United Hospital Fund

December 2018

Field Report: Lessons from the Patient-Reported Outcomes in Primary Care–New York Collaborative Participants

Institute for Family Health

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The Patient-Reported Outcomes in Primary Care–New York (PROPC-NY) collaborative, developed by United Hospital Fund, brought together three innovative health care organizations to consider a critical question: how can providers shift their focus from what is done for patients during a visit to what happens to those patients as a result. Over the course of 18 months, the Institute for Family Health, Montefiore Health System, and Northwell Health launched a major effort to find answers. The Institute for Family Health sought to improve patient goal-setting related to social determinants of health, Montefiore focused on improving families' ability to manage social and economic health stressors during pregnancy and the first year of a child's life, and Northwell aimed to improve patients' depression symptoms and physical function. After identifying appropriate patient populations, they selected or developed appropriate tools for eliciting feedback from patients on what prompted them to seek care and what outcomes or goals matter to them most. They also developed processes for consistently collecting, analyzing, and acting on the patient-reported data. Their efforts yielded many discoveries about patient-reported outcomes, or PROs, that were both conceptual and practical.

The following field reports build on a variety of assessments over the course of the initiative: each team's end-of-project self-evaluation, including surveys of health care team members and patients, patient focus groups, and chart reviews to assess the reliability of the processes developed to collect, use, and track PROs; four structured interviews of each team by UHF staff and project faculty; and team presentations during three, day-long meetings of learning collaborative participants.

This publication is part of a collection of resources that grew out of a United Hospital Fund initiative to examine the role and value of patient-reported outcomes in primary care. It includes an implementation guide, three field reports, and an overview of implications for practice and policy.

Institute for Family Health: Goal Achievement as a Patient-Reported Outcome Related to Social Determinants of Health

The Urban Horizons Family Health Center, a primary care site in the Bronx, was chosen by the Institute for Family Health (IFH) as its PROPC-NY participant. One of the highest-performing providers in the IFH network of 32 sites across New York State, Urban Horizons (UH) serves a population that is largely covered by Medicaid (50 percent) or is uninsured (10 percent); 5.8 percent of patients are covered by Medicare. The majority of patients are Hispanic or Latino (67 percent), and the remaining third are African-American. Urban Horizons is not only a site for medical care but also an important socioeconomic resource for the local South Bronx community. In 2017, it served over 4,500 patients in nearly 22,000 visits.

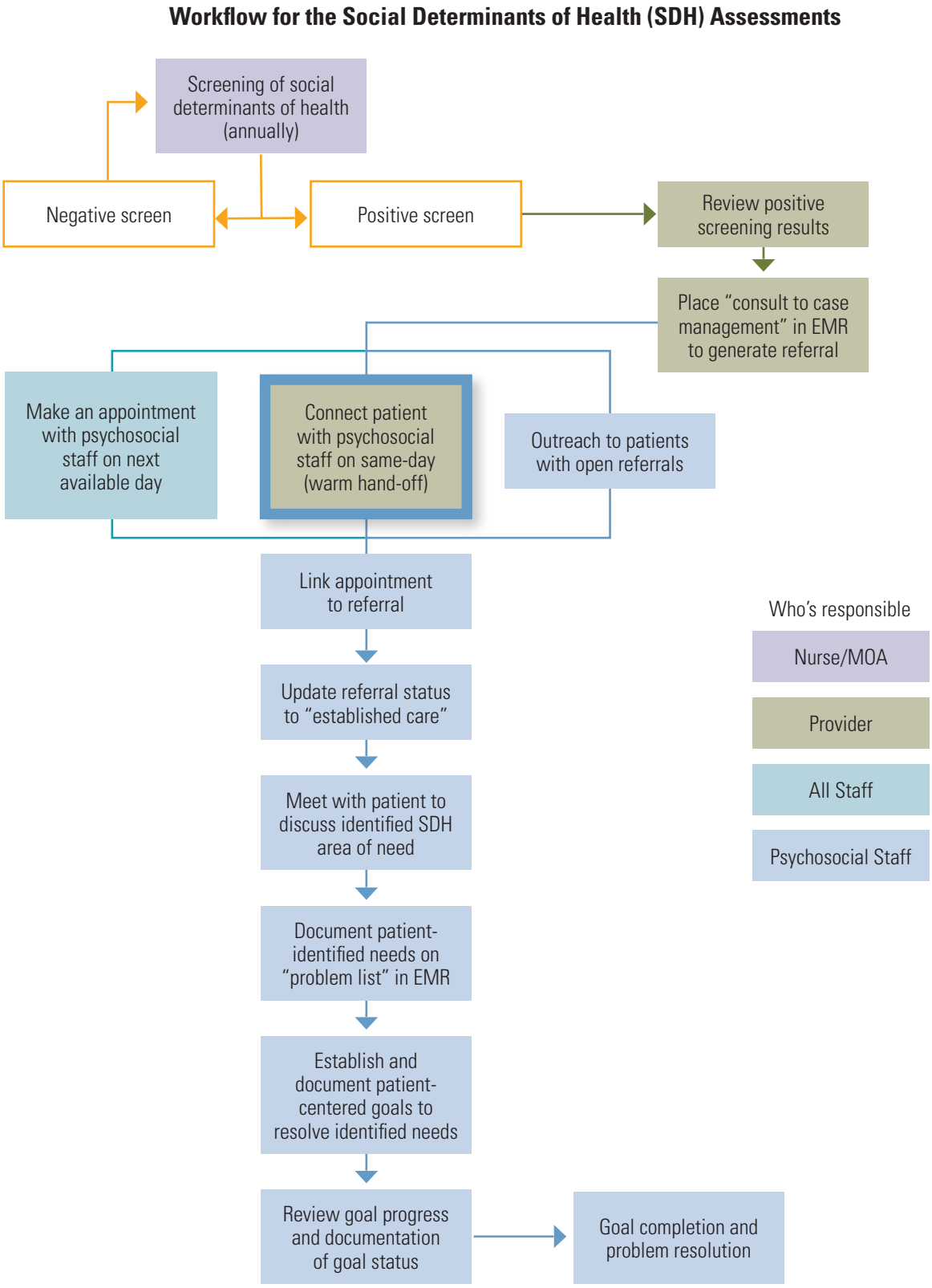
Leaders at Urban Horizons at first greeted the idea of implementing PROs in routine care with some healthy skepticism. The national conversation on PROs has emphasized their measurement aspect. Given the collection and reporting burden that providers increasingly face with the proliferation of quality measures, it is not surprising that a project focused on adding new measures would be met with concern. Those implementing PROs, therefore, had to make their case with a solid rationale.

Urban Horizons ultimately sought to articulate the value of PROs not simply as a new type of measurement but also as a means of addressing a perceived discrepancy between the reasons patients seek care and the nature of their interactions with providers. Lack of alignment between patient and provider goals can result in inappropriate care management plans, use of unnecessary services, and poorer patient outcomes. Because Urban Horizons is a safety-net clinic, issues related to social determinants of health—housing, food insecurity, and community violence, for example—were particularly salient to patients' health and often came up in conversations between patients and staff. But the practice of systematically gathering such information and eliciting patients' goals to develop care plans and track progress was still nascent. A project focused on patient-reported information provided an unprecedented opportunity to integrate such a structured approach into routine care.

Integrating PROs into Clinic Visits: An Evolutionary Process

For over a decade, through ongoing innovations and process improvements, IFH has created a culture and infrastructure that is truly patient-centric and tailored to the community it serves. The clinic has customized its electronic medical records (using the EPIC system) and developed a sophisticated HIT platform that allows all staff to deliver high-quality, patient-centered care in a number of ways: documenting and accessing patient information to support decision-making at the point of care; conducting follow-up care via team feedback reports; and addressing population health through quality-of-care profiles. The EMR facilitates interdisciplinary team communication, care planning, and coordination.

Figure 1. Patient-Reported Outcomes Workflow



Source: Institute for Family Health

Through the PROPC-NY Collaborative, Urban Horizons further refined its use of the EMR to identify patient-reported problems related to social determinants of health and reframed those problems as goals that can be tracked over time. It also made a point to specifically prioritize the degree to which a patient reports achieving his or her goals as a patient-reported outcome. The team developed a clinic workflow to support this outcomes-based management model (Figure 1) and a brief Social Determinants of Health Questionnaire (Figure 2). The questionnaire was administered in person to all patients every year. Staff members asked patients about five nonmedical aspects of their lives that could affect health and wellness: housing, food, affordability of care, interpersonal violence, and community violence. The team improved its workflow by using the EMR as a decision support tool to document the patient's path and progress toward the stated outcome: from problem identification and prioritization to the setting and achievement of goals.

Patients' concerns were addressed by a multi-disciplinary team that emphasized "warm handoffs" (transfer of care between two members of the health care team, which occurred in front of the patient); concurrent team visits with the patient (as opposed to individual, separate visits); and personal partnerships with community-based service organizations to which patients were referred.

Figure 2. IFH Social Determinants of Health Questionnaire

1. Housing Security

At any time in the last 30 days have there been any issues with your housing that concern you?

2. Food Security

At any time in the last 30 days have you had trouble providing enough food, or food that was sufficiently healthy, for yourself or your family?

3. Financial/Medical Security

At any time in the last 30 days have you delayed (put off) getting health care or buying medications because of money?

4. Home Safety

At any time in the last 30 days have you experienced or witnessed violence or abuse in your home or relationships?

5. Community Safety

At any time in the last 30 days have you felt unsafe in your community?

Collaborative Findings and Lessons

Urban Horizons' participation in PROPC-NY provides valuable insights into the experience and impact of PRO implementation from the perspective of patients, providers, and the broader health care team. Highlights included below are based on patient and provider focus groups, chart reviews, and structured interviews of health care team members by United Hospital Fund.

The Patient Perspective

Most patients reported feeling comfortable with the screening questions, and nearly all felt the questions addressed issues that were important for their doctors to know about.

> ***"You asking me that question gave me the doorway to say what I needed."***

Patients emphasized that follow-up conversations were important to maintain their trust and ensure that the process would result in concrete solutions.

> ***"It's okay to ask me the question, but if you're not going to help me with it, then what's the point?"***

Some patients also noted challenges in connecting and following up with case managers—an issue staff addressed by creating a culture in which warm handoffs became routine (see section below).

Care teams often found that they could best address stressors related to social determinants of health by helping patients manage their reactions to new stressors—which became the focus of conversations with case managers. Goal identification processes also helped patients prioritize competing concerns (e.g., unemployment, child care, diabetes), which improved their ability to take action.

> ***"I think having someone on my side when making the report, not just doing it myself, actually helped the situation. The social worker seemed to be very helpful."***

Beyond direct action, patients also reported that being heard was often the most important aspect of their interactions with the care team. It was important that staff interacted with them "as humans, not just as patients."

> ***"How's your housing situation? Do you feel safe? Is there any abuse going on? Sometimes people won't talk about that when they go to the doctor—they don't think they're supposed to. But those are all things that affect your mental health and physical health."***

The Health Care Team Perspective

Nearly all team members involved in direct patient care acknowledged that what they learned from patient reporting on the social determinants of health questionnaire influenced their decisions about the subsequent treatment plan. The information made possible conversations about socioeconomic, cultural, and personal realities that would not otherwise be routinely discussed. Providers discovered just how significant these issues were to their patients' health and how strongly patients wanted to resolve them.

> ***"The screening brought it more to my attention that people were saying, 'You know what? I can't eat healthy food. I can't afford it. I'm eating rice and beans. I know it's terrible for my diabetes, but it's the only thing I can afford for myself and my family.' And I think that it allowed patients to be more direct and clear with me and allowed me to be more focused and direct about what are some of the obstacles to optimal care."***

Providers noted the complexity of social health stressors and the importance of being realistic about which patient goals could be addressed in the health center and which required a broader set of resources from local community partners or other sectors. The team found, for example, that it was more successful helping patients achieve goals related to food insecurity than those related to housing issues.

Providers identified several roles they could play to support patients in reaching their goals: breaking large goals into smaller objectives, facilitating direct access to resources, and advocating for patients directly with external organizations.

> ***"Some situations we won't be able to resolve—abuse, violence in the community. We respect patients' autonomy and can only give resources."***

> ***"Discovering a patient lives in a shelter without a kitchen or air conditioning, or other things that might worsen their clinical conditions, has allowed me to write letters on their behalf or connect them with nutrition and other resources to continue to improve health while the patients' social circumstances are addressed."***

The use of PROs also led to greater collaboration among medical office assistants (MOAs), primary care clinicians, and the case management team. Patients' responses to the PRO questionnaire revealed common reference points which staff could use to communicate with patients and coordinate with each other.

> ***"Before it was, okay, maybe the doctor would have that conversation. But now it's like, everybody's on it."***

The project also helped Urban Horizons prioritize timely follow-up with patients and use a variety of means—telephone, mail, texts, patient portal—to connect with them after their visits.

> *"We try to not let a patient fall through the cracks. We squeeze in extra time to reach a patient whenever we can; higher-risk patients are prioritized."*

Insights on Implementing PROs in Primary Care

Patient-Reported Goal Achievement on Social Determinants of Health as an Outcome

Urban Horizons' experience speaks directly to the value of patient-reported outcomes in an urban primary care setting involving predominantly vulnerable populations. The prevalence of social health stressors among the practice's patients meant that addressing those stressors in the context of other health conditions was clearly a priority. The care team had previously implemented a questionnaire to screen patients for socioeconomic risk factors; with their piloting of PROs, they treated social determinants of health—and the team's accountability in influencing them—as outcomes.

The health care team worked to ensure that goal-setting and achievement tracking constituted a feasible, effective, and appropriate outcomes-based management strategy.[1] For example, while screening helped identify patients with housing insecurity issues, the outcome was not necessarily seen as the number of patients reporting that they had secured permanent housing. Rather, a number of intermediate outcomes were used to assess the effectiveness of care management plans; these included selection of an appropriate medication that did not require refrigeration as well as the patient's initiation and completion of tasks needed for a Medicaid or housing assistance application.

Urban Horizons also capitalized on its unique and innovative EMR-based decision support system, which allows the team to respond to patients' reported needs by creating a step-by step path for moving from problem to goal to resolution. For example, a patient reporting "housing" as an issue negatively affecting her health will be engaged in a conversation with staff to better understand the nature of the problem; housing will be added to the active "problem list" in the EMR, which is accessible to all team members. The staff member and patient will then develop a series of actionable and manageable goals and milestones that will be tracked over time. The patient-reported outcome consists of an achievement based on those milestones as well as a longer-term goal. The EMR is equipped with drop-down menus to facilitate specific types of follow-up actions (e.g., referral, advocacy)

1 Giovannetti E. Developing Person-Driven Outcomes. National Committee for Quality Assurance (2017). http://www.allhealthpolicy.org/wp-content/uploads/2017/10/GIOVANNETTI-for-web.pdf

and recording of status (e.g., in progress, achieved) to allow for meticulous documentation by staff along the way.

A Culture of Warm Handoffs

One of the most challenging aspects of embracing an outcomes-based model of care is finding an efficient and reliable way to follow up with patients—since only they can provide the information required to assess whether outcomes were achieved.

In previous work, Urban Horizons had found a strong inverse relationship between same-day, on-site problem-solving with a case manager and the number of "no-shows" for follow-up appointments—the more same-day, in-person problem-solving, the lower the number of follow-up no-shows; same-day case management also helped expedite eventual problem resolution. As a result, the practice invested in a full-time case manager and aimed to increase coordination through warm handoffs between team members. It also prioritized co-visits in which a patient could simultaneously meet with her physician as well as another care team member, such as a case manager or behavioral health specialist.

At the beginning of the PROPC-NY initiative, the practice's warm handoff and goal documentation rates were 47 percent and 45 percent, respectively. After a series of improvement cycles that included provider focus groups and interviews, data analysis, protocol revisions, development of training resources, and staff boot camps, the results were notable: screening of eligible patients reached 93 percent (1,815 out of 1,947), warm handoffs to the case management team were conducted for 73 percent of those who identified at least one social determinant of health and indicated a desire for assistance from a case manager, and identification and EMR goal documentation of patients reached 100 percent. This commitment to data-driven quality improvement is crucial to Urban Horizons' effective implementation and sustaining of innovations, including the adoption of PROs.

Organizational culture is a main driver of such success. Personal commitment demonstrated by leadership through behaviors and actions can inspire staff to work at "getting it right" for patients and the community. This includes purposeful listening to help patients define goals and outcomes that matter to them as well as the collaborative development of strategies to help them achieve those goals. A starting place of humility and empathic curiosity to learn more about a patient—rather than an assumption that the care provider already knows enough—is also a part of a needed culture shift that can be nurtured by continuous staff training and a mission-driven hiring philosophy.

> ***"I treat my patients like family; they are my family. They cry, I cry."***
>
> *—Clinician*

Organizational Impact

The PROPC-NY collaborative has made a substantial impact on the pilot site (Urban Horizons) and the broader organization (IFH). It has strengthened Urban Horizons' ability to use and adapt case management services to specifically address issues related to social determinants of health (SDH). It has also led to improvements in patients' medical management: providers use the results of SDH screening and goal-setting to ensure that care plans are appropriate and feasible. This may include, for example, changing a medication in response to insurance restrictions or identifying alternate pharmacy locations in response to neighborhood safety issues. The project has also resulted in greater integration of primary care and psychosocial services and a more universal and systematic approach to holistic patient care.

Looking Ahead

The innovative PRO work at Urban Horizons continues to evolve. Based on its PROPC-NY collaborative experience, the practice plans to explore additional uses of goal-setting and achievement-tracking to strengthen its capacity to address a diverse set of patient outcomes within the primary care setting.

Additionally, Institute for Family Health is planning to extend the outcomes-based model of care to another one of its Bronx sites, Mt. Hope Family Practice, which is similar to the pilot site in practice size and patient population. The professional relationship between the medical directors of the two health centers can be leveraged to help make the replication of Urban Horizons' workflow successful; staff at the two sites also share IFH's common EMR platform and its decision-support capacities. Expanding the model will require additional investments, staff buy-in, appropriate staffing and training, and a robust referral network.

IFH has successfully implemented agreements with a number of organizations regarding referrals for specific medical services. This has allowed better access and care coordination for patients. The goal is to broaden this model and to develop memoranda of understanding or formal business agreements with social service agencies. As part of IFH's goal of building a reliable network of referral partners to address social determinants of health, these agreements ensure that its staff receive appropriate follow-up reports on patients and updated information on operations and service capacity.

IFH's PROPC-NY Project at a Glance

Project site	Urban Horizons Family Center
Site attributes	Federally qualified health center; in 2017, over 4,500 patients served in nearly 22,000 visits
Location	South Bronx, NY
Targeted population	All patients 18 and older
Outcomes of focus	Goals related to social determinants of health (housing, food insecurity, affordable care, interpersonal violence, community violence)
PRO measure instruments	Social Determinant Screening, goal-setting, and goal achievement
Key team members involved in patient-reported outcomes workflow	• Medical office assistants, nurses (administration, scoring, documentation): 12 • Physicians, nurse practitioners, case managers (communication with patients about results, care plan development): 6 • Case managers (goal-setting, referrals, follow-up): 3
HIT system	Epic
Assets	• Sophisticated use of the EMR, with ongoing innovations and customization to ensure open and efficient use by all team members. • Commitment to highly specific documentation processes to assess patient needs, prioritize problems, set goals, and track goal achievement. • Demonstrated trust and impact in the community served. • Commitment to invest in human resources and ongoing staff training. • Mature use of continuous quality improvement. • Visionary leadership.

Additional Institute for Family Health team members who contributed to this project:

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The care team at Urban Horizons Family Health Center

United Hospital Fund acknowledges the Institute for Family Health team for its outstanding work and efforts during all phases of the PROPC-NY collaborative and The Engelberg Foundation for its generous support.