



**POPULATION HEALTH SERIES:**



***The Voice of the Patient***  
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**CE STATEMENT**



The **Georgia Board of Nursing** deems **Southwest Georgia Area Health Education Center (SOWEGA-AHEC)** as an approved provider for nursing continuing education (CE). This activity is approved for **1.0** contact hour towards the continuing education competency requirement for Georgia nursing licensure renewal. No partial credit offered. Activity #2020-04a.

**Note:** Submission of registration information, attendance and completed evaluation/successful post-test required for Nursing continuing education certificates.

2

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**DISCLOSURES & COMMERCIAL SUPPORT**

Planners & presenter disclosed no potential conflicts of interest at this time.

No commercial support provided for this educational activity.

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LEARNING OUTCOMES

- Define patient engagement
- Identify perspectives on patient-centered care
- Describe effective strategies for patient-centered care and the role of healthcare delivery redesign to advance patient-centered care

4

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Patient engagement can be defined as a concept that combines a patient's knowledge, skills, ability and willingness to manage his own health and care with interventions designed to increase activation and promote positive patient behavior.

DEFINITIONS OF "PATIENT ENGAGEMENT"

[http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=86](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86)

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"...care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions"

PATIENT CENTERED CARE

Reference: IOM. (2001). *Crossing the Quality Chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

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### PATIENT CENTERED CARE COMPONENTS

1. Respect for patient's values, preferences, & expressed needs
2. Coordination & integration of care
3. Information, communication, education
4. Physical comfort
5. Emotional support
6. Involvement of family and friends
7. Transition and continuity

Reference: Picker Institute - Picker Institute FAQ, Retrieved from the Picker Institute <http://www.pickerinstitute.org/about/FAQ.html>

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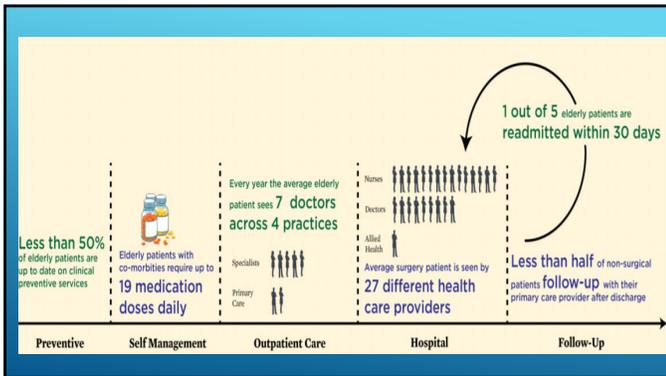
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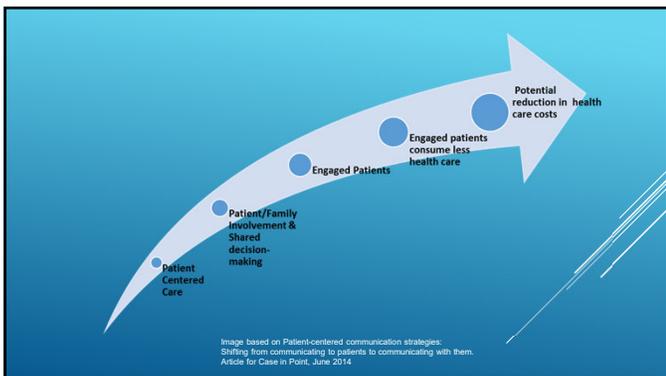
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Education

- ▶ Information, technical skills
- ▶ Problems due to poor disease control
- ▶ Disease-specific knowledge, technical skills
- ▶ Goal is compliance with behavior to improve outcomes

EDUCATION

10

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<p>Education</p> <ul style="list-style-type: none"><li>▶ Information, technical skills</li><li>▶ Problems due to poor disease control</li><li>▶ Disease-specific knowledge, technical skills</li><li>▶ Goal is compliance with behavior to improve outcomes</li></ul>	<p>Self-Management</p> <ul style="list-style-type: none"><li>▶ Skills to act on problems</li><li>▶ Patients identify problems in management</li><li>▶ Improving patient confidence in abilities to make changes</li><li>▶ Goal is increased self efficacy to improve outcomes</li></ul>
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EDUCATION + SELF-MANAGEMENT

11

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Patient-centered healthcare organizations are increasingly adopting specific strategies that facilitate the shift from communicating **to** patients and families to communicating **with** them.

PATIENT CENTERED COMMUNICATIONS

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People with limited or inaccurate knowledge about the body and the causes of disease may not:

- Understand the relationship between lifestyle factors (such as diet and exercise) and health outcomes
- Recognize when they need to seek care

Health information can overwhelm people with advanced literacy skills.

WHAT FACTORS AFFECT HEALTH LITERACY?

16

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Culture affects:

- How people communicate and understand health information
- How people think and feel about their health
- When and from whom people seek care
- How people respond to recommendations for lifestyle change and treatment

HEALTH LITERACY IS DEPENDENT ON CULTURE

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- Health contexts are unusual compared to other contexts because of an underlying stress or fear factor.
- Healthcare contexts may involve unique conditions such as physical or mental impairment due to illness.
- Health situations are often new, unfamiliar, and intimidating.

HEALTH LITERACY IS DEPENDENT ON THE DEMANDS OF THE SITUATION/CONTEXT

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IDENTIFY THE INTENDED USERS OF THE HEALTH INFORMATION AND SERVICES

- ▶ Know the intended users of the health information and services:
  - ▶ Demographics
  - ▶ Behavior
  - ▶ Culture
  - ▶ Attitude
  - ▶ Literacy skills
  - ▶ Language
  - ▶ Socioeconomic status
  - ▶ Access to services
- ▶ Decide which channel(s) and format are most appropriate.

19

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Evaluate users' understanding *before* (formative), *during* (process), and *after* (outcome) the introduction of materials.

**Test! Test! Test!**

EVALUATION

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- ▶ Accepted roles of men and women
- ▶ Value of traditional vs. Western medicine
- ▶ Favorite or forbidden foods
- ▶ Manner of dress
- ▶ Body language, especially touching or proximity

ACKNOWLEDGE CULTURAL DIFFERENCES AND PRACTICE RESPECT

21

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Cultural competency is the ability of health organizations and practitioners to recognize the following in diverse populations to produce a positive health outcome:

- ▶ Cultural beliefs
- ▶ Values
- ▶ Attitudes
- ▶ Traditions
- ▶ Language preferences
- ▶ Health practices

**WHAT IS CULTURAL COMPETENCY?**

22

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Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels, personalize risk based on a person's history or behavior; highlight perceived susceptibility if too low
Perceived Severity	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take, how, where, when; clarify the positive effects to be expected
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance
Cues to Action	Strategies to activate readiness	Provide how-to information, promote awareness, reminders
Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action

**HEALTH BELIEFS**

23

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- ▶ Measuring Patient Activation
- ▶ Health Coaching
- ▶ Teach-Back
- ▶ Motivational Interviewing
- ▶ OARS
- ▶ Self-Management Education

**STRATEGIES**

24

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"Patient activation" refers to a patient's knowledge, skills, ability, and willingness to manage his or her own health and care.

## PATIENT ACTIVATION

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Name: \_\_\_\_\_

### Patient Activation Assessment

Level of Performance (Please rate 1 point each)

Medication Management	Red Flags	Medical Care Follow Up	Personal Health Record (PHR)	Comments
<ul style="list-style-type: none"> <li>— Demonstrates effective use of Medication Management System (medication organizer, flow chart, etc.)</li> <li>— For each medication, understands the purpose, when and how to take, and possible side effects</li> <li>— Demonstrates ability to accurately update medication list</li> <li>— Confirms medication list with PCP and/or Specialist</li> </ul>	<ul style="list-style-type: none"> <li>— Demonstrates understanding of Red Flags, or warning signs that condition may be worsening</li> <li>— Reacts appropriately to Red Flags per education given (or understands how to react appropriately)</li> </ul>	<ul style="list-style-type: none"> <li>— Schedules and follows through on appointment(s)</li> <li>— Writes a list of questions for PCP and/or specialist and brings to appointment</li> </ul>	<ul style="list-style-type: none"> <li>— Understands the purpose of PHR and the importance of updating PHR</li> <li>— Brings PHR to every health encounter</li> </ul>	
Sum: /4	Sum: /2	Sum: /2	Sum: /2	
Total Score: /10				

## MEASURING PATIENT ACTIVATION

26

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Level 1	Level 2	Level 3	Level 4
<p><b>Disengaged and overwhelmed</b></p> <p>Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor. Their perspective: "My doctor is in charge of my health."</p>	<p><b>Becoming aware, but still struggling</b></p> <p>Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: "I could be doing more."</p>	<p><b>Taking action</b></p> <p>Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented. Their perspective: "I'm part of my health care team."</p>	<p><b>Maintaining behaviors and pushing further</b></p> <p>Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus. Their perspective: "I'm my own advocate."</p>
<p>Increasing Level of Activation </p>			
<p><small>©2016 Insignia Health. Patient Activation Measure® (PAM®) Survey Levels. All rights reserved.</small></p>			

## MEASURING PATIENT ACTIVATION

27

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**Method to guide patients to address health, make needed behavior changes**

- Involves goal setting, identifying obstacles, using support systems
- Relationship between coach and "coachee" is an **accountability** partnership focused on health goals defined by both

HEALTH COACHING

28

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**Method to confirm patients understand what we tell them**

- "Tell me why you need this medication"
- "Tell me how you would take this medication"

• **Teach Back not a test of patient's knowledge**

• **Is a test of how well we explain something**

Kessels, R. P. (2003). Patients' memory for medical information. *Journal of Social Medicine*, 96(5), 219-222.

TEACH-BACK

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A collaborative, patient-centered form of guiding to elicit and strengthen motivation for change

Three Key elements

1. Collaboration (vs Confrontation)
2. Evocation (Drawing Out, rather than Imposing Ideas)
3. Autonomy (vs Authority)

MOTIVATIONAL INTERVIEWING

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**1. Express empathy**  
– See things through the client's eyes

**2. Develop discrepancy**  
– Explore how they want their life and how it is now

**3. Roll with resistance**  
– Do not fight client resistance, but "roll" with it

**4. Support of self-efficacy**  
– Embrace client autonomy

4 PRINCIPLES OF MOTIVATIONAL INTERVIEWING

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Open-ended questions  
Affirmations  
Reflections  
Summaries

OARS

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✓It takes time to engage patients; you may have to adjust your workflow

✓Promote planned care, and team-based care

✓Don't try to fix patients' problems, help them fix their own

✓It works—start with small changes

REALITY AND PRACTICALITY

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33



The Stanford Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals.

People with different chronic health problems attend together.

Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

Subjects covered include:

- ▶ Techniques to deal with problems such as frustration, fatigue, pain and isolation.
- ▶ Appropriate exercise for maintaining and improving strength, flexibility, and endurance.
- ▶ Appropriate use of medications.
- ▶ Communicating effectively with family, friends, and health professionals.
- ▶ Nutrition.
- ▶ Decision making.
- ▶ How to evaluate new treatments.

34

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### HEALTHCARE DELIVERY REDESIGN



Technology as a change agent

There's an App For That

Welcome to your School-Based Health Center!

I Need A Doctor

eClinicalWeb

Patient Portal

health happens here In The Workplace

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A Patient and Family Advisory Council (PFAC) partners patients and families with members of the healthcare team to provide guidance on how to improve the patient and family experience.

As part of this PFAC process, patients and families are invited to serve on healthcare provider committees to ensure that the consumer's point of view, perspective, and experience are not only heard, but also integrated into the service and quality improvements that are engineered to ensure high-quality, customer-centered care.

References:  
[http://c.vmechn.com/sites/www.theberylsinstitute.org/resource/esmar/webinar\\_pact/pfac\\_toolkit\\_shared\\_version.pdf](http://c.vmechn.com/sites/www.theberylsinstitute.org/resource/esmar/webinar_pact/pfac_toolkit_shared_version.pdf)

### PATIENT AND FAMILY ADVISORY COUNCIL

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▶ "Treating people, not diseases"  
▶ Paradigm shift from "come and get it healthcare delivery"  
▶ The right resources at the right time  
▶ Self-Help resources and tools  
▶ Education, Coaching, Mentoring

CLOSING THOUGHTS

37

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LEARNING OUTCOMES

- Define patient engagement
- Identify perspectives on patient-centered care
- Describe effective strategies for patient-centered care and the role of healthcare delivery redesign to advance patient-centered care

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EVALUATION

Submission of registration information, attendance and completed evaluation/successful post-test required for CE certificates.

<https://www.surveymonkey.com/r/pophealthdemand8>

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