency: Its fee-for-service formula endorses an episodic relationship between physicians and patients which places primary care providers in a perpetual state of troubleshooting and leads them to order a variety of unnecessary tests and/or procedures which further drive up the cost of medical care. As America's political and health care leaders debate whether or not the most sustainable way to manage those costs is by offering preventive care – helping address problems before they arise/escalate and avoiding the need for expensive and, at times, extensive lists of services – this problem persists. The principles presented here are aimed at helping osteopathic providers better manage their practices and transition away from outmoded fee-for-service models toward a quality-of-care-based reimbursement system which is proactive, preventive and highly amenable to patient activation.

As America's political and health care leaders debate whether or not the most sustainable way to manage medical costs is by offering preventive care—helping address problems before they arise or escalate and avoiding the need for expensive and, at times, extensive services—the cost of medical care continues to rise. For medical costs to be brought under control and for patient health status to improve, there must be a dramatic shift in the way health care is delivered and financed. Osteopathic care physicians can help by better managing their practices, transitioning away from fee-for-service models and adopting behaviors and policies supportive of to a quality-of-care-based reimbursement system: an approach which is simultaneously proactive, preventive and proven to increase patient activation levels.

The principles and information presented here are aimed at helping osteopathic and other holistic care providers do just that, by offering a glimpse at how Population Health Management (PHM) affects medical care; exploring Patient-Centered Medical Homes, PHM and related finance issues; defining and delving into Patient Activation; conducting an overview of related research; and, delving into disruptive Patient Activation innovations which have positively impacted patient health, wellness and engagement levels.

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THE EFFECTS OF POPULATION HEALTH MANAGEMENT

Populations can be assessed and stratified according to any number of factors: gender, ethnicity, age, and medical condition (i.e., diabetes, COPD, CHF and so forth). Defining populations within the realm of health care has traditionally been limited to making diagnoses. That limited view neglects to the various dimensions of patient-centered care: clinical informatics, quality improvement, patient engagement and a team, or coordinated, approach to care delivery.[1] However, population management in health care has begun to take on new meaning, as physicians and practice groups (especially those offering primary care services) transition away from a fee-for-service formula toward a quality-of-care-based reimbursement system which provides a better means for managing patients.

Under the old method, providers focused their efforts on the episodic treatment of individuals seeking care related to specific complaints. Physicians then charge patients or payors for services rendered. As such, running a case-by-case operation may help fix problems, but it does nothing to prevent them. This leads to the costly misuse of resources, as well as missed opportunities for assessing and addressing a patients' total health care picture, in that it dissuades providers from working with their patients to stave off the onset of disease, slow disease progression and strive for optimum health.

Moreover, in the current health care environment, patients are often coping with multiple chronic conditions and are receiving treatment from several physicians simultaneously—some of whom may be unaware of the others' diagnoses, treatment directives or choice of prescribed medications. Physicians

must, therefore, rely on their patients to be forthright and to provide accurate accounts of all other, pertinent medical data. This scenario also fails to take into account non-medical factors that affect patient health and patient compliance with care plans. For example, the National Committee on Quality Assurance, as cited by the American Medical Group Association, asserts that the likelihood of "care gaps" increases significantly when patients have multiple chronic conditions.[2] This is cause for concern, as the number of patients dealing with multiple chronic conditions grows, partly due to an aging U.S. population—with chronic conditions responsible for nearly 70 percent of all health care expenditures.[3] This, in turn, increases the need for more highly coordinated care efforts.

POPULATION HEALTH MANAGEMENT

This is where the Population Health Management (PHM) approach factors in. PHM is a framework for preventive care that empowers physicians and practice groups to divide patients into clusters, or groups, which are comprised of individuals who are dealing with similar sets of circumstances and with whom those physicians can then partner to take a decidedly more proactive approach to care. It is a systematic method through which physicians can gather up related patient records, flag them with specific care instructions and observe or monitor trends related to treatment and outcomes.

For example, a physician using the PHM approach might focus their attention on patients with a condition in common such as diabetes. By corralling all diabetic patient records, they can more effectively initiate contact with those patients and send out reminders related to A1C testing and lab work. Those preventive care alerts can be earmarked for transmission by email, text message or post and related file notations eliminate the need to spend time researching when or how long ago patients' tests were ordered. For diabetic patients who also have heart disease and/or obesity, a PHM approach facilitates communication regarding blood pressure medication refills and weight-loss strategies—thus enabling physicians to preempt negative outcomes rather than treat patients who come into their practice after suffering adverse symptoms and related complications.

There are no steadfast guidelines for categorizing patient data, in order to mine it for shared characteristics, but rather suggestions for applying that approach to benefit patient populations: "Essentially, a population is any community in which you are going to focus on improving outcomes, quality and cost," says Steve Goldstein, CEO of Strong Memorial and Highland Hospitals of the University of Rochester Medical Center (URMC) in Rochester, NY.[4] "The interventions you design to manage its care will be unique to the needs of the population itself."

The key to turning PHM into an effective tool which can help patients strive for better health, then, is to avoid making it a catch-all repository of information. It should instead serve as a starting point from which physicians, staff and patients actively work toward preventive care—at the practice level—and from which they can begin to more effectively manage issues related to population health.

PATIENT-CENTERED MEDICAL HOME AND FINANCE ISSUES

The Patient-Centered Medical Home (PCMH) is the core for successful PHM. Originally developed in the 1960s, the PCMH model was intended to facilitate communication and shared decision-making authority between physicians, patients, supporting providers and patients' family members or caregivers.[5] Although the concept has been around for more than 50 years, it did not gain widespread acceptance until there was a push for health care reform and greater accountability related to quality improvement. Unlike traditional models, in which physicians intervene to correct medical issues, within the PCMH a team of nurses, therapists, care coordinators and even social workers also engage patients—encouraging them to adopt more healthful behaviors and to make choices that prevent or reduce the need for intervention.

"Physicians are developing the tools to look across their patient population, sort and group patients by common traits, make informed choices about where dollars and energy are best spent, and then measure their progress in real time," explains Betty Rabinowitz, MD, medical director for the Center for Primary Care at University of Rochester Medical Center (URMC) in Rochester, NY.[6]

In cases where medical care is an absolute necessity, physicians are able to focus their expertise, while PCMH team members handle the practice's other responsibilities: Nurses triage non-critical cases; care coordinators communicate with patients and/or caregivers regarding compliance and follow-up; and, social workers connect patients with community resources. Before that collaboration can take place, however, providers must determine which set of services would most benefit their patients. Using a PHM approach, those patients are grouped together based on shared criteria. Once providers identify those issues that negatively affect their patients' health, PCMH team members can be assigned to work directly with patients to rectify those issues.

For example, a PHM approach can be utilized to identify patients who routinely miss appointments due to a lack of reliable transportation. Knowing that, a care coordinator can reach out and connect those patients with community resources that help remove that particular obstacle to

care compliance. Other ways PCMHs are striving to keep individual patients healthy is by sending out reminders related to vaccinations, mammograms, etc., ensuring timely care in a way that engages patients even further.

Although PCMH is a fundamental building block of PHM—one intended to deliver higher quality care while lowering overall medical costs, in support of population management—it is necessary to explore financing models which are more flexible; ones which empower provider networks to decide where, within their systems, they should be directing their dollars in order to achieve the best possible outcomes for patients. That alone would shift the bulk of the risk from payors to networked providers. Those networked providers could then generate cost savings by avoiding the need for unnecessary procedures or hospitalizations. Those savings could then, theoretically, be reinvested in prevention and other patient wellness programs to bring the cycle of proactive care, preventive care and patient engagement full circle and encourage delivery of medical care and services in a way which is both more holistic and financially sound.

> *"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that ever has." – Margaret Mead*

Lastly, a key requirement of PHM is increasing patient involvement in self-management and risk- or behavior-modification activities, yet patient compliance routinely proves to be a challenge. There are ways in which health care organizations can better engage and empower the patients under their care. Namely, through care coordination, technological innovation and community outreach activities—which remove barriers to care and give patients a reason and the motivation to actively participate in the health care process. Indeed, research has shown that patients who are more active in attending to their health and participating in the health care process are more apt to stay current with their medications, be lively and engaged during medical encounters, seek out health-related information and, in addition, eat healthy foods, exercise and get preventive care.[7] However, fewer than half of U.S. adults are currently activated in that way.[8]

DEFINING AND DELVING INTO PATIENT ACTIVATION

The term patient activation refers to a patient's likelihood to participate in actions and behaviors which improve their chances of recovery.[9] According to Dr. Judith Hibbard, a professor of health policy at the University of Oregon's Department of Planning, Public Policy and Management: "An active patient is one who is armed with the skills, knowledge and motivation to be an effective member of the health care team."[10]

Along with Dr. Bill Mahoney and other colleagues at the University of Oregon, Hibbard developed the Patient Activation Measure™ (PAM), a self-assessment tool that measures traits associated with managing one's own health and health care activities. PAM , which is licensed and marketed by Insignia Health, consists of a 10- to 13-question survey that makes inquiries into people's beliefs, knowledge, skills and confidence when it comes to engaging in a wide range of health behaviors. Based on their responses to the survey, consumers are assigned individual activation scores and are segmented into one of four progressively higher activation levels.

At the low end of the spectrum, individuals tend to be passive about managing their health and may fail to see the connection between their own behaviors and related health outcomes. At the high end, individuals have a strong understanding of that relationship and have become good self-managers. Still, it is important to note that even high-activation-level individuals show opportunities for improvement and can benefit from coaching which helps them stay on course, particularly in times of stress or when experiencing changes in their care routine.

Once a patient's activation level is defined, health care providers, health plan administrators and wellness coaches can approach the individual with ideas for creating a tailored plan which makes sense given their activation score; plans they are more likely to adopt and carry out, in an effort to improve their own levels of wellness. For instance, rather than ask a patient with a low activation level to run two miles a day, it would be more beneficial to ask them to consider getting their exercise by walking around the block a few times per week and/or parking farther away from their destination, whether they go shopping, out to eat, etc.

"Pounding people over the head doesn't work," says Hibbard. "Understanding the person and meeting them where they are is the key, (as is) having a standardized approach for supporting patients and, finally, having a way to track progress."[11]

PAM, PHM AND OTHER RELATED RESEARCH

At least 85 studies have documented PAM's ability to effectively measure patient activation and to predict a range of behaviors (even in instances of wide demographic and socioeconomic variability). Research has also shown that there is a direct correlation between increased patient activation and improved levels of self-care, with the Hibbard study demonstrating that PAM scores increased an average

of 4.6 points among members of intervention groups while scores among control group participants increased an average of 1.4 points, demonstrating that increased patient activation also leads to an increase in patients' ability and desire to more successfully manage their conditions.[12]

Hibbard indicates that, based on 2010 research from the Center for Studying Health System Change (HSC), patients who are able to do the following are likely to achieve better health outcomes at a lower cost overall:[13]

- Navigate the health care system
- Collaborate with various care providers
- Self-manage health-related symptoms/problems
- Involve themselves in the treatment and diagnostic process
- Engage in activities which maintain functioning and reduce health declines
- Select providers and provider organizations based on performance or quality

CONCLUSION

A "small group of thoughtful, committed citizens," as Margaret Mead suggested of change itself, can create a noticeable shift and make a meaningful difference in the lives of osteopathic physicians, staff and patients. With patient activation as the end goal, a proactive and preventive approach to health care which is supported by a quality-of-care-based reimbursement system and bolstered by disruptive innovation can reduce the cost of medical care and achieve desired results where patient involvement is concerned.

As America's political and health care leaders debate whether or not the most sustainable way to manage medical costs is by offering preventive care, the osteopathic community can begin to take a grassroots approach to actively addressing that problem. After all, a dramatic shift often begins with a series of small, first steps away from outmoded ideologies, practices and procedures (i.e., a fee-for-service model) toward behaviors, beliefs and policies which are simultaneously more proactive, preventive and proven to activate patients.

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