Use of Clinical Outcomes Assessments (COAS) By Hospitals in the USA, UK, France and Sweden: Multi-Stakeholder Viewpoints

Poster Code: **HPR128**

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Background

Clinical Outcome Assessment (COA) tools have the potential to be used as quality measures in Value-based Health Care (VBHC).

Objective

Clinical Outcome Assessment (COA) tools have been lately the topic of much interest in medical community as tools to capture patinets' perspective on their disease and quality of life. Besides routine application of COAs as clinical diagnostic and monitoring tools, there is frequent use of COAs across settings to improve quality of care and patient experience, as well as novel applications in Value-based Health Care (VBHC). However, due to the complexity of healthcare systems in different countries and differences in approaches, it is not clear if COAs are used similarly, and what factors facilitate or reduce use of COAs across hospitals in various countries. Interviews with hospital and payer representatives and COA developers were conducted to understand how stakeholders view hospital use of COAs in general and with respect to VBHC. This research is part of a Mapi research study on the subject and will be used to identify key themes in development of a hospital provider survey across US, UK, France and Sweden.

Methods

Stakeholder interviews were conducted to elicit key concepts regarding use of COAs in hospitals across 4 countries: US, UK, France and Sweden. Interviewees were selected from hospital and payer organizations (private and public sectors) in each country. In order to obtain a high-level view of COA in the care system with focus on VBHC, we recruited interviewees at directorial or executive positions in organizations with a large patient cohort, informed by the context and structure of the healthcare system in each country. Seven hospital and 10 payer representatives were recruited (*table 1*).

***Table 1**: Interviewees across private and public sector in US, UK, France and Sweden.*

Stakeholder	Planned interview	Completed
Hospitals	1 private	
	1 public	
Payers	2 private	
	2 public	

Structured interviews were carried out with open-ended questions. This was designed based on *a priori* framework of use of COAs in clinical practice. All interviews were carried out in English and recorded. Interviews were transcribed and thematic analysis was carried out by 3 different analysis and reviewed and summarized by the lead investigator.

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Findings

Hospitals use COAs in a variety of different ways. When asked specifically about individual patient care, understanding patient experience and treatment monitoring, responders indicated a variety of indications e.g. cardiology, neurology, sleep medicine. **Purpose of use** (table-2): Key themes mentioned by participants from all 4 countries. All groups mentioned use of COAs in hospital quality improvement and all, but French responders mentioned VBHC. Half of the interviewees from the USA mentioned VBHC. **Facilitators** (table-3): We identified 8 high-level themes and several as facilitators of use of COAs. Drivers for use of COAs in VBHC included encouragement from public/national payer and health authorities. Provision of COA via health authorities and within NHS guidelines promotes use of these instruments and recognized as recommendations for high-value care. There are multiple institutional factors in the US that incentivize use of COAs, many related to the affiliation and organizational structure of hospital. **Obstacles** (table-4): Responders from France and UK mentioned that there are no incentives for hospitals to adopt COAs at large scale. Barriers to use of COAs in hospitals included lack of IT structure and resources, and inadequacy of evidence of validity, usefulness and interpretation. We were not able to identify differences in adoption or use of COAs by private/public sector..

Table 2 - Purpose of use of COAs in hospitals

Medical research
Regulatory requirements (gov, regional health authorities)
Improve quality in hospital setting
Public health surveillance (national surveys)
Business decision (mostly to meet underlying non-clinical goal)
Payment and contracting (VBP)
Patient's voice (experience, surrounding, big picture)
VBHC and cost-effectiveness
Routine patient care (screening, diagnosis, treatment decisions, monitoring, etc.)
System improvement (healthcare network/system)
Accountability and compliance
Payer mandate
Help reduce cost
Reduction of medical errors

Conclusion

The use of COAs by hospitals in quality assessment and VBHC is limited/fragmented. Endorsement by medical authorities and incentivization by payers may promote use of COAs in VBHC. Interview findings will be used to develop a survey of approximately 3000 hospitals and medical practices to gain a broader understanding of if/how COAs are used including VBHC.

Table 3 - Facilitators of use (high-level themes marked in dark shades)

Technical/operational facilitators	License being free or purchased by authorities/payers
Technical/operational facilitators	Ease of use
Payers using COAs	
Technical/operational facilitators	COA is used in OTHER care settings (outside hospitals)
Professional factors	Regulatory requirements (gov, regional health authorities)
Technical/operational facilitators	Self-entry by patients
Education helps future use of COAs	
Professional factors	Use in patient registries
Professional factors	Use in research protocol
Technical/operational facilitators	Nurses administering COAs
Technical/operational facilitators	Use in clinical apps
Institutional factors	Affiliation with university
Technical/operational facilitators	Data collection/handling and analysis by third party
underlying non-clinical goal)	Payer mandate
Technical/operational facilitators	Future technology
Professional factors	Priority areas
Professional factors	Recommended by professional societies / really deemed necessary
Professional factors	aligned with digital maturity agenda
underlying non-clinical goal)	Competitition in marketplace
Technical/operational facilitators	Centralized data
Institutional factors	Accountable Care Organization, centers of excellence
Institutional factors	Endowment supporting these efforts
Institutional factors	Employer coalitions
Institutional factors	Having a healthplan with multiple settings (hospital system)
Institutional factors	Payer owning the hospital system
Forward-thinking leadership	
Business decision (mostly to meet underlying non-clinical goal)	misc. (alignment public/private payers, partnership with profit sharing, bundled services, alignment with pharmaceutical research)

Table 4 - Purpose of use (high-level themes marked in dark shades)

Doubt in scientific soundness of COAs or data capture in clinic	[COAs] not backed by adequate & sound methodology
Burden (cost, time, effort)	
Inadequate operational and data infrastructure	paper-based
Inadequate operational and data infrastructure	response rate (from patients)
Doubt in scientific soundness of COAs or data capture in clinic	not convinced it is worth using or how to take action
Inadequate operational and data infrastructure	interoperability
Access to COAs is not free	
Lack of technical knowledge by hospital staff (administration of COA)	
Scarcity of resources	
Inadequate operational and data infrastructure	the system does not work this way
Inadequate operational and data infrastructure	low number of cases in each institution
Inadequate operational and data infrastructure	Very slow uptake of COA
Inadequate operational and data infrastructure	translation
No incentive to use COAs	
Requirement of author permission	
Additional reimbursement for administering COA DOES NOT facilitate their use	
Inadequate operational and data infrastructure	compatibility of data systems
Inadequate operational and data infrastructure	data linkage
Inadequate operational and data infrastructure	delay for the data to be available
Inadequate operational and data infrastructure	errors in data capture
Inadequate operational and data infrastructure	not coded into the system
Inadequate operational and data infrastructure	patchy data (not systematically collected)
Inadequate operational and data infrastructure	unavailability of data
Hospitals do not proactively use COAs	