Patient Engagement and Patient Reported Outcomes of Care: Findings and Lessons Learned

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Outline

- Definitions
- Patient engagement and Outcomes of Care in two Large ACOs
- Policy and Practice Implications

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Key Definition

Patient Activation and Engagement = extent to which patients have the knowledge, skills, confidence, and motivation to actively participate in all aspects of their care.

Patient Engagement Survey: Far to Go to Meaningful Participation

Insights Reports by Kevin Volpp and Namita S. Mohta

Results of the second NEJM Catalyst survey on patient engagement show early success, but most initiatives have yet to be scaled up.

“Prepared, Engaged Patients are a Fundamental Precursor to High-Quality Care, Lower-Costs, and Better-Health”

Institute of Medicine Workshop, 2013

Preliminary results from a study of two large ACOs' outcomes of care for patients with diabetes and/or cardiovascular disease.

Participating Organizations

Advocate Health Care ACO – Chicago

- Multi-Hospital System with Owned Medical Group of 300 plus Physicians
- Major Clinical Integration Effort over 12 years
- Several Years Experience with At-Risk Contracts

DaVita HealthCare Partners

- Owned and Affiliated Primary Care and Multi-Specialty Groups
- Early Medicare Shared Savings ACO
- Hold Commercial At-Risk Contracts as well

Sample Selection

- 16 Primary Care Practice Sites – Eight from Each ACO
- 8 Randomly Selected from Top Quartile on Number of Patient Activation and Engagement Initiatives
- 8 Randomly Selected from Lowest Quartile

	Advocate	Healthcare Partners
Average Panel Size	9,700	6,900
Patient Visits	39,900	43,274
Percent Medicare	18.6%	39.4%
Years in Existence	21.5	13.6

Central Thesis

Patients receiving care from primary care teams with a more patient-centered culture, greater shared decision-making, and better communication and coordination among team members will have better patient-reported outcomes of care.

The above relationships may be mediated by how activated patients are in their care.

PAE Baseline Survey (All Physicians, About Half, Some, None)

1. Conducts a Health Risk Assessment (HRA) Survey with Patients
2. Provides Patients Feedback on their HRA Results
3. Provides Ongoing Monitor of HRA Results (assessing over time changes)
4. Refers Patients to a Disease Prevention or Health Promotion Program as a Result of the HRA
5. Encourages Relevant Patients to Participate in a Healthy Eating Program
6. Encourages Relevant Patients to Participate in a Physical Activity Program
7. Encourages Relevant Patients to Participate in an Employee Health Promotion/Prevention/Wellness Program
8. Sponsors or Participates in School Health Clinic Interventions
9. Health Risk Assessment Results are Available Electronically to Care Team Members (through the Electronic Medical record) at the Point of Care
10. Clinicians are Trained in Motivational Interviewing Techniques
11. Clinicians Consistently use Motivational Interviewing Techniques in Communicating with Patients (e.g. encourage patients to ask questions)

(CONT'D) PAE Baseline Survey (All Physicians, About Half, Some, None)

12. Clinicians Consistently Encourage Patients to Discuss Their Work, Home Life, and Social Situation
13. Staff are Trained in Motivational Interviewing Techniques
14. Staff Consistently use Motivational Interviewing Techniques in Communicating with Patients (e.g. encourage patients to ask questions)
15. Staff Note Patient Preferences for Treatment in the Patient's Record
16. Select Staff Serve as "Health Coaches" for Patients Seeking to Modify Their Lifestyle
17. Patients can Routinely Provide Information on Their Care and Their Health via Patient Portal (not just access)
18. Telehealth is Consistently made Available to Patients with Diabetes
19. Telehealth is Consistently made Available to Patients with Cardiovascular Disease
20. Clinicians Consistently Involve Patients in Developing Treatment Goals
21. Clinicians or Staff Review Goal-Setting for Behavioral Changes with Patients as a Result of Their HRA

(CONT'D) PAE BASELINE SURVEY (All Physicians, About Half, Some, None)

22. Practice Provides Eligible Patients with Shared Decision Making Videos
23. Physicians Consistently have Follow Up Discussions with Patients Regarding Their Treatment Options and Preferences
24. There is a Formal Evaluation of the Impact of Shared Decision Making on Patient Care Choices, Outcomes of Care, and Patient Experience with Their Care
25. There Exists an Organized Follow Up Program to Assist Patients in Managing Their Medications at Home (e.g., pharmacist-led medication management)
26. Shared Medical Appointments (group visits) are Available for Patients with Diabetes
27. Shared Medical Appointments (group visits) are Available for Patients with Cardiovascular Disease
28. Peer to Peer (Patient to Patient) Programs are Available for Patients with Diabetes
29. Peer to Peer (Patient to Patient) Programs are Available for Patients with Cardiovascular Disease
30. Programs Exist to Improve Family Participation and Support for Patients with Diabetes

(CONT'D) PAE BASELINE SURVEY (All Physicians, About Half, Some, None)

31. Programs Exist to Improve Family Participation and Support for Patients with Cardiovascular Disease
32. At Home Monitoring Devices and/or Tools to Assess Medication Management, Blood Pressure, Blood Sugar, and Lipids
33. Clinicians Consistently Discuss the Importance of Patient Advanced Directives (Care for Older/Vulnerable Adults)
34. Clinicians Consistently Discuss Hospice Care Options with Patients (Care for Older/Vulnerable Adults
35. Clinicians Consistently Discuss the Availability of both Hospital Based and Community Based Palliative Care with Patients (Care for Older/Vulnerable Adults)
36. Patient Advisory Councils Exist for Patients with Diabetes
37. Patient Advisory Councils Exist for Patients with Cardiovascular Disease
38. Patients Consistently Participate in Quality Improvement Teams
39. Patients are Involved in Helping to Govern the Clinic/Practice

Patient-Reported Outcome Measures – Physical Functioning

- Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports? (Not at All, Very Little, Somewhat, Quite a Lot, Cannot Do)
- **Does your health now limit you in…**
  - Walking more than a mile?
  - Climbing one flight of stairs?
  - Lifting or carrying groceries?
  - Bending, kneeling, or stooping?
- **Are you able to…**
  - Do chores such as vacuuming or yard work?
  - Dress yourself, including tying shoelaces and doing buttons?
  - Shampoo your hair?
  - Wash and dry your body?
  - Get on and off the toilet?

Patient-Reported Outcome Measures – Social Functioning

- **I have trouble doing…** (Never, Rarely, Sometimes, Usually, Always)
  - All of my regular leisure activities with others
  - All of the family activities that I want to do
  - All of my usual work (include work at home)
  - All of the activities with friends that I want to do
  - all of the work that is really important to me (include work at home)
- **I have to limit…** (Never, Rarely, Sometimes, Usually, Always)
  - the things I do for fun with others
  - my regular activities with friends
  - my regular family activities

Patient-Reported Outcome Measures – Emotional Functioning

- Over the last 2 weeks, how often have you been bothered by the following problems? (Not at All, Several Days, More than Half the days, Nearly Every Day)
  - Feeling nervous, anxious or on edge
  - Not being able to stop or control worrying
  - Feeling down, depressed, or hopeless
  - Little interest or pleasure in doing things

Primary Care Organization Variables of Interest

Patient-Centered Culture

<u>Example items:</u>

We are interested in the extent of your agreement or disagreement disagree to agree with each of the statements below, as they relate to your practice as a whole.

- *The practice does a good job of assessing current patient needs and expectations. (Disagree to Agree)*
- *Patients' complaints are studied to identify patterns and prevent the same problems from recurring.*

Primary Care Organization Variables of Interest

Between Group Relational Coordination

Example items:

*How **frequently** do the people in each of these groups communicate with you about providing care to **patients with diabetes and/or cardiovascular disease**?*
(Not Nearly Enough, Not Enough, Just Right, Too Often, Much Too Often)

*Do they communicate with you in a **timely** way about providing care to **patients with diabetes and/or cardiovascular disease**?*
(Never, Rarely, Sometimes, Often, Always)

[Workgroups: PCPs (MD, NP, or PA), Nursing (RN Care Manager, LVN), MA, Receptionist, Social Worker, Dietician, Diabetes Educator (RN/Health/Peer), Specialist physicians]

PRIMARY CARE ORGANIZATION VARIABLES OF INTEREST

Shared Decision-Making / Patient Assessment of Chronic Illness Care

Example items:

In the last 6 months, when I received care for my chronic condition, I was given choices about treatments to think about.
(Never, Sometimes, Usually, Always)

In the last 6 months, when you received care for your chronic condition, how much effort was made to help you understand your health issues?

PRIMARY CARE ORGANIZATION VARIABLES OF INTEREST

The Patient Activation Measure

Example items:

When all is said and done, I am the person who is responsible for managing my health condition. (Disagree Strongly to Agree Strongly)

I am confident I can tell my health care provider concerns I have even when he or she does not ask.

CONTROLLING FOR:

AGE

SEX

EDUCATION

INSURANCE STATUS

ENGLISH LITERACY

DISEASE BURDEN (# CO-MORBID CONDITIONS)

Key Findings to Date

- Patient-centered culture is positively associated with better physical and emotional health outcomes.
- Patient assessment of chronic illness care is positively associated with better physical, social, and emotional patient-reported outcomes.

BUT

- When PAM is introduced into the equation, shared decision-making is no longer significant. PAM is significantly associated with all three PROs, thus mediating the relationship of shared decision-making.

Team Participation Influences on Patient Engagement and Patient-Reported Outcomes of Care

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Research Objective

To compare primary care team experiences of engaging patients with diabetes and/or cardiovascular disease (CVD)* in 8 practices highly involved in PA&E and 8 practices with limited involvement in PA&E.

- To compare patients' experiences of care and outcomes in high vs. low PA&E practices.

* Excludes hypertension only

Data Sources and Samples

- Practice Survey of Patient Activation and Engagement Strategies: 2 ACOs, 71 practices; October 2014 → 16 randomly sampled from top and bottom quartiles (8 from each of 2 ACOs).
- Primary Care Teamwork Surveys: 411 primary care physicians and staff, 34 items (Response Rate= 84%; January 2015 – March 2015).
- Key Informant Interviews: 48 primary care physicians, staff, and practice managers, 1 hour long, 44 of 48 were in person (May 2015).
- Patient Experience and Patient-Reported Outcomes Survey: 2,176 patients with diabetes and/or CAD (Response Rate= 51%; April 2015 – September 2015).
- Administrative and clinical encounter data from all survey respondents (January 2014 – December 2014).

PA&E Strategies Used by Practices

STRATEGY	# High PAE Practices	# Low PAE Practices	TOTAL
At-home Monitoring Devices/Tools	8	4	12
Patient Treatment Preferences in EHR	7	4	11
Motivational Interviewing Training (clinicians)	8	2	10
Health Risk Assessment (HRA) Results in EHR	8	2	10
Ongoing Monitoring of HRA Results	8	2	10
Medication Management Follow-up	8	2	10
Family Participation Programs (diabetes pts)	7	2	9
Health Promotion Program referrals based on HRA	8	1	9
Shared Decision-Making Impact Evaluation	8	1	9
Health Risk Assessment	8	0	8
Health Coaches	6	2	8
Motivational Interviewing Training (staff)	6	1	7

PA&E Strategies Used by Practices (cont'd)

STRATEGY	# High PAE Practices	# Low PAE Practices	TOTAL
Peer to Peer Programs (diabetes pts)	6	0	6
Family Participation Programs (CVD pts)	4	2	6
Group Visits (diabetes pts)	6	0	6
Telehealth (diabetes pts)	6	0	6
Telehealth (CVD pts)	6	0	6
Patients on Quality Improvement Teams	5	0	5
Group Visits (CVD pts)	5	0	5
Patient Advisory Councils (diabetes pts)	4	0	4
Patients help govern the practice	4	0	4
Peer to Peer programs (CVD pts)	4	0	4
Shared Decision-Making Videos	4	0	4
Patient Advisory Councils (CVD pts)	3	0	3

Most Frequent Codes, by High vs. Low PA&E Key Informants

CODE	High PAE	Low PAE	TOTAL	High PAE	Low PAE
Empowering Self-Management	76	58	134	56.7%	43.3%
Team meetings/communication	56	45	101	55.4%	44.6%
Team Structure & functioning	47	53	100	47.0%	53.0%
Team Structure & functioning: Delegation of roles	50	47	97	51.5%	48.5%
Patient Outreach	49	42	91	53.8%	46.2%
PAE Challenges & Obstacles	40	41	81	49.4%	50.6%
Goal Setting with Patients	35	38	73	47.9%	52.1%
Roles and Responsibilities	35	30	65	53.8%	46.2%
QI Initiatives	34	26	60	56.7%	43.3%
Communication with Patient: Handouts	31	26	57	54.4%	45.6%

Team Structure Differs in High vs. Low PA&E Practices

High PA&E

- Frequently referred to bounded teams or formal/high frequency interactions between roles.
- Teams often work together to address a range of social issues (transportation, finances, social support, etc.)

Low PA&E

- Varying conceptions of a "team":
  - Nurse follow-up calls
  - Referrals to related services
  - Doctor-Patient
  - Patient-Family
- Only one mention of addressing non-medical needs.

Challenges of Patient Engagement in High vs. Low PA&E Practices

High PA&E

- Mentioned low engagement when asked to name challenges to PA&E, but generally not when discussing other topics.

Low PA&E

- Often mentioned low engagement as a challenge when discussing other topics.

Time & Resource Constraints

High PA&E

- Doctor: I run the Weight Loss Clinic here …and, we really need to expand. We really need to grow more. Because one of the biggest factors that causes diabetes is obesity. (44:50)
- Nurse: everything that I do in the morning [huddle] is to improve access right now. It's a knife in my heart. (46:46)

Low PA&E

- Doctor: I really felt I had all these new tools to break through resistance and everything, in truth when you're seeing patients every 15 to 30 minutes, it was not practical. (48:17)
- Nurse: they're expecting to have them do an additional 100 things, so it's not so easy to care about the patients' outcomes when you are expected to do so much. (49:61)

Patients Experiences of Care were Better in High PA&E Practices

	Overall	**High PA&E**	**Low PA&E**	p-value
n	2,171	1,079	1,092	
Patient Assessment of Chronic Illness Care- PACIC-11 (mean(SD))	56.4 (27.8)	57.6 (27.5)	55.1 (28.0)	0.04
CollaboRATE – Shared Decision-Making (mean(SD))	64.0 (28.0)	65.3 (28.3)	62.6 (28.3)	0.03

Patient-Reported Outcomes were Similar for High vs. Low PA&E Practices

	Overall	High PAE	Low PAE	p-value (low vs. high sites)
n	2,171	1,079	1,092	
Patient Activation (mean(SD))	76.1 (14.8)	76.1 (15.0)	76.1 (14.7)	0.96
Physical Health- SF-12 (mean(SD))	77.3 (19.4)	77.0 (19.7)	77.5 (19.1)	0.52
Social Health- PROMIS (mean(SD))	69.9 (22.6)	69.1 (22.7)	71.0 (22.5)	0.11
PHQ-4 (mean(SD))	82.5 (24.5)	81.8 (25.0)	83.2 (24.0)	0.18

Summary

- Team members of low PA&E practices had a greater tendency to attribute engagement challenges to patients compared to high PA&E practices *(supporting H2).*
- Patients' experiences of shared decision making and of chronic care were better in high PA&E practices compared to low PA&E practices *(supporting H3).*

Example of Recommendations and Suggestions Provided to Participating Sites

- Consider Implementing a Call Center to Increase Access
- Consider Implementing a Walk-In Clinic
- Expand Access to Health Educators, Nutritionists, Behavioral Health Specialists, etc. for Patients with Complex Needs
- Expand the Role of the Medical Assistant
- Add Staff with Spanish Speaking Skills
- Expand Training in Motivational Interviewing and Shared Decision-Making
- Develop Measures of Continuity of Care

Patient Centeredness Competencies Examples

Ease of Use

- Provide each patient with 24/7 access to a member of their care team
- Make in-home care available to patients with access, communication, or transportation issues
- Ensure that patients can refill their medication 24/7, including through online and mobile ordering
- Provide information on preferred providers, including their results and rates
- Provide patients access to their personal health record, including access to their cumulative out-of-packet expenditures

Source: Accountable Care Learning Collaborative, 2016

PATIENT CENTEREDNESS COMPETENCIES EXAMPLES

GOVERNANCE AND CULTURE

- Ensure patient participation on governing on governing boards, patient advisory committees, leadership committees, and oversight committees
- Incorporate patient-related concerns into efforts relating to staff support redesign, quality improvement, and assessment of capital investments
- Foster a culture of teamwork and mutual dependence within your organization

….Cont'd

Patient Centeredness Competencies Examples

Patient Involvement

- Measure patient satisfaction, incorporate feedback, and respond to specific complaints or grievances in a transparent manner
- Make available a complete record of every medical encounter (audio recording or transcript)
- Give patients and providers the opportunity to sign quality contracts, which include care plans and goals for the year, and to evaluate each other's performance
- Educate patients on the wise use of health care services
- Employ behavioral science techniques, such as motivational interviewing, to engage patients

PATIENT CENTEREDNESS COMPETENCIES EXAMPLES

WHOLE PERSON ORIENTATION

- Making use of connection opportunities when patients end up in acute care settings such as hospitals or skilled nursing facilities
- Monitor patient care plan milestones and goals
- Proactively reach out to patients to prevent them from becoming high or rising-risk patients

Source: Accountable Care Learning Collaborative (ACLC), 2016

In Process

EXAMINING DIFFERENCES OVER TIME

What Accounts for Some Practices That Improve Patient Outcomes More Than Others?

- Increase in Patient Centered Culture?
- Increase in Relational Coordination?
- Increase in Team Participation?
- Increase in Patient Activation?

Thank You!

Your Questions

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