Vision for Human-Centered Design Sessions

To inspire a more expansive, flexible vision for how care teams can better collaborate with adults with or at risk of arthritis in shared decision making to increase self-management behaviors, including physical activity and lifestyle change, ultimately improving function and quality of life.

Scope

Why arthritis?

Arthritis affects one U.S. adult in every four, costing billions in direct medical costs and significantly impacting quality of life.

Why osteoarthritis of the knee/hip?

Osteoarthritis (OA) is the most common form of arthritis and is the leading cause of chronic disability, specifically OA of the knee or hip.

Why adults aged 18 and older?

Appropriately integrating physical activity into screening, counseling, and referral is recommended for all adults 18 and older.

Why physical activity and other self-management?

Physical activity can reduce pain, improve physical function, delay disease progression, reduce anxiety/depression, and impact co-occurring chronic conditions. Other self-management behaviors include maintaining a healthy weight; protecting joints or avoiding further injury; and participating in self-management education programs.

Why primary care?

Primary care settings—where patients with OA are treated most frequently—present an opportunity to set patients on a path toward increased physical activity and self-management. The current work will focus on primary care as a starting point, with the intention of creating a framework that will apply in other settings, including rheumatology.

Ideal State

An ideal environment would result in an informed, activated patient that is ready to increase physical activity and other self-management behaviors. The ideal model would seamlessly integrate screening tools, involve diverse care members, reflect the needs and goals of the patient, and connect patients with resources. It would also acknowledge and address patient barriers, including fear and social determinants of health. This ideal state would leverage all possible care teams—including clinical, non-clinical, and community resources—to co-create a care experience unique to the needs of each patient.

Current State

The current state of arthritis care is a fragmented system that significantly limits the ability of self-management behaviors to be integrated in the screening, counseling, and referral process. Screening tools are difficult to implement (because of barriers to time, technology, and reimbursement), care is difficult to coordinate, clinicians don't have sufficient time or training to counsel patients, and it's difficult to follow-up on resources recommended to patients.

Barrier of Focus for HCD Sessions

During Year 1 of this project, a number of barriers were identified in the current healthcare landscape that were preventing patients with arthritis from being screened, counseled, and referred to self-management programs. These sessions will focus on addressing one of those significant barriers: limited provider time prevents effective screening, counseling, and referral.

Across interviews, a lack of time with patients was cited as a significant provider barrier to effective counseling, noting that some specialists may only get 10 – 15 minutes with each patient while primary care providers may only get seven minutes. The lack of time can therefore prevent effective screening, counseling, and referral to physical activity and self-management interventions.

Rationale for addressing this barrier:

- Consistently referenced as a barrier by interviewees
- Roles need to be re-imagined
- Expert panelists have a diverse experience to share
- Identifying opportunities for additional care teams to be involved in the process can provide useful information for model design process

Problem

Incorporating self-management behaviors is a promising strategy to improve the quality of life for patients with arthritis, but limited time prevents effective screening and counseling, and referral for such programs. Therefore, care for patients often does not sufficiently invite patient collaboration or other strategies to increase physical activity and self-management behaviors.

Approach

Apply design thinking to re-imagine ways in which diverse care teams—including patients, clinical staff, CBOs, caregivers, etc.—can be incorporated into the screening, counseling, and referral process.

Goal

Provide creative, patient-centric recommendations in which diverse individuals and resources can be incorporated into the screening, counseling, and referral process for physical activity and self-management interventions. Recommendations will include how each individual can positively impact patients' self-management behaviors and will also highlight potential barriers.

Inputs

Advisory Panel: Experts from diverse backgrounds that can apply their experience, subject matter expertise and perspectives, including patients, patient advocacy, clinical professional organizations, primary care, clinical specialties, physical therapy, public health, community health workers, community-based organizations, and payers.

Design Thinking: The goal of human-centered design is to build empathy and creativity to put patients at the center. The tools we will use in these sessions will be imagination, exploration, ideation, examination, and empathy.

Landscape Assessment: Environmental scan of known literature related to arthritis care, including sources from arthritis experts, research reports, health system case studies, advocacy and public health organizations, promising models of care, and other crucial sources. It also includes learnings from 12 stakeholder interviews and 3 listening sessions with key advocacy organizations, health systems, providers/clinicians, payers, and public health experts at state health departments.

Outputs

Human-centered Design Sessions:

A better understanding of how different care teams can contribute to an engaged, activated patient. Expert Panelists will co-create empathy maps for patients with arthritis, catalogue how different care team members can be utilized, and identify opportunities for using care team members to better address patient barriers. A final strategy report that will include recommendations from the Expert Panelists to consider during the model design portion of the project.

Model Design Sessions:

Develop and implement an evidence-informed arthritis care model that leverages care teams to conduct function, pain, and physical activity screenings; patient counseling on the benefits of physical activity for arthritis; and referrals to arthritis-appropriate physical activity and self-management education programs.