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REVIEW ARTICLE

Patient engagement: Changing pediatric practice to improve patient care

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Abstract Twenty-first century health care has evolved into a patient-centred enterprise that has changed the relationship between doctors and patients. Society now sets a high expectation for clinicians not only to impart knowledge to people about their illnesses and prescribe treatments to improve their clinical conditions but also to work with patients to ensure that the treatments are acceptable to ensure the patients' adherence to the recommendations. Most physicians are not trained for this change, but the principles of patient engagement can help clinicians meet these new challenges and perform well on measures of patient satisfaction and compliance with care recommendations. This article presents the basics of patient engagement for clinical staff to aid the facilitation of new approaches to patient care.

1. Background

The United States has observed growth in a new payment paradigm known as "value-based purchasing" over the past six years, and this approach has altered the accountability for patient treatment and adherence across the healthcare industry, including pediatrics. Although most of these changes are now directed at the Medicare program for older adults, these programs have also become widely adopted by private payers and state Medicaid programs.

Value-based payments are based on the business concept of "value" in which the value of services is directly related to the quality of care and inversely related to cost. This concept permeates the business world and influences consumer purchases of everything from tomatoes to sailing yachts; i.e., purchasers seek the highest quality product or service at the lowest possible cost. Health care payers have been trying to achieve this goal for decades, and the Patient Protection and Affordable Care Act (PPACA) of 2010 has put the U.S. on a path to value-based payments. Payment systems now balance cost reduction with quality performance to determine provider reimbursement, and these programs fall into three general categories:

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- Shared Savings Programs: In these programs, providers are given a target cost reduction that lowers the provider's payments by a certain percentage. If the provider meets that target, the payer reviews the provider performance on several relevant quality measures that are based on the quality issues that are important for that patient population. Providers who perform well on the quality measures are rewarded via the receipt of a portion of the cost savings as a bonus payment. The original Medicare payment reform system that launched with the PPACA used this approach with variable results [1].
- Capitation payments [2]: The system involves the reprising of payment programs from the 1970s. These programs pay providers a fixed monthly amount for all services provided for a patient. Typically, these payments are made to primary care physicians for all of the care they provide for patients, so each practice receives a lump sum for all of the patients covered in this manner. Thus, if a primary care practitioner has 100 patients under the plan, the total paid will be 100 times the capitation amount allowed for each patient. Covered patients receive all of their care each month at the primary care practice with few exceptions, and if the patient decides to go outside the practice for care without a specific referral, then the patient is liable for the cost of that care.
- Bundled payments: In this system, the continuum of patient care is divided into "episodes" of care, e.g., a surgical intervention for joint replacement or a hospitalization for asthma, and all providers of care during that episode are paid a lump sum as a group for the entire episode. These programs are especially popular for surgical procedures; for example, "global payments" for obstetric care have been common for perinatal care for many years. In a bundled payment system, all of the providers of care are included in the lump sum payment, i.e., hospitals, labs, imaging providers and facilities, and therapists. Indeed, all providers are paid from a single global payment. Providers must work together in a business arrangement to receive and distribute the payments, and everyone involved in a patient's care may be at risk for any complications or adverse events that occur during the episode. In other words, if care for the patient costs more than the payment received for the episode, then the providers share the responsibility for the overrun.

The common thread through all of these new methods of financing health care is the increased responsibility of health care providers to gain the trust and cooperation of patients to ensure that the patients follow the recommendations that the provider makes regarding taking medications on schedule or making lifestyle adjustments. This new requirement is termed "patient engagement" [3] and connotes one of the most important changes in the health care system in the modern era. The Institute for Healthcare Improvement in Boston has advanced the concept of the "Triple Aim" for the health care industry as illustrated in Fig. 1 [4].

These strategic objectives have become a mantra for health care in the United States and several other countries

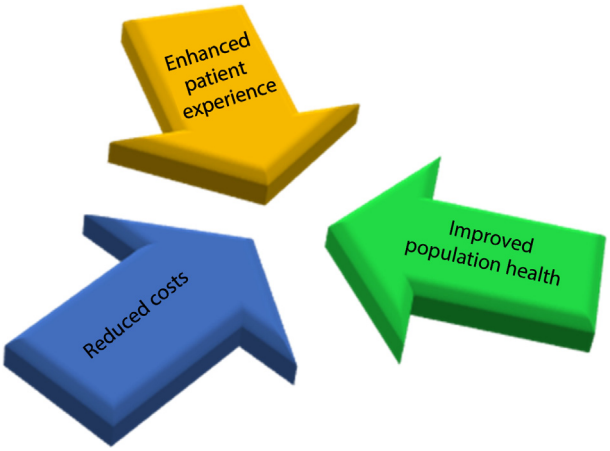

Figure 1 The Triple Aim of health care.

[5]. Experts agree [6] that achieving the Triple Aim requires providers, patients, and caregivers to work together to enhance access to care and the affordability of diagnostic and therapeutic modalities and to focus on improving individual and population outcomes.

2. Elements of patient engagement

Many pediatric primary care providers pride themselves on their ability to communicate with families and patients to help them understand prescribed tests and treatments. Gaining the trust of patients and caregivers has been a key characteristic of the primary care physician since the days of Aesculapius. However, medicine has evolved into a complex enterprise with multiple providers, exceptional technology, and more effective treatments and thus transcended the traditional medical approach that has been the foundation of health care for centuries. Team-based care is mandatory, and communication between everyone providing medical resources and the patients their families requires an extraordinary degree of coordination to create a clear, consistent message that respects the patient's level of understanding, culture, and socioeconomic milieu. Carman et al described a framework for patient engagement that addresses individual interactions and system design to ensure that patients, providers, and caregivers understand and participate collaboratively in patient care [7]. The authors describe different levels of interaction with patients that vary from consultation to full partnership between providers and families. Patient engagement relationships can differ across providers based on each provider's contribution to the patient's care from the traditionally close connection between patients and the providers whom they see most often, to the connection with providers who are less involved in direct patient care. Importantly though, engaging patients with all of their care providers both during acute episodes of care and throughout the care continuum must become a standard practice as a health care organization designs its policies, procedures, and operations. Patient engagement metrics must be included in the key measures that are tracked by leaders and frontline staff to anticipate problems and