

# WHEN THE PATIENT VOICE IS HEARD IN EDUCATION, DOES THE CLINICIAN LISTEN?



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## INTRODUCTION

In recent years, the US healthcare system has moved to adopt new models of care that focus on personalized medicine and patient-centricity. 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 common 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 2 successively editorials in 2015 and 2016,<sup>1,2</sup> the ACCME's Graham McMahon exhorted 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® 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.

RMEI asserts 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.



## POPULATION

DEMOGRAPHICS

**3449**

TOTAL LEARNERS

**1830**

TARGET PHYSICIAN SPECIALISTS

- 586 ALLERGY/IMMUNOLOGISTS
- 352 DERMATOLOGISTS
- 513 GASTROENTEROLOGISTS
- 379 ONCOLOGISTS

**25,047 to 46,421**

PATIENT ENCOUNTERS PER WEEK

## METHODOLOGY

This study explores whether differences in efficacy exist between education that includes real patients (RMEI's Clinical Convergence®; CC) versus education that includes a hypothetical case presentation. Specifically:

- What differences (if any) exist in objective proficiency as measured by the Pre- to Post-Test change in the Competence domain?
- Are there populations for whom including patients in the instructional design is more or less effective than a traditional hypothetical case-based presentation?

### INCLUSION CRITERIA

Both activities must have launched in the same year, shared all stated Learning Objectives, targeted the same profession/specialty, employed either a CC instructional design or a case-based instructional design without inclusion of real patients (non-CC).

Data were analyzed for programs in non-small cell lung cancer (NSCLC), HER2-positive breast cancer (HER2+BC), chronic urticaria (CU), and inflammatory bowel disease (IBD).

## POPULATION

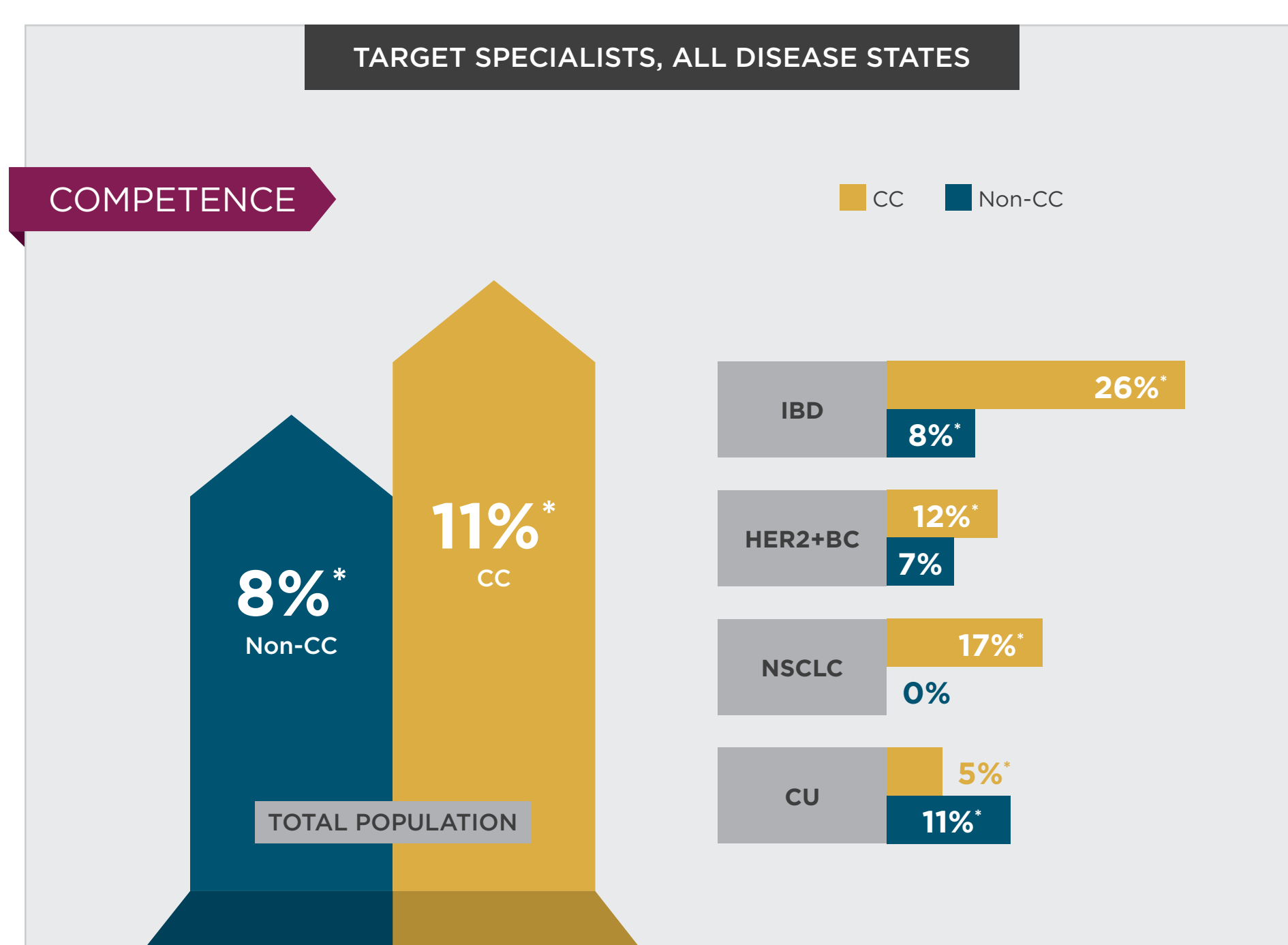
Cohorts, unique to each condition (CC or non-CC), were matched on demographic factors including Profession, Specialty, Years in Practice, Patient Volume, Intent to Change, and Practice Setting. Only learners who identified as members of the target audiences and reported actively treating patients with the specified disease state were included in the analysis.

All activities included in this retrospective analysis utilized a consistent matched pairs (Pre-Test/Post-Test) methodology, which included both objective and subjective metrics.

**Objective:** Multiple choice questions addressing procedural proficiency (Competence). These questions each had one correct answer and were scored 0% to 100%.

This metric (Competence) was aggregated at Pre-Test and Post-Test, then split along the previously identified demographic variables (profession specialty, years in practice, patient volume, practice setting, and intent to change). Distributions were tested for normality, after which their means were compared (within groups) using appropriate parametric or non-parametric tests.

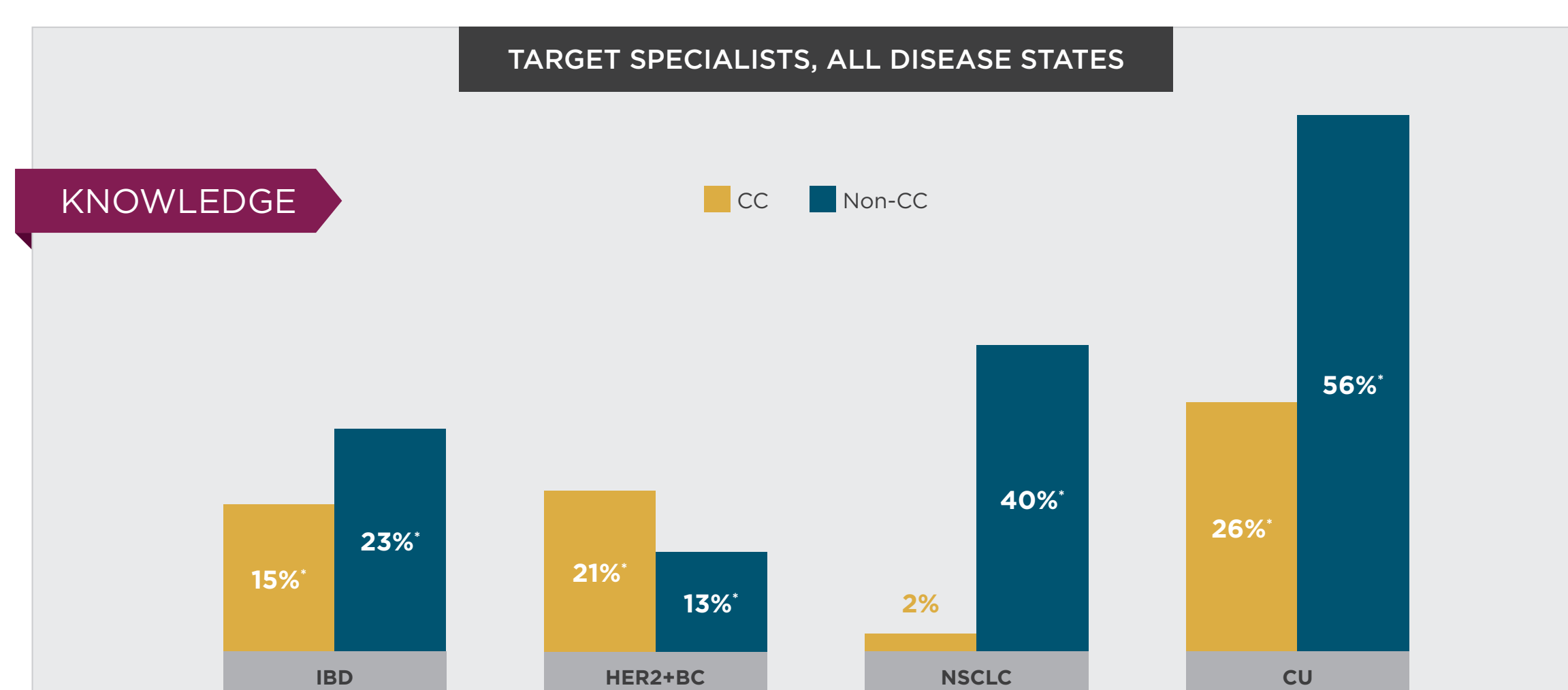
For the purposes of this study, we define “improvement” as percent change from Pre-Test.



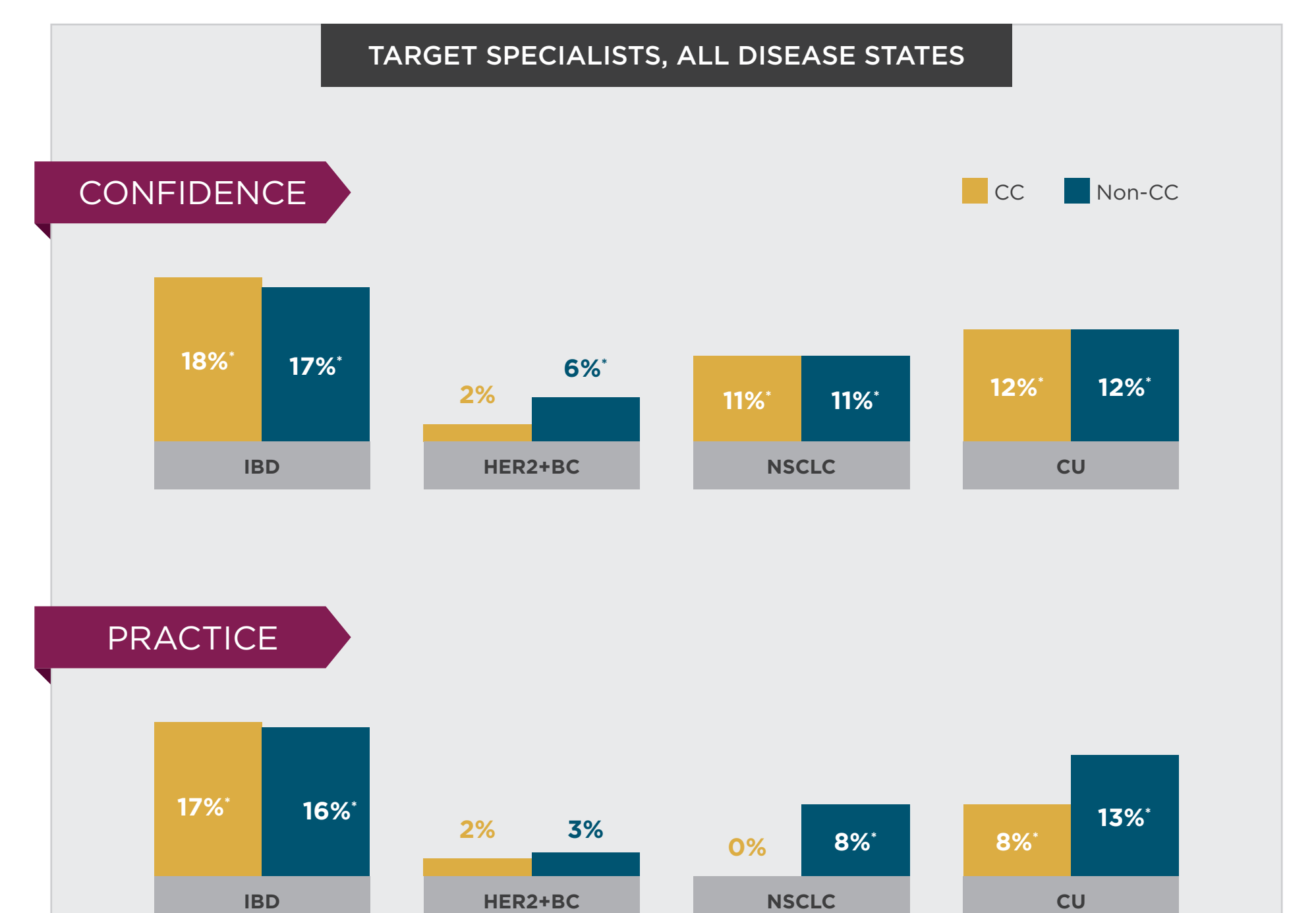
\*Note. p<.05

## FINDINGS

PERCENTAGE CHANGE FROM PRE-TEST TO POST-TEST IN BEHAVIORAL COMPETENCE



\*Note. p<.05



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## CONCLUSIONS & NEXT STEPS

Preliminary findings suggest that the inclusion of patient faculty has a demonstrably greater impact on improving procedural proficiency when compared to traditional case-based education.

Across the 4 disease states included in this analysis, these findings were most apparent in IBD, NSCLC, and HER2+BC. While these findings were not consistent in CU, preliminary retention data revealed that CC learners demonstrated substantially greater retention across both Objective and Subjective domains.

This is an ongoing study that will continue to expand addressing additional disease states/areas of specialization as well as including analysis on various presentation formats for the Clinical Convergence® instructional design.

