

Títol: Learnings and insights from the implementation of Patient Reported Measures Dashboards to support routine clinical practice

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Introduction

Using real-world data (RWD) dashboards, including Patient-Reported Measures (PRMs), is helpful in patient follow-ups and continuous improvement of healthcare processes and decision-making. We aim to communicate the learnings from elaborating PRM dashboards.

Methodology

Research was based on professional insights from four European hospitals and the Health Outcomes Observatory (H2O) project (2020-2024) collected through interviews. Professionals were recruited ensuring a diverse perspective range including clinical teams (Physicians, Nurses, Pharmaceuticals), managers, Information System Coordinators, Quality of care experts, and PRMs experts.

Results

The research yielded significant findings, including developing more than 10 disease outcomes follow-up dashboards and a template for describing 16 PREMs. The feedback by key areas was: :

1 HEADINGS

The most successful **headers** focus on the analysis of **one main score or the progression of up to 3 secondary scores**.

These can be stratified for example: 2023 vs. 2024, before and after interventions such as surgeries, the medication effect, or the variation before and after treatment cycles.

2 EXECUTION DATE

Last execution date

Invited	Responders	Type of answer
24	24 (100%)	Iterative answer
8	5 (62.5%)	No follow up

If answers come from a digital app data collection, it is important that headings indicate **execution date** as well as distinguish between patients among which the answer is requested vs answered.

3 MINIMUM-MAXIMUM AND/OR REFERENCE VALUES

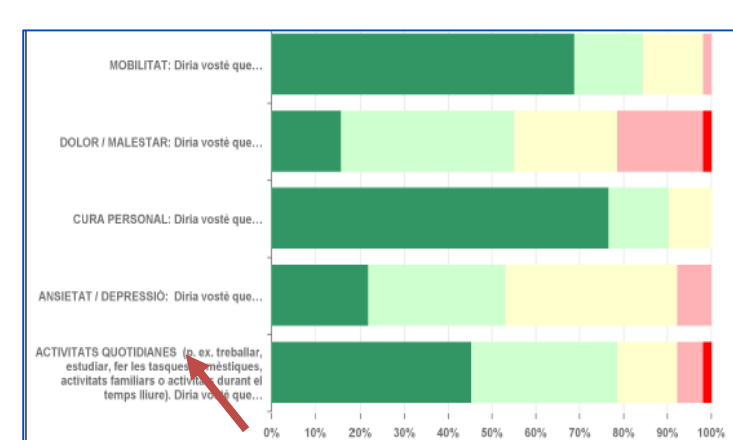
Severity test urinary incontin (Sandvick)

Interpretation: 1-2 mild, 3-6 mod, 8-9 severe, 10-12 very severe

Median value by t and IPU	N	T0 value
Pelvic Floor Rhb- 1	5	5
Pelvic Floor Rhb- 2	10	5

-Having available the minimum-maximum value/Distribution is crucial to take informed decisions.
-Also the availability of **reference values** from literature, the more similar to each center context, were well received.
-Minimal clinical differences (MCID) can also be added.

4 PACTS OF 20 CHARACTERS AND PILED COLUMNS



The items can't always resume in practical labels so **20 characters pacts** can be useful.

The **piled-column figures** were efficient for communication, even if the tables with N at each time-point are considered the essence for presenting data.

5 INDICATE DIMENSIONS AND ACRONYMS

ICIQ
EQ5DL
EORTC
FACT
MEDAS
IPAQ
HRQoL

It is beneficial to **indicate clearly each dimension** which is perceived by the patient to **amplify to the maximum the inevitable acronyms**. The user can be a direction not familiar with the name of each questionnaire. When health and economics indicators are combined, this practice is even more crucial.

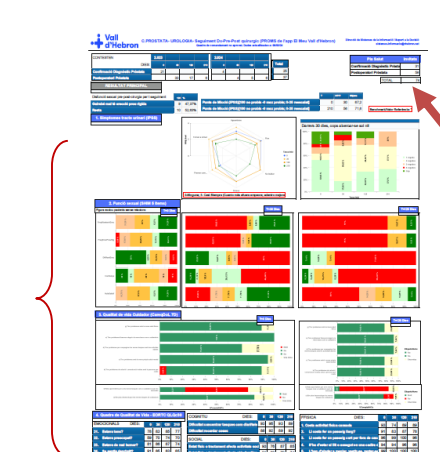
6 MAXIMUM OF 7 ITEMS AND LEVELS



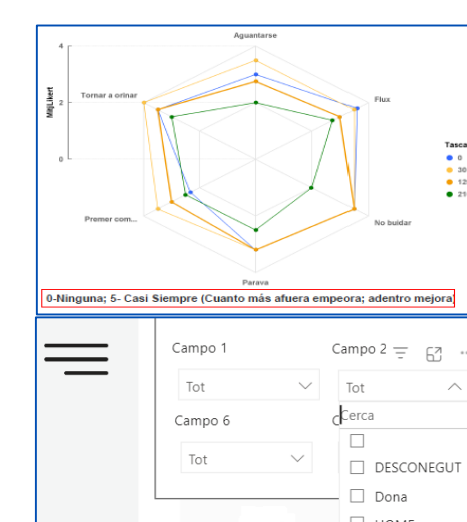
Relate a **maximum of 7 items and levels** in qualitative outcomes per figures or table, as well as **colours** related with results: **positive / intermediate / negatives / neutral**.
"Rules" can be used in the case of tables (e.g. if values are under a certain value → color).

7 MAXIMUM OF 7 TABLES AND FIGURES

Combine a **maximum of 7 tables and figures**, and always transmit the number of answerers, has been key for good feedbacks. A unique image has strengths but differentiating sheets gives clarity.

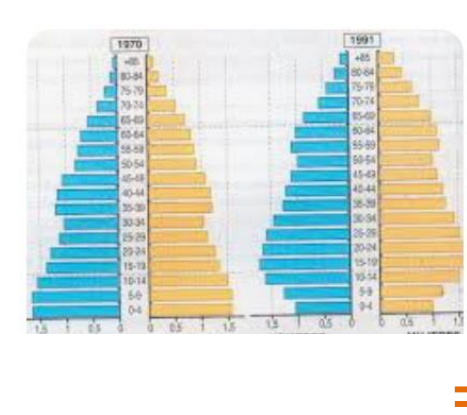


8 PERSONALIZATION CAPACITY



PROMs care leaders: appreciate **spider figures**, alerts average to monitor/deliver to cluster properly
Other care professionals: they want to reproduce to the real world the usual figures seen at the clinical trial publications.
Information Systems: they appreciate to have date **filters** to adjust data to certifications demands

9 RESPONSE COMPARISONS



A PRM usual challenge in clinical practice is participation and answering persistence in the follow-up.
It is useful to include in the first page a **socio-demographic figure and the comorbidity/complexity between those answering** and the ones accomplishing inclusion criteria.

10 ALERTS IN 1 PAGE AND ANONIMITIZATION



The alerts dashboard of usual clinical practice are practical when they can be managed in **1 page** per weekly or monthly update.

The **anonymization** is a challenge so that the lists are practical in case of derivation and the receiver, a priori, does not know the patient.

Conclusions

Analysing different institutions working on VBHC experiences provided valuable insights for future dashboard development. Well-designed inclusive dashboards with clinical and patient-reported information demonstrate potential as basis for care improvements based on follow-up real-world status assessments.