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A classification model of patient engagement methods and assessment of their feasibility in real-world settings

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ABSTRACT

Objective: Examine existing reviews of patient engagement methods to propose a model where the focus is on engaging patients in clinical workflows, and to assess the feasibility of advocated patient engagement methods.
Methods: A literature search of reviews of patient engagement methods was conducted. Included reviews were peer-reviewed, written in English, and focused on methods that targeted patients or patient–provider dyads. Methods were categorized to propose a conceptual model. The feasibility of methods was assessed using an adapted rating system.
Results: We observed that we could categorize patient engagement methods based on information provision, patient activation, and patient–provider collaboration. Methods could be divided by high and low feasibility, predicated on the extent of extra work required by the patient or clinical system. Methods that have good fit with existing workflows and that require proportional amounts of work by patients are likely to be the most feasible.
Conclusion: Implementation of patient engagement methods is likely to depend on finding a "sweet-spot" where demands required by patients generate improved knowledge and motivate active participation.
Practice implications: Attention should be given to those interventions and methods that advocate feasibility with patients, providers, and organizational workflows.

1. Introduction

In the US, as elsewhere, there is growing policy support for engaging patients [1–5]. Health care payers and insurers, like UnitedHealth, realizing the untapped benefits that might follow, also advocate for patient engagement [6]. Yet, while policy interest is high, the work required to implement patient engagement methods remains a perennial challenge [7]. Barriers to adoption, like workload pressures and complex organizational systems, are numerous and difficult to overcome [8,9]. As a consequence, efforts to engage patients in clinical settings have met resistance in real world settings [10].

Patient engagement has often been conflated with other terms like patient activation and, consequently, there is confusion in the literature. Hibbard and colleagues define patient activation as "understanding one's role in the care process and having the knowledge, skill and confidence to manage one's health and health care" [4]. Patient engagement has multiple definitions [3,11], but has broadly been defined as *the process of actively involving and supporting patients in health care and treatment decision making activities* [2,3,12,13]. Patient engagement can target professionals, patients, the organizational environment, and the intervention itself [14]. The literature on patient engagement recognizes policy level tensions where efforts to communicate risk and involve patients in their care [15] are seen as critical to improving quality and costs of patient care [5,13]; yet, many of these broader reflections on patient engagement have made it increasingly

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difficult to identify what, where, and how methods to engage patients can be introduced into routine clinical settings. To address this knowledge gap, we concentrate our attention on methods to engage patients, specifically, in clinical settings (i.e., the first level of engagement–direct care [3]).

The arguments in favor of engaging patients are numerous and include those derived from the ethical principles of enhancing agency and respecting autonomy [16]. Although not always referred to as patient engagement explicitly, the practice of engaging patients using decision support tools has been shown to have many positive outcomes, including reduced decisional conflict [17,18], improved treatment adherence to asthma pharmacotherapy [19], improved likelihood of receiving guideline-concordant depression care and improved symptoms [20], improved confidence in dealing with breathing problems and clinical care for patients with COPD [21], and enhanced health status [22]. However, despite this evidence of benefit, many methods fail to be implemented in routine clinical settings [7,23]. We observe that there has been insufficient attention given to this issue and suggest that it is time to assess the feasibility of advocated methods, especially in real world settings [24].

The purpose of this article is to assess the feasibility of suggested patient engagement methods in order to understand how implementation might be improved. Assessing feasibility of patient engagement methods in clinical practice, as for any innovation, requires an understanding of barriers to implementation [25]. Barriers to the implementation of shared decision making, one of many forms of patient engagement methods, include provider perceptions of lack of time [9] and limited applicability of the approach for some patients and clinical settings [9]. It is reasonable to assume that these cited barriers would also apply to other forms of patient engagement. While some reviews report the effectiveness of patient engagement methods, there are only a few examples of successful implementation strategies [23,26]. Given this mismatch between aspiration and reality, we have three objectives in this study: (1) to describe existing reviews of patient engagement methods; (2) to propose a model of patient engagement methods where the focus is on patient engagement in clinical workflows; and (3) to assess the feasibility of advocated patient engagement methods.

2. Method

We define patient engagement methods as tools or strategies, applied as part of the clinical workflow, that support patients through a process of being involved as partners in their own health care and decision making activities.

2.1. Search for reviews of patient engagement methods

Drawing from our definition of patient engagement, we searched the literature for existing reviews of patient engagement methods. We searched three databases (PubMed, Medline, and Google Scholar) using the following key words: patient, engagement, activation, communication, clinical encounter, shared decision making, intervention, and reviews.

2.2. Selection of reviews of patient engagement methods

We included reviews of patient engagement methods published in English in peer-reviewed journals. We excluded white papers, reports, and individual primary studies. Reviews had to include patient engagement methods targeted at patients (either alone or as part of the patient–provider dyad). Reviews were not included if they featured studies that targeted providers alone (e.g., provider training). Provider-targeted reviews of methods were excluded strictly for the purposes of clarity and scope. Two raters (SG and MF) independently checked the reviews for eligibility.

2.3. Working toward a model of patient engagement

We extracted data about the salient characteristics of reported patient engagement methods. We explored the timing of each method relative to the clinical encounter, *how* many individuals were involved in the delivery of the method, *how* the method was used by patients (directly or indirectly), and in what form the method was delivered to patients. These patient engagement methods were then categorized using an iterative process, based on a constant comparison of salient characteristics that is widely supported in the literature [27,28].

2.4. Feasibility of patient engagement methods

We assessed the feasibility of the reviewed patient engagement methods using a customized qualitative rating system. We defined feasibility as both likely uptake (i.e., acceptability) in routine clinical practice [29], and how successful the method may be when used within a specific context or setting [30]. Two researchers (SG and MF) qualitatively assessed the feasibility of each method, based on reported findings, using three scoring criteria: (1) how much work is required of the patient (patient effort—low, moderate, high, variable), (2) the number of additional human resources (e.g., time, expertise) likely required to implement the method (additional human resources—no, yes, variable), and (3) how well the method might fit into usual clinical workflows (built within existing system—poor, fair, good, high). Illustrative examples of qualitative assessment criteria from included reviews of methods were shared and consensus achieved prior to independent rating by SG and MF. Based on each individual qualitative assessment, overall feasibility of methods was assigned a "low" or "high" rating by two authors (SG and MF). Final rating validation was determined by convergence using investigator triangulation and reconfirmed by a third independent rater (GE).

3. Results

3.1. Literature review

After applying the inclusion and exclusion criteria, we included ten reviews of patient engagement methods [10,23,31–38]. We excluded seven reviews (see Appendix 1).

3.2. Reviews of methods

Table 1 provides details of the included reviews. The patient engagement methods included were extracted from articles from 1977 to 2011 that represent decades of research examining methods to activate and engage patients in and around the clinical encounter. A majority of articles have been published since 1990. The methods included using health coaches to inform and activate patients [37] and a wide variety of patient decision aids [38]—most often in the form of videos and handouts—that were designed to prepare patients and, in some cases, physicians, for the patient–provider conversation. Other methods included the use of educational materials [34] and the use of written materials to help patients communicate with physicians and clarify their health needs [35,38].

While some patient engagement strategies that adopt tools to inform patients are effective, findings reveal they work best to support, not replace, face-to-face communication within the clinical encounter [32]. Methods that prepare patients for the clinical encounter, like pre-consultation interviews [33] where clinical or non-clinical staff counsel patients prior to their