

# WHEN THE PATIENT VOICE IS HEARD IN EDUCATION, DOES THE CLINICIAN LISTEN? DUAL TRACK PATIENT/PROVIDER EDUCATION IN IBD INCORPORATING PATIENTS AS LEARNERS AND FACULTY



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## INTRODUCTION

In recent years, the U.S. healthcare system has moved to adopt new models of care that focus on personalized medicine and patient-centricity. It follows that the education developed for healthcare professionals must meaningfully empower them with insights for more effective patient engagement and facilitate patient activation. The challenge is, and has been, to meaningfully represent the patient "voice," or their real-world care experiences, in content developed by non-patient faculty.

One approach has been to provide healthcare professionals with education to convert knowledge-based information into hypothetical practice scenarios with patient vignettes. This has typically involved either a case study developed by a clinical expert, or an actor portraying a patient. Although these approaches deliver some value, they lack the "hearts and minds" impact of integrating actual patient perspectives within clinical content. Including patients as faculty allows for exposure to real-world patient engagement and communication strategies.

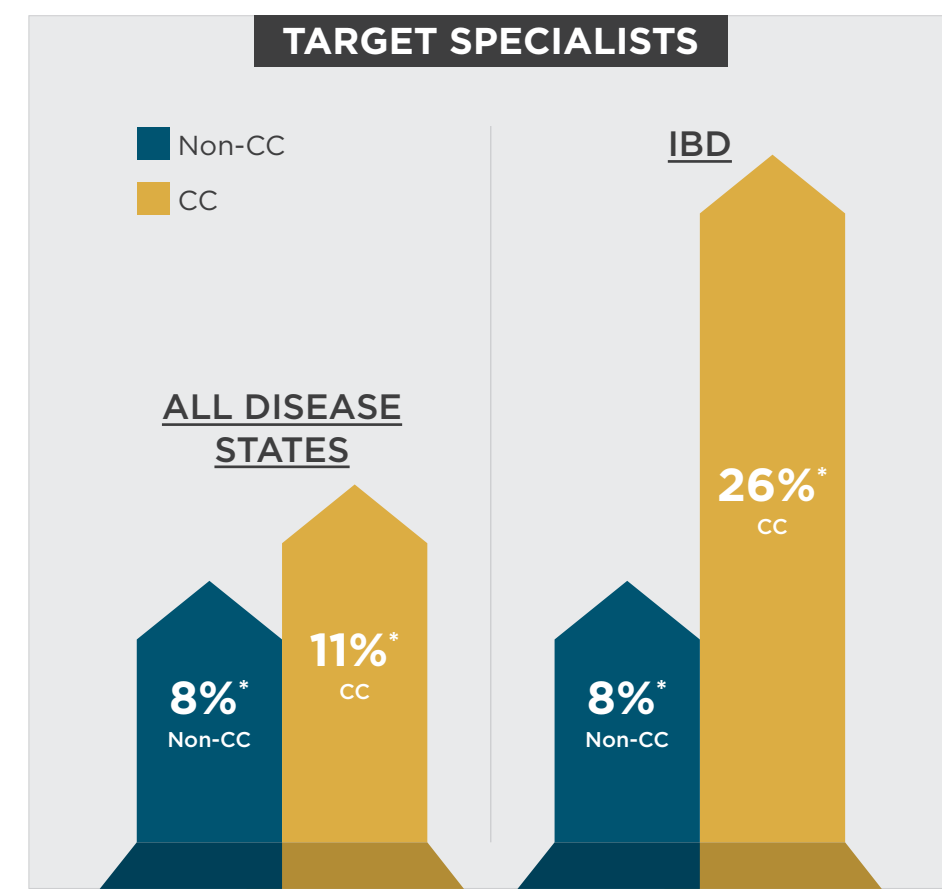
The mandate for integrating patient faculty into continuing medical education programming is clear. In two successive editorials in 2015 and 2016,<sup>1,2</sup> the ACCME's Graham McMahon urged the CME community to both recognize patients as part of the care team, and to meaningfully incorporate them as planners and teachers. Further, he asserted that inclusion of patients in education can make the education itself more relevant to clinicians by "engaging their hearts as well as their minds." While his conclusions make sense intuitively and are well reasoned, they have not been rigorously evaluated to identify what quantifiable effect patient faculty and the patient voice have on the outcomes for clinician learners.

RMEI's Clinical Convergence<sup>®</sup> platform engages learners by integrating the perspectives of actual patients, through inclusion of real patient faculty (in the live setting), or through HD video dialogues (in the online setting), with clinical content. Focused on clinicians in community practice, the design features encounters with 1 or 2 unique patients, engages learners with patient data and insights, and challenges them with knowledge- and competence-oriented questions followed by peer benchmarking and evidence-based explanations. Aspects of patient engagement and education are explored in the context of the targeted education provided.

It is RMEI's assertion that these CME interventions position specific aspects of management in their real-world applications, impact healthcare provider behavioral competence, and reinforce the importance of the patient/clinician relationship on patient outcomes.

For the purposes of better understanding the impact of patient faculty on learning outcomes, a study on the relative efficacy of Clinical Convergence programs (CC) compared to comparable Non-Clinical Convergence programs (case-based programs without patient faculty; non-CC) remains ongoing. Preliminary findings from this study revealed that among therapeutic areas in which CC and non-CC activities were launched concurrently, the CC design was more effective at increasing learner Competence than the non-CC format (N=3,499 total learners; n=1,830 target specialists).

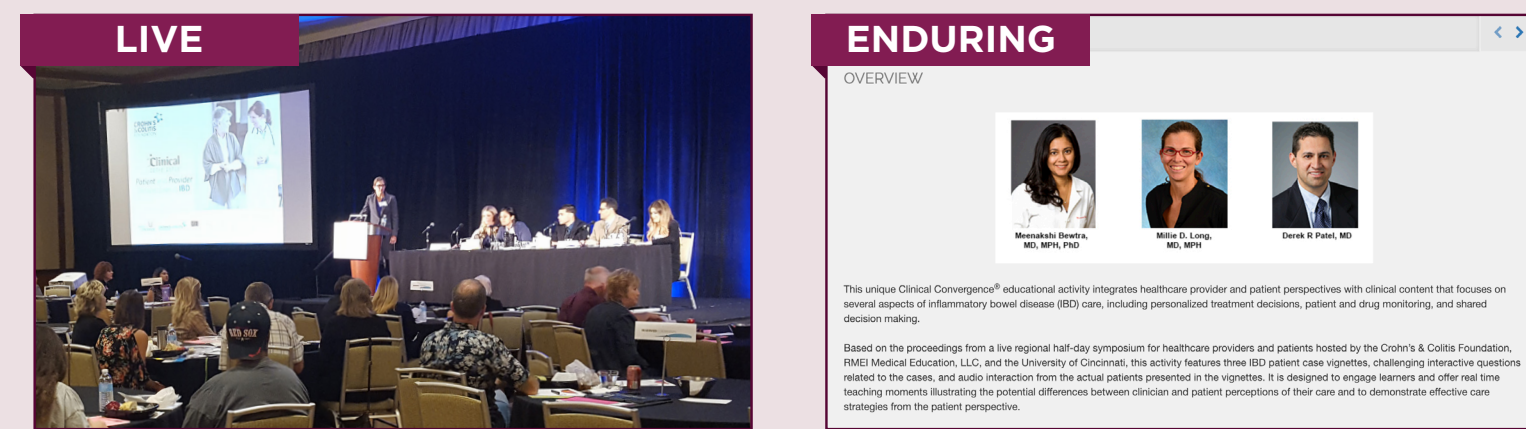
This was especially true for education in inflammatory bowel disease (IBD) (n=513 gastroenterologists) where the instructional design of the program was slightly modified.



\*Note. p<.05

## PROGRAM DETAILS

RMEI and the Crohn's & Colitis Foundation developed a Clinical Convergence<sup>®</sup> curriculum, comprised of a series of half-day regional meetings, aimed at gastroenterology/primary care providers who manage patients with IBD. Patients with IBD and their caregivers were also invited to participate in concurrent patient education. The patient/caregiver track included a workshop (led by the Foundation and faculty), focused on facilitating meaningful engagement with clinicians. Participants from both tracks then converged to discuss lessons learned. The provider track was endured online, expanding the reach to a national cohort of community clinicians.



These findings affirm the import and efficacy of incorporating patients in independent medical education (IME). This poster explores a further analysis of the nuanced differences between the online and live populations who participated in this unique educational format.

Specifically:

- What differences (if any) exist in objective proficiency as measured by the Pre- to Post-Test changes in the stated Curriculum Learning Objectives between the Live and Online population of specialists?
- What, if any, was the impact on the actual patients who participated in the "Live" Patient track?

## METHODOLOGY

Outcomes were measured via an audience response system (live), electronically (enduring), and electronically at follow-up.

Included in the outcomes for professional learners were Objective Metrics (Knowledge and Competence questions) and Subjective Metrics (Confidence and Practice Strategy questions).

Data for Learning Objectives were calculated by the aggregation of thematically related Knowledge and Competence questions. The curriculum Learning Objectives were:

### Learning objectives for healthcare professionals:

1. Differentiate between current, novel, and future IBD therapies based on their efficacy and safety data
2. Devise an individualized and adaptable treatment plan for patients with IBD to maximize remission, avoid relapse, and minimize toxicity
3. Assess disease progression and utilize drug monitoring strategies to optimize treatment of patients with IBD
4. Employ a strong patient-provider collaborative approach to managing patients with IBD that includes patient education, engagement, and shared decision making

### Lecture topics for patients/providers:

1. Personalized treatment in IBD
2. Monitoring you for best treatment outcomes
3. How your healthcare provider makes treatment recommendations

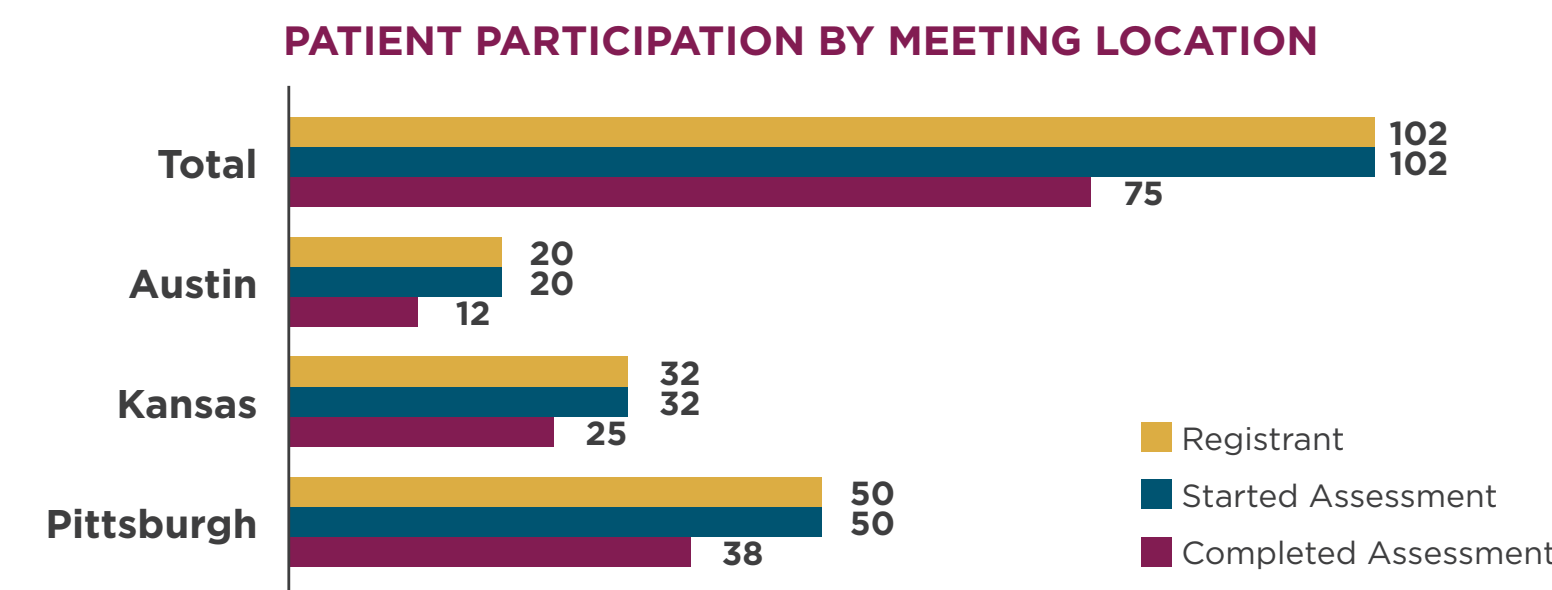
For patients, a composite **Wellness Index** measured the degree to which they felt able to actively participate in their care before and after the education.

All (professional and patient) outcomes reported represent matched pairs means comparisons.

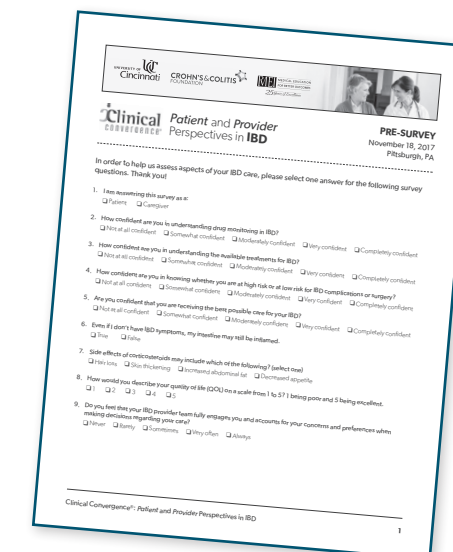
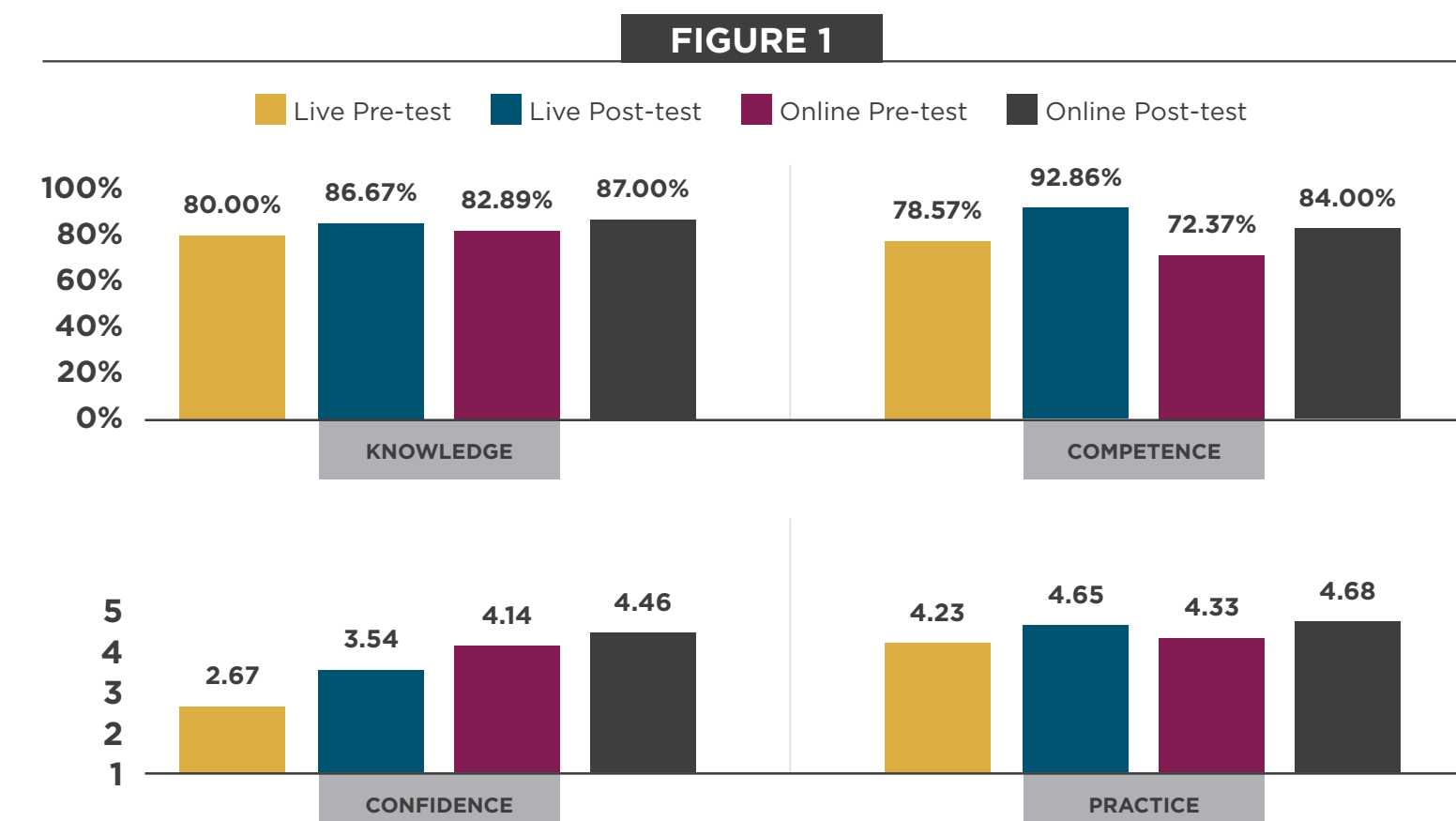
Learners' (professional and patient) performance changes on these metrics were used to evaluate changes in proficiency and, by extension, program efficacy.

## RESULTS

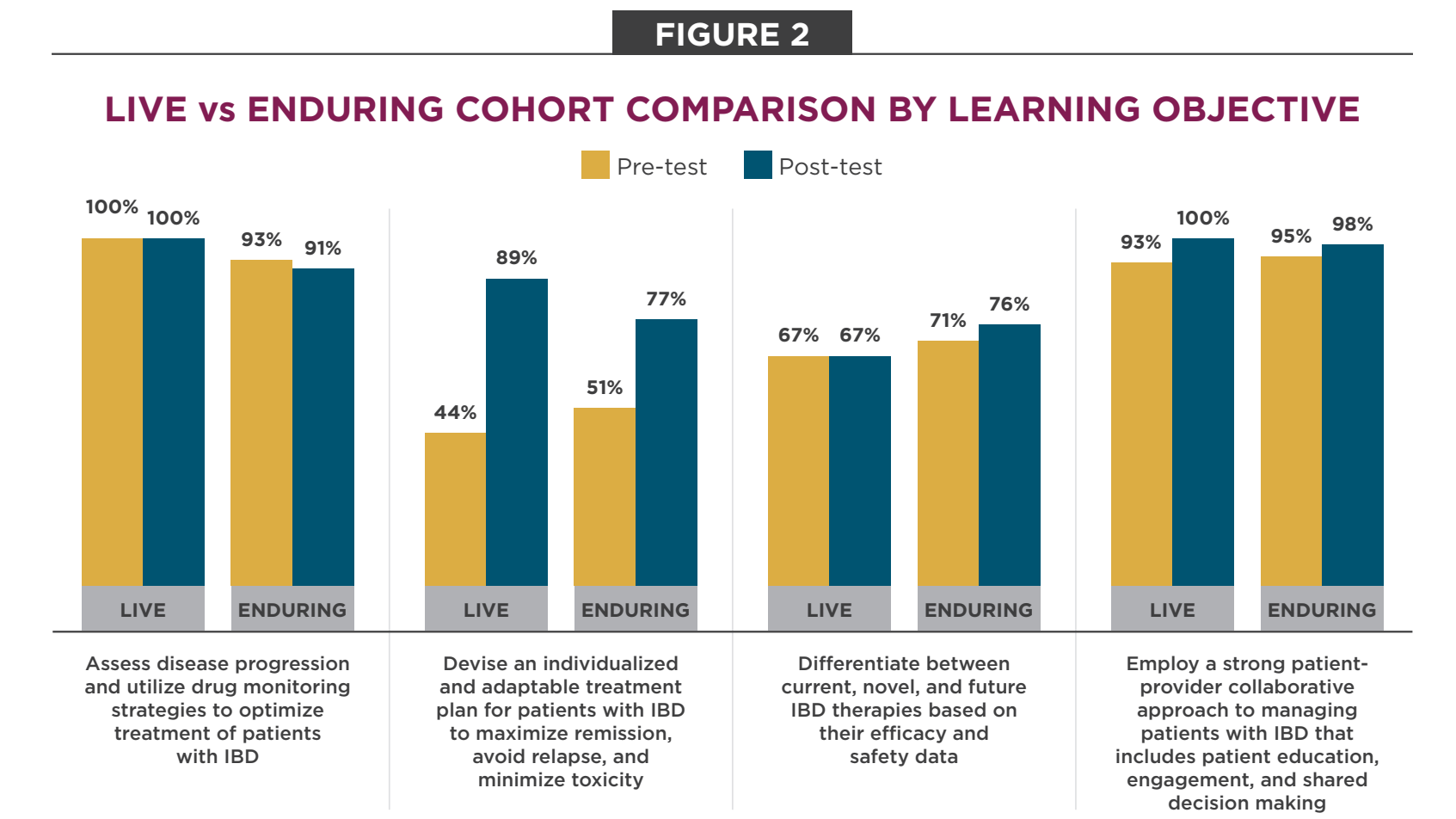
937 providers (92% physicians) participated in the four activities (506 were specialized gastroenterology providers), with N=108 completers. 102 patients participated in the live meetings. The professional participants in these educational activities encounter an average of 5,639 IBD patients per week, which translates to 293,240 IBD patient interactions annually.



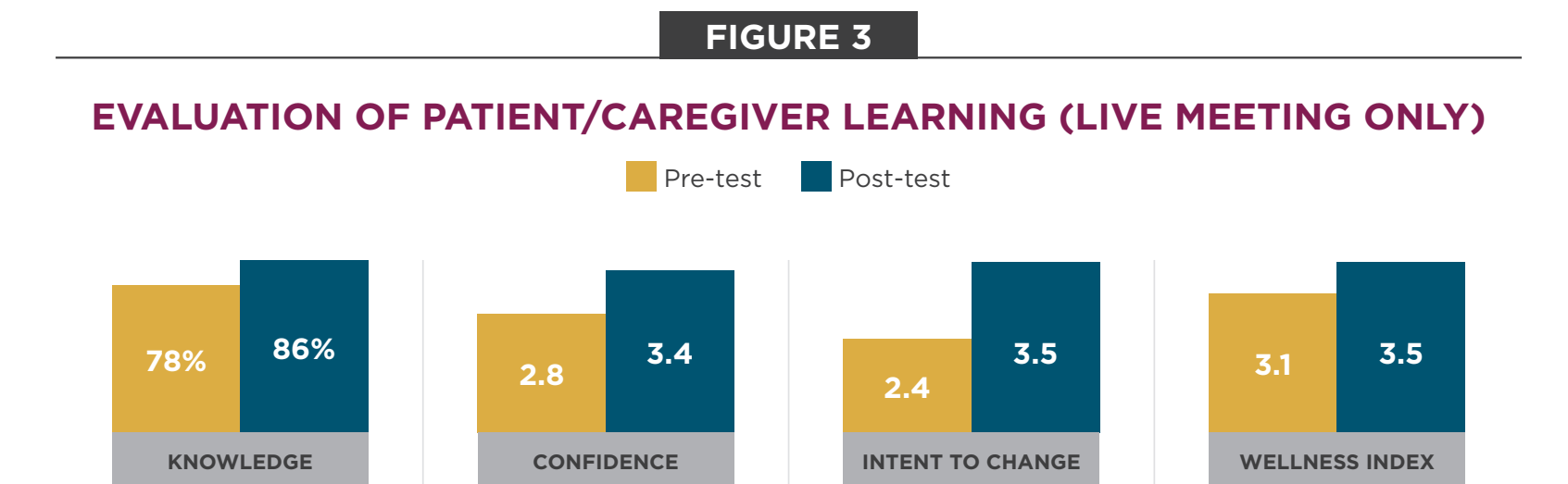
Analysis of professional performance on learning domains (Figure 1) revealed improved clinician proficiency and behavior change in both live and online formats. Post-test proficiency in Competence was more pronounced in the live meetings (change 18% vs 16% enduring) suggesting that peer-to-peer interaction may have contributed to improved integration of information.



These improvements resulted were reflected in the curriculum level change on stated Learning Objectives (Figure 2).



Patients/caregivers showed improvements in knowledge regarding symptoms and treatments with commensurate improvements in confidence and intent to change ratings (Figure 3). Patients showed universal improvement across the Wellness Index.



## CONCLUSIONS

This educational initiative represented an opportunity for clinicians and patients to come together for the purposes of improving overall provider and patient outcomes in an extra-clinical setting. The positioning of real patients as faculty members highlighted the importance of the clinician/patient collaboration which represents a departure from the previous standard of paternalistic engagement. Further, this population of highly skilled clinicians was open and engaged in the process of truly evolving their thinking and practice to incorporate a greater degree of patient involvement in treatment planning and care management.

These findings represent the first steps toward a truly collaborative approach to care which extends beyond the office visit. Most notably, clinicians were able to assimilate procedural/practice-based information more effectively when patients were included than when patients were not included across both live and enduring conditions. The observed benefit was not exclusive to clinicians, as patient participants were also more able and empowered to engage meaningfully in their care. Though this study (across therapeutic areas) remains ongoing, even these preliminary findings suggest that the way forward in IME is, as Dr. McMahon stated, clear.

1. McMahon GT. What Do I Need to Learn Today? — The Evolution of CME. *N Engl J Med*. 2016;374:1403-1406.  
2. McMahon GT. Advancing Continuing Medical Education. *JAMA*. 2015;314(6):561-562.

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