

KEY FINDINGS FROM THE CTHCS:

- Limited patient-provider discussion of health goals, patient self-management, and factors associated with increased health risk, such as stress and depression, were observed
- Patients' chronic disease status and obesity did not substantially increase patient-provider discussion of health goals and patient self-management, particularly related to patients' stress and depression

KEY INSIGHTS FOR POLICYMAKERS:

- Patient-provider communication that promotes patient self-management, particularly for patients with obesity or chronic conditions, should be more common and more comprehensive
- Medical home initiatives can help Connecticut achieve national benchmarks related to patient engagement and appropriate management of chronic conditions
- New technologies can and should be used to help identify at risk patients, personalize their care, and engage them in managing their health with an emphasis on improving population health outcomes

Connecticut Patients' Experience of Healthcare: Engaging Patients in Managing Chronic Disease

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Introduction

Chronic diseases are the leading causes of death and disability in the United States.¹ Cardiovascular disease, cancer, and stroke constitute the three most common causes of death in the US, collectively accounting for almost two-thirds of all deaths among adults.² National data indicate that half of all Americans have chronic conditions, and almost half of those have multiple chronic conditions.³ Chronic disease prevalence in Connecticut largely mirrors national rates, with Connecticut reporting slightly higher age adjusted rates of cancer and slightly lower rates of cardiovascular disease and stroke.²

Concerns over the burden of chronic disease may be tempered somewhat by the fact that these conditions are behaviorally driven, or at minimum have behavioral correlates, and thus are ostensibly modifiable. The Centers for Disease Control and Prevention identify four modifiable health risk behaviors—lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption—that are responsible for much of the undesirable health outcomes related to chronic diseases.^{4,5,6,7,8} Recent surveillance data indicate that problematic health behaviors put many Connecticut residents at risk of chronic



disease: only 54% of CT residents get the recommended levels of physical activity, only 28% have adequate intake of fruits and vegetables, and as a consequence, 23% of residents are obese.⁹

Recognition of the growing threat of chronic disease to population health has prompted changes in health care delivery to promote and support better patient engagement and self-management. Use of the Chronic Care Model in ambulatory settings, a practice transformation facilitating the delivery of patient-centered, evidence-based care, has been associated with improved health outcomes and lower health care costs among patients with chronic disease.^{10 11} Similarly, HRSA's Patient-Centered Medical/Home Initiative (PCMHH) encourages health centers to transform primary care to provide care that is comprehensive, coordinated, and patient-centered using a team-based approach. Among the practice standards expected for NCQA recognition are the use of comprehensive health assessments that include behaviors affecting health and other correlates of chronic disease, such as depression, and activities to support patients in self-management, including goal-setting and counseling patients to adopt healthy behaviors.¹²

These initiatives employ strategies to transform health care from a reactive system focused on treating disease to a system focused

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on promoting and maintaining health. In both, encouraging and supporting patients in self-management of health is critical. Hallmarks of both the CCM and PCMH initiatives are shared decision-making and patient engagement in their health and healthcare.^{13 10}

The Connecticut Health Care Survey provides a glimpse of the ways in which physicians are interacting with their patients in managing their health, particularly for patients with chronic illnesses. This brief highlights some findings from that survey and their implications for the management of chronic disease. As discussed more fully in this document, the CTHCS highlights gaps in provider-patient discussions related to modifiable behaviors that contribute to poor health, or conversely, can promote greatly improved health. Evidence cited throughout this brief indicates that improvement in the health status of Connecticut residents, particularly those with chronic disease, may be achieved by heightening providers' whole-person orientation and support for patient self-management. In short, a relatively accessible change in how health care is delivered holds real potential for measurable population health improvement.

How the Survey Was Conducted

The Connecticut Health Care Survey (CTHCS) was sponsored by six health foundations based in Connecticut: the Aetna Foundation, Children's Fund of Connecticut, Connecticut Health Foundation, The Patrick and Catherine Weldon Donaghue Medical Research Foundation, Foundation for Community Health, and Universal Health Care Foundation of Connecticut. The overarching goal of this project was to gather information from Connecticut residents relating to their experiences and perspective on their health and the health care system. The survey collected information by telephone using both landlines and cell phones from a sample of households across the state between June 2012 and February 2013. Adult residents of all ages were included in the survey, and some adults were asked to report information on the

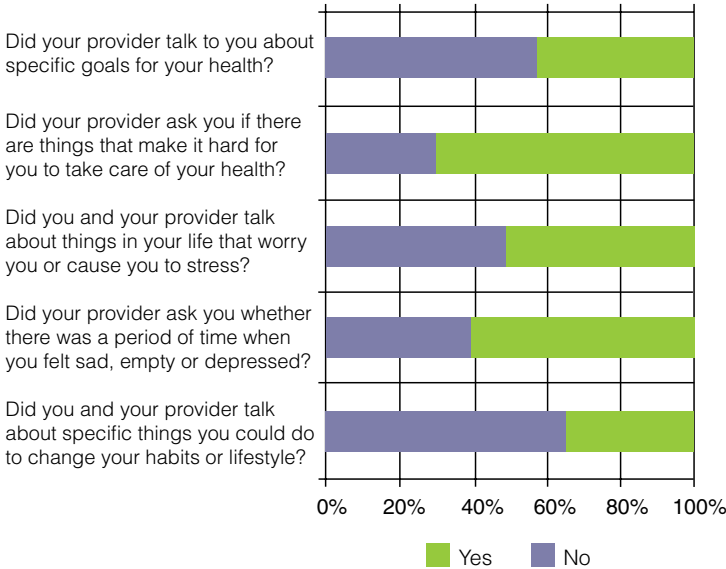


children in their household. In all, 4,608 surveys regarding adults and 839 surveys regarding children were completed. The Center for Health Policy and Research at the University of Massachusetts Medical School designed the survey, conducted the data collection, and did the initial analysis.

Survey Findings: Patient-Provider Discussion of Lifestyle and Health Issues

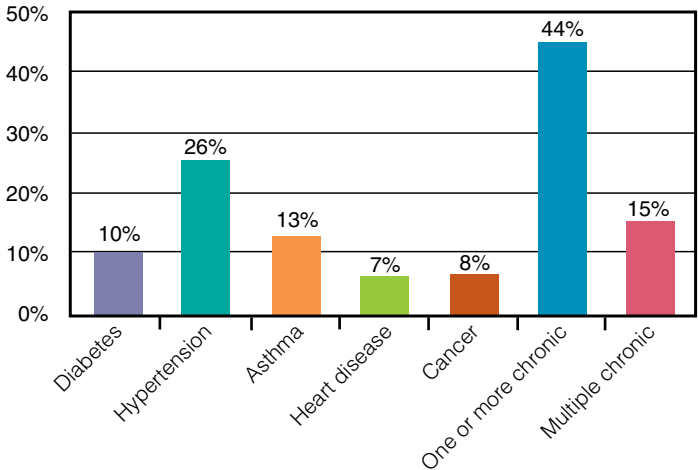
Patients reported modest to low levels of patient-provider discussion of health goals, patient self-management, and factors associated with increased health risk, such as stress and depression (Figure 1). One half to two thirds of patients reported that someone in their provider's office had talked with them about specific goals for their health (57%) or specific things they could do to change their habits or lifestyle (66%) during the past year. Fewer patients reported having discussed things in their lives that worry them or cause them stress (48%) or having been asked about feelings of sadness or depression (39%). **Finally, less than one third of CT patients reported having been asked if there were things that make it hard for them to take care of their health (29%).**

FIGURE 1: PATIENT-PROVIDER DISCUSSION OF LIFESTYLE AND HEALTH ISSUES



Prevalence of Chronic Illness and Obesity: CT Health Care Survey. Hypertension is the most prevalent chronic condition in Connecticut, affecting over 26% of patients. Rates of diabetes, heart disease, cancer, and asthma ranged between 7 – 13% of the Connecticut population. 15% of Connecticut residents had multiple chronic conditions. (Figure 2)

FIGURE 2: PREVALENCE OF CHRONIC ILLNESS IN CT % with condition



Survey Findings: Patient-Provider Discussion of Lifestyle and Health Issues among Patients with Chronic Conditions

While all patients can benefit from guidance related to lifestyle, health goals, and strategies for managing their health, patients with chronic illnesses are in particular need of such guidance. Data from the CTHCS indicate that patients with chronic conditions were somewhat more likely to have discussed these issues with their providers in the past year (Figure 3). Those with multiple chronic conditions were significantly more likely to have discussed with their providers specific health goals, and changes in their habits or lifestyle, than were patients without chronic conditions. However, patients with only one chronic condition (which constitute 28% of Connecticut patients) were no more likely to have discussed any of these issues with their providers as those without chronic conditions. The magnitude of differences based on chronic disease status were small: for example, 64% of those with no chronic conditions had discussed things they could do to change their habits or lifestyle with their provider, compared to 67% of those

with one chronic condition and 73% of those with multiple chronic conditions. Those with chronic conditions were no more likely than those with no chronic conditions to have discussed with their providers difficulties they had in taking care of their health, whether there were things in their life that worry them or cause them stress, or whether they had feelings of depression or sadness. Of the patients surveyed in the CTHCS, 22% were obese (i.e., having body mass indexes greater than 30). Healthcare providers were significantly more likely to have discussed specific health goals or changes in their habits or lifestyle with their patients who struggle with their weight. As was true for chronic conditions, the magnitude of differences between obese and nonobese patients in discussing these issues with their providers was small (Figure 4). For example, 64% of nonobese patients had discussed things they could do to change their habits or lifestyle with their provider, compared to 75% of obese patients, which constitutes a 17% increase in the likelihood of discussing these issues. Obese patients were no more likely than nonobese patients to have talked about things that worry or stress them, whether they had had feelings of depression and sadness, or whether it was difficult for them take care of their health.

FIGURE 3: PATIENT-PROVIDER DISCUSSION OF LIFESTYLE AND HEALTH ISSUES BY CHRONIC DISEASE STATUS

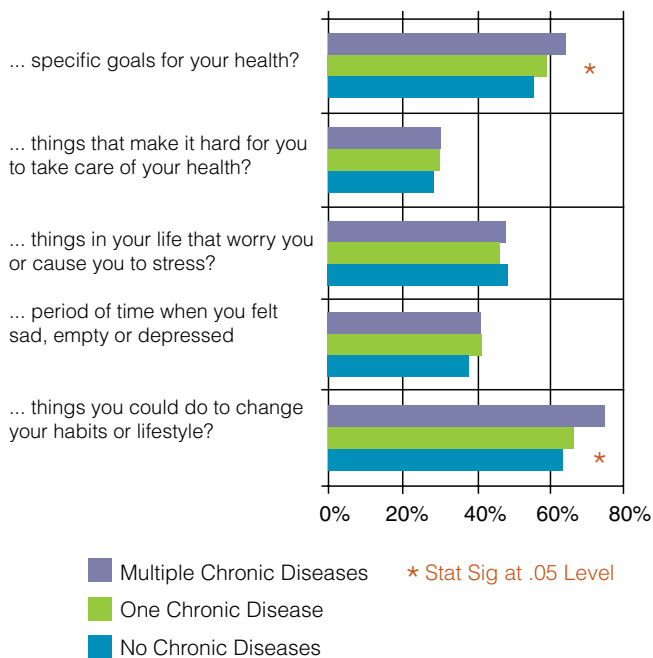
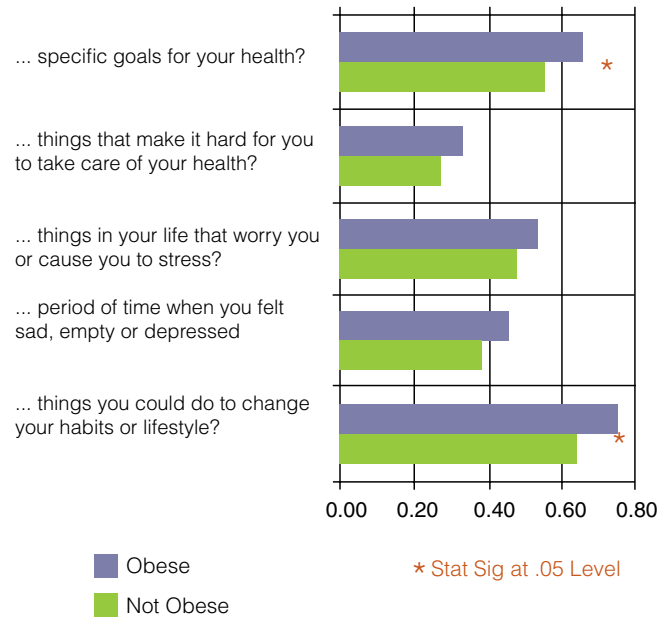


FIGURE 4: PATIENT-PROVIDER DISCUSSION OF LIFESTYLE AND HEALTH ISSUES: OBESE AND NON-OBESE PATIENTS



Policy Implications

Patient-provider communication that promotes patient self-management, particularly for patients with obesity or chronic conditions, should be more common and more comprehensive. The limited levels of patient engagement related to self-management observed in the CTHCS highlight a relatively accessible means for improving the management of chronic disease and overall population health in Connecticut. Although more than half of Connecticut patients have talked with their medical providers about setting goals and altering their habits and lifestyle to improve their health, patient-provider discussions related to stress and feelings of depression were not as commonplace. Of particular concern was the absence of higher rates of engagement related to stress and depression among obese patients given the well-documented association between stress, depression, and obesity.¹⁴ Data from the CTHCS indicate that a third of obese patients had not discussed setting health goals with their healthcare provider in the past year and a quarter had not discussed altering their health habits and lifestyle, clearly highlighting a missed opportunity to intervene with a substantial number of high risk patients.

Medical home initiatives can help Connecticut achieve national benchmarks related to health counseling, patient engagement, and appropriate management of chronic conditions. The patient-centered medical home (PCMH), the nation's fastest growing practice transformation innovation, urges healthcare providers to systematically assess risk factors and behaviors that affect patient health, equip patients to manage chronic conditions, and counsel patients to adopt healthy behaviors. Over 35,000 clinicians in almost 7000 sites across the country have achieved NCQA recognition.¹⁵ The Agency for Healthcare Research and Quality's state level ratings of Connecticut's performance on a number of criteria related to patient-centered care, such as the quality of patient-provider communication, counseling related to healthy behaviors, or hospitalizations for chronic conditions that could be managed in ambulatory setting, show the state to be performing below or far below national benchmarks.¹⁶ Connecticut is currently pursuing major initiatives that would foster a more patient-centered care experience. Connecticut's State Innovation Model (SIM) Plan, a roadmap for transforming the state's healthcare delivery system into a more effective, efficient, and patient-centered enterprise, promotes the adoption of the medical home as a key objective.¹⁷ Support for more patient-centered, wellness-oriented care is clearly an area in which Connecticut can improve significantly.

New technologies can help identify at-risk patients, personalize their care, and engage them in managing their health.

Identifying and treating patients suffering from or at risk for chronic disease can be a daunting task for clinicians, particularly for those treating medically and socially complex populations (e.g., the underserved, seniors, children). Technologies such as electronic health records hold great potential for improving and personalizing patient care. A 2013 survey of primary care physicians in CT found that 57% were using electronic medical records,¹⁸ many of which feature modules facilitating patient risk assessment, medication monitoring, support for standard care plans, guidelines, protocols, and so on.¹⁹ Newer technologies, particularly those accessible to patients on mobile devices such as tablets and smartphones, offer much promise for facilitating clinical assessment and enabling patient self-management. The mobile health marketplace is burgeoning: there are more than 97,000 mobile health apps currently available for download on 62 app stores.²⁰ While most of these apps target patients and consumers, it is estimated that 15% are exclusively for use by medical providers. When deployed in clinical settings such technologies can reduce the burden on clinicians by automating mechanisms to screen and refer patients for needed services, such as nutrition counseling or behavioral health. Findings from a Connecticut study employing mobile devices to assist in identifying at risk patients indicates that such technologies can dramatically improve the detection of problems such as depression and other mental health problems, alcohol misuse, food insecurity, and oral health problems.²¹

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- ¹ Kung HC, Hoyert DL, Xu JQ, Murphy SL. Deaths: final data for 2005. *National Vital Statistics Reports* 2008;56(10).
- ² Centers for Disease Control and Prevention. <http://apps.nccd.cdc.gov/cdi/>
- ³ Anderson, G. Chronic Care: Making the Case for Ongoing Care. 2010. Robert Wood Johnson Foundation, Princeton, NJ. www.rwjf.org/pr/product.jsp?id=50968
- ⁴ Centers for Disease Control and Prevention. <http://www.cdc.gov/chronicdisease/overview/index.htm>
- ⁵ Telford, RD. Low Physical Activity and Obesity: Causes of Chronic Disease or Simply Predictors? *Med. Sci. Sports Exerc.*, 2007;39(8):1233–1240.
- ⁶ Harris JR, Wallace RB. The Institute of Medicine's New Report on Living Well With Chronic Illness. *Prev Chronic Dis* 2012;9:120-126. DOI: <http://dx.doi.org/10.5888/pcd9.120126>
- ⁷ U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General—Smoking Among Adults in the United States: Cancer. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
- ⁸ Centers for Disease Control and Prevention (CDC). Alcohol Use and Health. Atlanta, GA: CDC. <http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm>.
- ⁹ Centers for Disease Control and Prevention. <http://apps.nccd.cdc.gov/brfss/>
- ¹⁰ Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the Chronic Care Model in the new millennium. *Health Aff (Millwood)*. 2009 Jan-Feb;28(1):75-85. doi: 10.1377/hlthaff.28.1.75.
- ¹¹ Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients With Chronic Illness: The Chronic Care Model, Part 2. *JAMA*. 2002;288(15):1909-1914. doi:10.1001/jama.288.15.1909.
- ¹² NCQA PCMH 2011 Standards, Elements and Factors: Documentation Guideline/ Data Sources. http://www.ncqa.org/portals/0/Programs/Recognition/PCMH_2011_Data_Sources_6.6.12.pdf
- ¹³ NCQA: The Future of Patient-Centered Medical Homes Foundation for a Better Health Care System. <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/BeforeLearnItPCMH/PatientCenteredMedicalHomeResources.aspx>
- ¹⁴ Björntorp, P. Do stress reactions cause abdominal obesity and comorbidities?. *Obesity Reviews* 2001;2: 73–86. doi: 10.1046/j.1467-789x.2001.00027.
- ¹⁵ National Center for Quality Assurance. Sneak Preview: 2014 Patient-Centered Medical Home Recognition presentation. <https://www.ncqa.org/Newsroom/MediaEvents/SneakPreviewNewNCQAPCMHStandards.aspx>
- ¹⁶ Agency for Healthcare Research and Quality. http://nhqrnet.ahrq.gov/inhqrdr/Connecticut/benchmark/table/All_Measures/All_Topics#far
- ¹⁷ Connecticut Health Reform Central. http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf
- ¹⁸ Tikoo M, Costello D. Evaluating Connecticut's Health Information Technology Exchange: Physician Survey Report. Farmington, CT: University of Connecticut Health Center; 2014.
- ¹⁹ Health Level Seven International. http://www.hl7.org/implement/standards/product_brief.cfm?product_id=269
- ²⁰ research2guidance. <http://research2guidance.com/the-market-for-mhealth-app-services-will-reach-26-billion-by-2017/>
- ²¹ Aseltine RH Jr. Relating Research to Clinical Activity: Using Research Strategies to Improve Primary Care. U21 Health Sciences Group Annual Meeting, Auckland, New Zealand, September 2012.