

I-MPACT Patient Reported Outcomes Survey (PROs) – 2018 – 2019

Background

The Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) is a collaborative quality improvement (CQI) project funded by Blue Cross and Blue Shield of Michigan (BCBSM). The focus of I-MPACT is to evaluate and improve care transitions in three specific patient populations: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and patients transitioning from a hospital to a skilled nursing facility (SNF) and then from the SNF to home. I-MPACT is a unique CQI, requiring hospitals and physician organizations (PO) to work together in partnership (we call the partnership a “cluster”) to improve care transitions in a patient population of their choice. Quite often, the requirement for hospitals and POs to work together means these entities are formally working together for the first time when they partner for I-MPACT. Each cluster is required to perform a minimum of three interventions on target population patients as it has been shown in the literature that multifaceted interventions improve patient satisfaction as well as reduce hospital readmissions and ED utilization. One of the three interventions must increase the seven-day follow up appointments post-discharge. I-MPACT has chosen to focus on increasing the number of patients who are seen by a provider within 7 days of hospital discharge because of strong evidence in the literature that patients who see a provider within 7 or 14 days of discharge have better outcomes. I-MPACT collects clinical patient data from hospital electronic medical records (EMRs) to assess patient health, services utilized while in-patient, medications, readmissions, and ED utilization. In addition, I-MPACT gathers data on how well patient information is transferred from inpatient to outpatient provider and from inpatient provider to the patient.

Objectives

As a component of I-MPACT’s work to evaluate and improve patient care transitions, the Patient Reported Outcomes survey (PROs) was developed to capture the patient’s voice after the initial care transition process from a hospital or SNF to return home. Currently, there is little information regarding the patient’s perspective of their experience returning home, and I-MPACT wanted to gather data about this segment of the patient experience. I-MPACT was also interested in developing a deeper understanding of what is needed to improve transitions of care from a patient’s perspective. Goals of the program were to collect data and identify gaps in care during a patient’s transition based on patient interviews. We collected data regarding patient follow-up calls, readiness for discharge, medical equipment, and SDOH concerns. We also sought to evaluate how follow-up with doctors was associated with race, health goals, post-discharge phone calls, and social factors in our target populations of CHF, COPD, and SNF patients.

Methodology

I-MPACT was approved by the University of Michigan Institutional Review Board as a quality improvement project exempt from further review. PROs survey questions were developed by the I-MPACT coordinating center with input from patient advisors and I-MPACT participants, as well as information gathered from a review of literature. Many factors were considered in the development of the survey including: ensuring adherence to Center for Medicare and Medicaid Services (CMS) requirements to avoid overlap with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) questions, limiting liability, using plain language for patient understanding, and creating uniformity in survey administration.

Interviews were conducted with patients by a cluster representative 8-12 days after discharge and gathered information about the patients’ post-discharge experience, such as: attendance of a follow-up appointment since being discharged from the hospital/SNF, issues (e.g. medications, timing of discharge, clarity of discharge instructions, support at home) after discharge, concerns related to social determinants of health (SDOH), and any other concerns or positive experiences. A few additional demographic questions were answered by the

interviewer after a survey was completed with a patient. Patients or their caregivers (required to be 18 years of age) were allowed to answer PROs survey questions. All survey questions directed to patients were voluntary and allowed to be skipped.

In preparation for PROs data collection, I-MPACT cluster teams were required to work in new and different ways to collaborate and share information. Each cluster had to develop a process for identifying their shared target population patients within 7 days of the patient's discharge and conveying their medical and contact information, which enabled trained interviewer(s) to begin interviewing patients 8-12 days post-discharge. Also, hospitals and POs had to develop processes to navigate any urgent patient needs, or reported health concerns, arising during interviews. Many clusters did not have processes and resources in place to navigate these issues and new ones had to be put in place.

The survey and script were piloted for three months, July - September 2018. Based on pilot data, final modifications were made to the survey, script, and process. Data collection with the final survey began in October 2018 and continued through December 2019.

Results

Over the course of the 15-month data collection period, PROs solicited information directly from 1,257 patients or caregivers, capturing information about the transition of care period after being home for several days. Because answers were voluntary and allowed to be skipped, there are variances in the number of responses for each question.

Aggregate Data

Figure 1. 78.6% (N=1243) of patients reported receiving at least one follow-up call before their interview (8-12 days post-discharge). Of the patients who received at least 1 phone call, 89.9% (N=867) described the call(s) as either helpful or very helpful.

Patients Receiving Follow-up Calls within 12 Days Post Discharge (N=1243)	#	%
Did not receive a follow-up call	266	21.4%
Received 1-2 follow-up calls	589	47.4%
Received 3-4 follow-up calls	277	22.3%
Received 5 or more follow-up calls	111	8.9%
Patients who received calls and found them very helpful/helpful	867	89.9%

Figure 2. In regards to patients' perceived readiness for discharge home, 14.1% of patients (N=1238) reported not feeling prepared to go home, with 4.4% of those who felt unprepared also perceiving a negative impact on their health.

Did the patient feel prepared to go home when discharged? (N=1238)	#	%
I felt prepared to go home	1063	85.9%
I didn't feel prepared to go home, but it did not affect my health	121	9.8%
I didn't feel prepared to go home, and it did affect my health	54	4.4%

Figure 3. Of patients who required medical equipment for home use, 7.6% of patients were not confident using the equipment at home. At the time of the interview, 1.9% of patients reported never receiving the equipment that was prescribed for home use.

Patients Requiring Medical Equipment/Inhalers on Discharge (N=899)	#	%
Confident using equipment/inhalers	814	90.5%
Not confident using equipment/inhalers	68	7.6%
Never received equipment/inhalers	17	1.9%

Figure 4. 20.8% of patients interviewed self-reported a social concern. This question allowed respondents to select all that apply, which allows the individual concerns percentage to be a sum greater than the total sum of “patients reporting at least one SDOH concern.”

All Patient Reported SDOH Concerns by Type (N=1256)	#	%
Affording prescriptions, medical equipment, PT, home health	93	7.6%
Transportation to doctor appointments, pharmacy, grocery store, etc.	74	5.6%
Affording doctor visits and co-pays	69	2.9%
Having enough help at home to take care of myself	66	6.0%
Affording basic needs – food, heating/cooling	37	5.4%
Other issues	27	2.2%
Patients reporting at least one SDOH concern	282	20.8%
No issues reported	945	79.2%

Follow-up Appointment Related Data

Figure 5. 1223 respondents with CHF, COPD, or discharged to SNF answered the survey question regarding follow-up appointment attendance. 61.9% of patients had attended a follow-up appointment by the time of the interview. On aggregate and in target populations, more patients attending follow-up visits received post-discharge follow-up calls, had conversations about goals with their doctor, cited fewer SDOH concerns, and tended to live with others. A breakdown of follow-up appointments by target population demonstrates CHF patients had a greater likelihood of seeing a doctor, with 65.1% having been to an appointment, 59.4% of patients discharged from SNFs visited doctors, while only 50.2% of the COPD population had visited doctors at the time they were surveyed.

Figure 5.

Question	Aggregate		CHF		COPD		SNF	
	Attended follow-up appt.	Did not attend follow-up appt.	Attended follow-up appt.	Did not attend follow-up appt.	Attended follow-up appt.	Did not attend follow-up appt.	Attended follow-up appt.	Did not attend follow-up appt.
Patient has seen a doctor w/in 12 days post-discharge from hospital	61.9% (757)	38.1% (338)	65.1% (572)	34.9% (307)	50.2% (106)	49.8% (105)	59.4% (79)	40.6% (54)
Talked to doctor about personal health goals								
Yes	83.7% (627)	54.0% (243)	88.5% (500)	65.3% (192)	72.4% (76)	42.2% (43)	64.6% (51)	14.8% (8)
No	16.3% (122)	46.0% (207)	11.5% (65)	34.7% (102)	27.6% (29)	57.8% (59)	35.4% (28)	85.2% (46)
Received at least one follow-up call post-discharge								
Yes	80.8% (601)	74.8% (348)	88.5% (500)	76.5% (235)	81.0% (85)	76.0% (79)	68.4% (54)	63.0% (34)
No	19.2% (143)	25.2% (117)	11.5% (65)	23.5% (72)	19.0% (20)	24.0% (25)	31.6% (25)	37.0% (20)
Patient lives at home with others								
Yes	71.1% (536)	59.5% (275)	70.5% (402)	59.1% (179)	74.5% (79)	61.9% (65)	70.5% (55)	57.4% (31)
No	28.9% (218)	40.5% (187)	29.5% (168)	40.9% (124)	25.5% (27)	38.1% (40)	29.5% (23)	42.6% (23)
Reported at least one (1) SDOH concern								
Yes	17.0% (128)	83.0% (627)	17.0% (95)	29.8% (89)	18.1% (19)	22.9% (24)	15.6% (12)	24.5% (13)
No	27.4% (127)	72.6% (337)	83.0% (463)	70.2% (210)	81.9% (86)	77.1% (81)	84.4% (65)	75.5% (40)

Figure 6. White/Caucasian patients attended follow-up visits at greater rates than Black patients. Races other than White/Caucasian and Black had very small numbers reported and were therefore grouped in “other.”

Reported Patient Race (N=1091)	Attended follow-up appt.	Did not attend follow-up appt.
White	65.2% (525)	34.8% (280)
Black	50.6% (125)	49.4% (122)
Other	71.8% (28)	28.2% (11)

The survey also asked patients if they had any additional comments or questions before ending the interview. Patients provided many comments noting gaps in care such as: lack of information on how to operate medical equipment or trouble experienced with medications. These responses also provided I-MPACT clusters the opportunity to review processes and implement new quality efforts for improvement.

Discussion

The PROS project, as part of I-MPACT, is a unique evaluation of patients’ perspectives about the transition of care processes from the hospital or the SNF. At the aggregate level, we found that the vast majority of patients receive a post- discharge follow-up phone call and find them valuable. Many clinicians anecdotally feel that patients are “bombarded” by too many calls. Indeed, close to 50% of patients receive 1-2 calls within 12 days of discharge. However, our study finds that close to 90% of the time, patients found the calls very helpful/helpful. For example, in the PROs open ended question, patients provided additional feedback such as: “Nurse calling to explain my diet (CHF) in more detail and how to limit fluid intake was helpful” and “Pharmacy called me to go over my medications again after I returned home. That was helpful.” Being able to provide this feedback to care managers, nurses, etc., who complete post-discharge follow-up calls, is important in reassuring them their time is well spent.

Of concern, one out of five patients expressed a SDOH concern such as affording prescriptions for medical care and doctors' appointments, transportation issues, assistance at home, and affording basic needs. In a 2019 survey of Michigan seniors 34.7% of those surveyed noted that their reason for not seeing a doctor was because they could not afford it, another 18.1% didn't see a physician because it wasn't covered by their insurance and 22.1% didn't go to see a doctor due to lack of transportation.

We also found that patients who attended their appointments received more follow-up phone calls, talked to their doctors about personal health goals more often, had more support at home, and reported fewer SDOH concerns. Unfortunately, we were unable to discern whether the follow-up appointments took care of these issues, or whether there is a bias that patients who are more engaged and have more resources follow-up with their doctors.

Our study was limited, without the ability to correlate whether the presence of SDOH found during the survey were associated with readmissions or emergency utilization. However, there is a growing body of evidence from the Medicare funded Community-based Care Transition Programs that show interventions addressing social needs can often decrease unnecessary hospital utilization. I-MPACT is currently working to identify SDOH efforts and tools already in place, to better understand the feasibility and challenges related to assessing and addressing patient specific SDOH needs.

Lastly, our survey showed significant racial disparities in terms of the attendance of follow-up appointments. Unfortunately, our study was not designed to capture the reasons why Black patients did not attend follow-up post-discharge. We hope to perform more analysis through our care transition data registry to understand whether appointments were not scheduled for Black patients as often as other patients, or whether there is a type of follow-up (in-person, versus video or telephone) that is more amenable to the population.

I-MPACT is one of the few CQIs that requires hospitals and physician organizations to work together toward a common goal--in this case to improve care transitions and reduce unnecessary hospital utilization. The PROs study was a unique opportunity in which the POs and hospitals had to develop shared processes in order to reach patients in the post-discharge period. Surveys were conducted by staff within the PO or by staff shared between the PO and hospital. This required hospitals and POs to develop a process for timely and effective communication of patient discharges prior to the 8-12 day post-discharge window for the survey, creating challenges for many. Each cluster needed to work together to ensure the process identified patients: falling within their chosen patient population, discharged from the partner hospital, and having established care with the PO partner. Some clusters were ready with a well-established process at the time of the pilot in July, while others needed additional time prior to the formal launch in October 2018. Also, each cluster also needed to prepare policies and procedures to address health issues and other patient care issues that might arise while conducting interviews. Most did not have mechanisms in place to do this and there were concerns about liability or the inability of a PROs interviewer to aid a patient if an issue was discovered during an interview.

I-MPACT succeeded in requiring clusters to work together to create processes for communication around patient discharges where previously there had been none, or when existing processes were not reliable. While many clusters implemented a process specifically for I-MPACT purposes, and not to be generalized to all patients, clusters did identify other essential gaps in communications around patient status. I-MPACT did a deep dive with a pilot cluster to better understand obstacles in communicating patient status between hospitals and POs and included a team from Michigan Health Information Network (MiHIN) to assist with connecting the POs to an auto file transfer feed and then problem solve issues in the relay of information to and from them. Lessons learned

from the deep dive were shared with others in the collaborative and largely centered around IT issues with transmission of information. Both hospitals and POs worked with their IT groups to identify why certain details, like patient phone numbers, were missing in discharge information transmitted by hospitals, or if details were transmitted by hospitals, why the information did not appear in PO notifications.

One limitation with PROs was that the patients/caregivers answering PROs surveys were, arguably, part of the healthiest segment of the demographic since patients had returned to their homes, and were still at home 8-12 days post discharge. However, even in the context of that limitation, more than 20% of PROs respondents self-reported concerns related to SDOH. It is widely understood patients tend to underreport their SDOH concerns due to a desire for privacy or unwillingness to share such sensitive information with someone when they do not have a trusted relationship already formed with that person. So, for patients who are less healthy, or unable to return to home, the number of SDOH concerns is likely to be higher.

Conclusion

The I-MPACT PROs initiative provided data about the care transition process from the patients' perspective. Because information was specific to each cluster, it was a rich source of real and actionable information to reference and inform future work with I-MPACT and their target populations. Results from PROs will help shed light on vulnerabilities for patients when they are discharged from the hospital, particularly when they are unable/unwilling to attend a post-discharge follow-up appointment with a doctor within 8-12 days of leaving the hospital. When evaluating patients who attended a follow-up appointment vs. those who did not, we know that patients who did not attend an appointment appear to share several other characteristics that may put them at greater risk for health-related challenges, such as: living alone, not discussing health goals with a doctor, having more SDOH concerns, and receiving fewer calls after they leave the hospital. Also, Black patients appear to see doctors at a lower rate after they leave the hospital. We hope that this detailed information will help clusters tailor care transition interventions that are specific to their patients' needs.

As demonstrated by the efforts needed to organize and prepare hospitals and POs to participate in this project, communication across the continuum of care, between the inpatient and outpatient setting, has vast room for improvement. I-MPACT's pilot, utilizing MiHIN data feeds highlighted on way to improve communications. Coming up with standard IT settings or guidelines for the data transferred and received between organizations can help. Another option is the ability to share EMR data. Finally, ongoing communication between hospitals and outpatient providers collaborating on standards of information transfer between patient settings is encouraged.

As I-MPACT plans for next steps, it is important to keep this PROs information in mind. This work, along with literature and information gathered from local resources such as: Area Agencies on Aging, community health worker initiatives, current physician organization efforts directed at improving care transitions, telehealth, etc., will help us develop new patient-centered initiatives aimed at improving care transition and preventing readmissions and emergency department utilization.