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Review article

What are the contents of patient engagement interventions for older adults? A systematic review of randomized controlled trials

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ABSTRACT

Objective: To describe the contents of interventions reported in RCTs focusing on patient engagement of older adults.
Methods: A systematic literature review based on a search for "patient engagement/activation/empowerment/involvement/participation". Interventions were classified according to: (i) specific components (micro level), (ii) single/multiple dimensions (educational, behavioral, affective) (meso level), and (iii) the studies' main educational, behavioral or affective dimension (macro level).
Results: After screening 2749 articles, 35 were included. 20 unique components were identified, mostly behavioral or educational (45.5% each) (e.g., goal setting or written informational materials). Most interventions with a single-focus were classified as educational (31%), one was solely affective (3%). Half of the interventions covered more than one dimension, with four (11%) combining all three dimensions. Studies mainly focusing on the affective dimension included older participants (72 vs. 67 years), had a higher proportion of females (71% vs. 44%), and included other dimensions more frequently (67% vs. 31%) than did studies with a main focus on the educational dimension.
Conclusion: The contents of the interventions that focused on patient engagement of older adults tend to focus more on behavioral and educational dimensions than the affective dimension.
Practice implications: The possibility of adding the affective dimension into behavioral and/or educational interventions should be explored.

Contents

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1. Introduction

By the year 2025, the number of people worldwide aged 60 and over will exceed 1.2 billion [1]. This will create significant demands on healthcare services [2], along with the risks of exacerbating already long wait times for visits, reducing access to care for vulnerable patients, and lowering older patients' quality of life [3]. Making older patients participants in their own health and care management has been argued to be a key strategy [4,5]. Research has demonstrated that individuals who are engaged in their health are more likely to achieve better physical [6,7], psychological [8], relational [9], and organizational outcomes [10]. Older patients in particular should play an active role in their care, because of the multiple self-care tasks and healthcare decisions they are asked to manage [4].

Considering individuals' role in the care process may mean different things, including considering how patients comply and adhere to medical recommendations and treatments [11]. "The extent to which a person's behavior coincides with medical advice" (i.e., patient compliance) [12], or "the extent to which patients follow the instructions they are given for prescribed treatments" (i.e., patient adherence) [13], are important aspects to be considered to ensure that prescribed treatments are properly followed by patients.

Concepts like patient participation, engagement and activation have become more common in recent years [14]. Patient participation and involvement point to the role of the patient as an active participant within the clinical consultations to allow for shared medical decisions [15–17]. Concepts like patient empowerment and patient activation focus on enabling patients to play an engaged role in their care management [16,18,19]. Patient engagement has been described as an umbrella term for all these new concepts, reflecting a multi-dimensional psychosocial process wherein the patients play an active role and are supported by the health care at the cognitive, emotional, and behavioral levels [20–22].

A range of studies have investigated the effect of interventions aimed at supporting patients like patient education and self-management support [23,24]. However, it is unclear whether supporting compliance/adherence behaviors or processes like patient engagement means changing the contents of such interventions (i.e., does the change in the terms used mean a shift in contents of the interventions?). It is also unclear whether the contents of such interventions follow the care needs of an increasingly older population (i.e., does targeting older patients have specific effects on the interventions delivered?).

Describing and evaluating the contents of the interventions can help to pave the way toward more efficient interventions [25,26]. A literature search revealed studies that have classified the contents of interventions focusing specifically on patient compliance/adherence. The first review was published in 1998 by Roter et al. [27], who developed a definition grid to classify interventions for patient compliance according to three main dimensions: educational, behavioral, and affective (as well as combinations of these) [27]. They also defined specific components within each dimension. Other reviews on medication adherence interventions followed, using the same or slightly modified versions of Roter et al.'s classification criteria [28–34]. Results of these reviews and of a review of reviews on medication adherence [35] revealed that interventions combining educational, behavioral, and affective dimensions showed the best outcome. However, most interventions were educational, meaning providing knowledge to patients [27]. Conversely, the affective dimension was less often covered. Moreover, none of these studies looked specifically at older people. Thus, it remains in question how this target group can be made capable of achieving the tasks associated with their complex care responsibilities [36].

No reviews were found classifying the contents of interventions in studies focusing on the emerging concepts linked to patient engagement and targeting older people. It is thus an open question whether such interventions have different contents and whether targeting older patients has consequences for the contents delivered. Consequently, a review of RCTs (especially those targeting older persons) with such a focus is needed.

The overall aim of this study was therefore to conduct a systematic review to describe the contents of interventions used in publications reporting studies on RCTs focused on patient engagement where the average age of the participants was 60 or older and to compare interventions and studies according to the educational, behavioral and affective dimensions.

The specific aims were to describe the:

- Type and frequency of components used by patient engagement interventions for older people (micro-level)
- Differences between interventions using different combinations of educational, behavioral and affective dimensions (meso-level)
- Differences among the studies with a main focus on the educational, behavioral and affective dimensions (macro-level)

2. Methods

A systematic review of RCTs was conducted, purposively using a broad search strategy, followed by a step-by-step screening of articles through a funneling approach.

The methods used for retrieving, selecting and synthetizing data were based on PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines [37]. However, as the focus of this review was on contents rather than on outcomes of studies, some aspects of the PRISMA statement were not applicable (see Appendix for PRISMA checklist).

2.1. Eligibility criteria

Studies eligible for inclusion were required to:

(i) include the searched terms relevant for patient engagement (see the "2.3. Search" section for details) in the title, abstract, or keywords;
(ii) have individual patients as the main target of the intervention;

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