

Patient Goals (Priority)-Directed Care: True Value-based Care

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Mr. T: 83 year-old man with fatigue, decreased appetite, weakness



- Prior heart attack
- Diabetes
- Hypertension
- Heart failure
- Atrial fibrillation
- Osteoporosis
- Chronic kidney disease
- Peptic ulcer disease
- Depression

Mr. T's disease-based care

- **Cardiologist:** ↑ β -blocker; continue warfarin
- **Endocrinologist:** Start insulin, bisphosphonate
- **Nephrologist:** start dialysis soon
- **Gastroenterologist:** Stop bisphosphonate,
↓warfarin, endoscopy
- **Psychiatrist:** stop β -blocker
- **Disease outcomes** – BP, stroke, MI, fracture,
rehospitalizations, GI bleed, depression

What is the problem?

- Older adults with multiple and complex conditions receive a lot of care...
 - fragmented across clinicians and settings
 - each clinician focuses on subset of patient's conditions
 - often of unclear benefit & potential harm
 - not always targeted at what matters to patients

The care is fragmented



For patients: see average of 7 MDs /year, focus on individual conditions

For clinicians: 1° care clinician who cares for persons with 4+ conditions must coordinates care with 229 providers

Pham, Ann Inter Med, 2009

The care is of uncertain benefit



Excluded from clinical trials:

- Trial participants healthier & fewer conditions than clinical populations

With multiple conditions: what outcome defines benefit?

The care is of potential harm



20% (1 of 5) Medicare beneficiaries receive guideline-recommended medications that may harm coexisting conditions (“guideline recommended harm”)

Lorgunpai, Tinetti, PLoS ONE, 2014

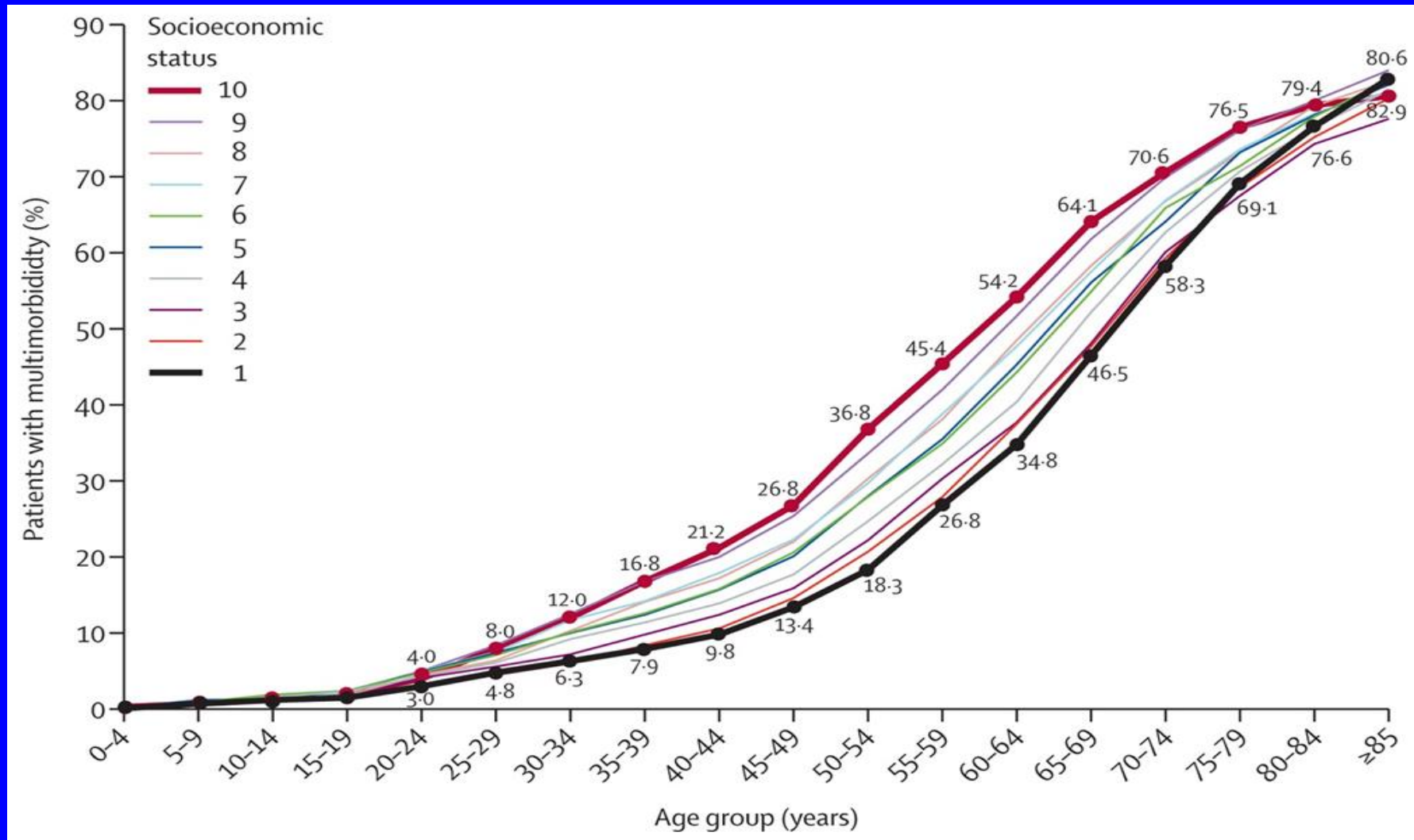
Care may not align with what matters most to patients

- Patients with multiple conditions:
 - Think in terms of personal outcomes and care preferences
 - Vary in their:
 - Health outcome goals
(Fried TR, Arch Intern Med, 2011; Patient Educ Couns, 2010; J Am Geriatr Soc, 2008)
 - Care preferences / acceptable treatment burden
(May, Montori, Boyd)
- Disease-specific outcomes may not measure what matters most

What are patient goals and care preferences?

- **Health outcome goals** – Personal life outcomes patients want from their health care (specific, measurable, and actionable (e.g. pain control allows 5 hours sleep))
- **Care preferences** – acceptable patient workload; care activities and consequences (what patient willing and able to do to achieve their health outcome goals)

How big of a problem is this? Is Mr. T. an outlier?: # conditions by age & socioeconomic status



How big of a problem is this?

- 18,500,000 (37%) Medicare beneficiaries with 4+ chronic conditions consume 74% of Medicare budget (CMS, 2012)
- All adults: Majority of health care used by those with \geq 2 conditions (Anderson G, RWJF.org)
- Multiple conditions is the norm; single disease is the outlier

Solution: Building patient goals-directed care

- We convened advisory groups of patients, caregivers, 1° & specialty clinicians, health system leaders, payers, HIT, systems design, policy makers (~150) to...
 - Identify modifiable contributors to fragmented, burdensome care for older adults with multiple chronic conditions
 - Build a feasible, sustainable approach to care that addresses the identified modifiable contributors

Building patient goals-directed care: Modifiable causes

- Decision-making and care focused on diseases not patients
- Lack of delineation of roles and responsibilities & accountability; no one in charge
- Lack of attention to what matters to patients & caregivers (their own health priorities)

Solution is a move from...

Disease-based
decision-making &
care

TO

Patient goals-
directed decision-
making & care



Patient goals-directed care: 3 core components

- Patient's health outcome goals & care preferences elicited & shared
- Clinicians translate these goals into care options
- All care aligned with patient's health outcome goals within the context of care preferences



Patient health outcome goals & care preferences

Domains (examples) of specific, measurable, actionable health outcomes	Domains (examples) of patient workload / care preferences**
Survival (e.g., live to see grandson graduate high school in 5 years)	Health care utilization (e.g. # visits, hospitalizations; providers; diagnostics)
Function (e.g., walk 2 blocks to store)	Medication management (e.g., complexity; adverse effects; monitoring)
Symptoms (e.g. Not SOB with gardening)	Self-management tasks (e.g., diet, exercise, check weights, bp, glucose)
Well-being (maintain ability to enjoy)	Procedures (time, anxiety, complications)

** AKA care burden, patient activity/workload

Disease vs. Patient goals-directed care for Mr. T

	Current disease-based care	Patient goals-based care
Health Outcome (s)	Blood pressure; stroke, MI, fracture, hospitalization for heart failure, UGI bleed; depression	<u>Outcomes</u> : Fewer symptoms & better function now, not life prolongation <u>Preferences</u> : Fewer visits, labs, meds, clinicians, procedures
Clinicians	6 MDs + other providers; (no one in charge)	1° care + nephrologist (others e-consult)
No. Visits	~ 20/ month; INR blood draw	~5 per month & no blood draw
Meds. (adverse effects)	12 (fatigue, appetite, bleeding)	7 (none or reduced)
Monitoring	BP, glucose multiple daily, INR	Occasional blood sugar
Self-management	Diet for heart failure, DM, CKD, warfarin; inject insulin	Restrict salt, limit processed carbs, eat what likes; physical activity
Procedures	Upper GI endoscopy, cardiac	Time limited trial of dialysis

Guiding principles for patient goals-directed care



1. Patient outcome goals and care preferences drive all care
2. Clinicians roles and responsibilities are agreed to, including quarterback
3. Current care planning
4. Care across conditions and clinicians integrated and shared

What patients & caregivers said

- Patient defines what is a “bad outcome”
- Care based on their health outcome goals and “acceptable” care burden (workload)
- Single point of contact; “who should I call?”; who’s in charge?
- Open access to Electronic health records
- Goal-driven EHR and care

What primary & specialty clinicians said

- Embedded care manager
- Primary/Specialty compacts (clear roles and responsibilities; framework for communication)
- Smaller networks of providers
- Quality metrics that are patient, not disease-oriented
- Payment system support complex care
- Evidence of what works in this population

What health systems leaders said

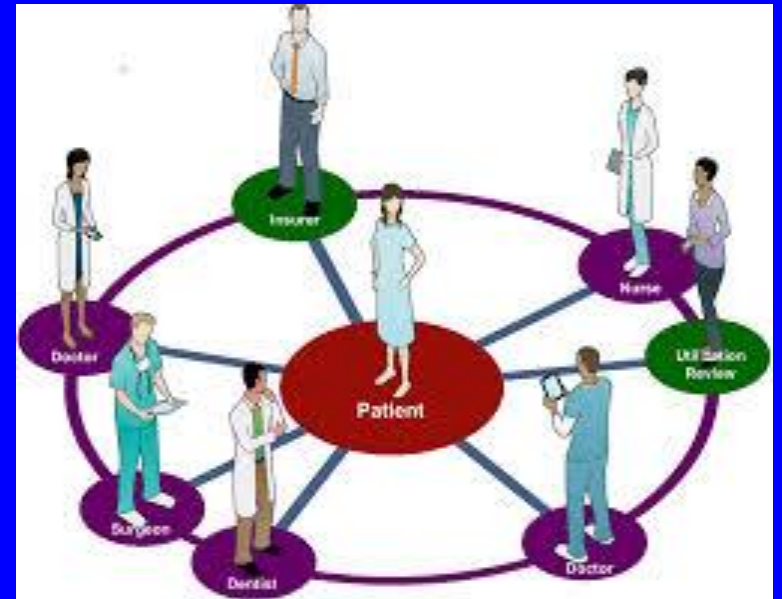
- Need to learn how to provide care more efficiently and cost-effectively
- Don't know how to do that for this population
- Do not want to add staff, rather change what staff do
- There needs to be a return on investment (training, HIT, clinical time)

Barriers to patient goals-directed care

- Innovation fatigue; many payment and delivery changes
- Some may misinterpret this approach as withholding care
- Patients may prioritize unrealistic goals; change goals
- Health information technology inadequate to support
- Clinical workflows may not allow time tailor care to individual goals
- Payment models don't support
- Quality metrics counterproductive

Define & Measure Value & Quality

Quality = High Value =
Outcomes (outputs) /
Costs (inputs)



QUALITY
QUALITY
HIGH

How we define & measure quality & value

- From population perspective (one size fits all)
- Disease-specific (~700 measures) or
- Event-specific (e.g. readmissions)
- Ok if everyone has a single disease and values the same disease or event outcome...

What should we measure?...

Disease-outcome
centered metrics

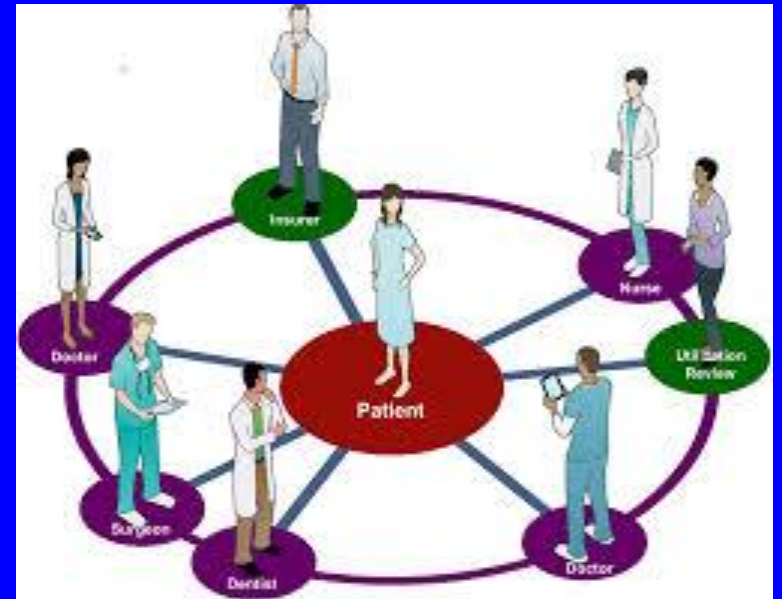
TO

Patient-centered
metrics



Value & Quality from patient's perspective

Value =
Own health outcomes
(outputs) /
Care preferences
(inputs)



Appropriate quality metrics for older adults with multiple chronic conditions

- Measure what matters to patients
 - Were patients' outcome goals ascertained, addressed, and improved
 - Was treatment & care burden measured & minimized
 - Were roles across clinicians agreed upon
 - Were conflicting recommendations avoided?
 - Were patient-reported outcomes such as function, symptoms measured? (need to be in EHR)

Many challenges but...

