

Existent

*What are future opportunities for enhancing the interconnections of PREMs and PROMs in clinical practice?*

**A Patient-Powered Quality Improvement Technology  
Will  
Remodel Primary Services and Restore Honesty in Health Care**

**(Proof of Concept Using GLP-1 Agonists)**

*John H Wasson MD*

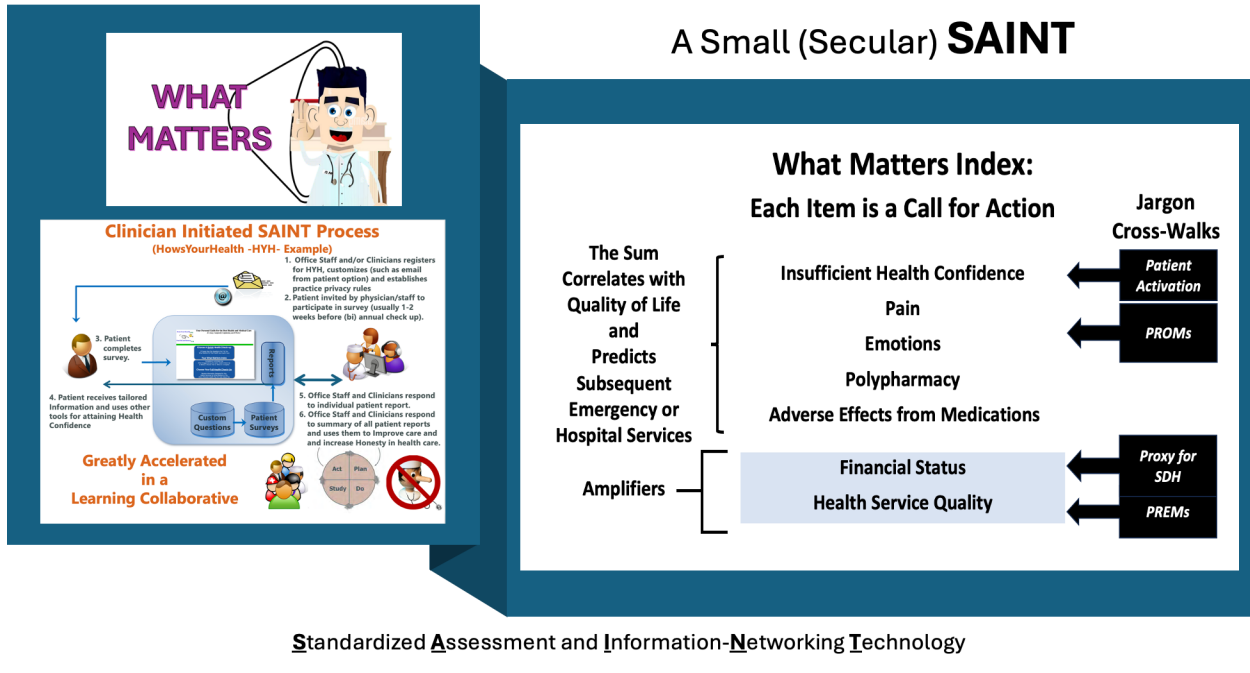
*Adam Schwarz MD and Eliza Hearst, BA*

**For this presentation** we must talk about a SAINT. No, not one you find depicted in a church or statue. Rather, SAINT is an acronym for standardized assessment and information networking technology a technology that places what matters to patients at the center of health care service. Although secular, patient-powered SAINTS have been shown to improve the quality of health care delivery, for this presentation we are going to focus on a related SAINTLY power, its capacity to restore honesty in primary care. In so doing, SAINTs can help primary care remodel its role, services and dignity to meet the evolving challenges of the health service marketplace.

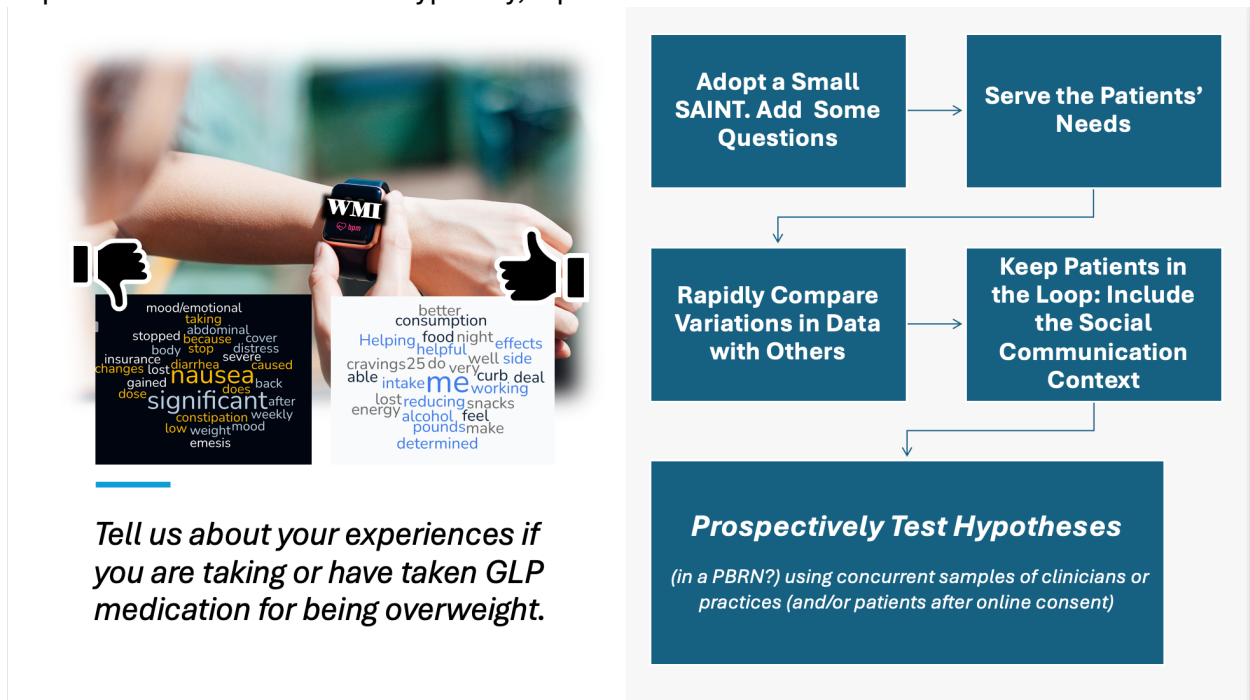
A high-level view for a SAINT called [HowsYourHealth.org](http://HowsYourHealth.org) is illustrated on the left of this slide.

From patient responses to that SAINT primary care clinicians have identified the least number of items that reliably reflect what matters to adults who have non-acute health problems or concerns. Naturally these measures also crosswalk with attributes of PROMS and PREMS that have been the subject of this meeting. The resultant What Matters Index or WMI assesses concepts of health confidence, bothersome pain and emotional issues, polypharmacy, and possible adverse effect of medications. The sum of these five measures forecasts risk for subsequent use of costly care and is strongly correlated with a person's quality of life. Poor care quality and poverty amplify the risk.

# A Small (Secular) SAINT



The straightforward process for linking a patient-powered SAINT data to quality improvement is shown here. Typically, a practice will:



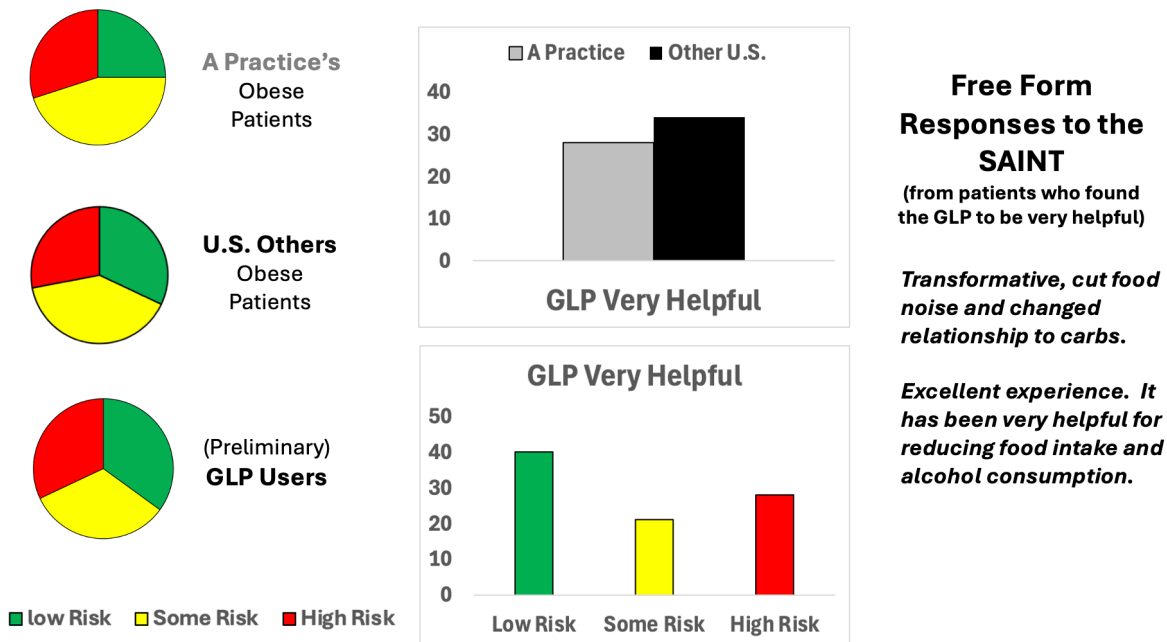
FIRST: Adopt a small SAINT to minimize respondent burden and perhaps add a question or two to explore a topic of interest. For example, because recently direct to consumer advertisers and social media influencers have persuaded innumerable overweight and obese people to "talk to their doctors" about GLPs as weight loss drugs, a practice could ask its patients about their experience taking a GLP.

SECOND: After receiving the responses, the practice focuses on reliably serving the standard, universal needs identified by the SAINT and, in this case, learns about GLPs so that real world patient experience can be shared with future GLP candidates.

THIRD: Since the SAINT makes accruing data immediately available, the clinician sees opportunities for improvement.

FOURTH: The practice keeps patients in the loop since a productive clinician-patient relationship nurtures better services and more honest insights. The word clouds on the left remind us of patient-powered information that helps others feel comfortable, understand more, become confident, and cope with their personal concerns.

FINALLY, a secular SAINT encourages inquisitive clinicians to prospectively test hypotheses. For example, what might be the optimum GLP for patients like those seen in my practice? With the right incentives practice-based research networks (PBRNs) can coordinate inter-practice activities to quickly and efficiently address questions that matter.



To provide its patients relevant, real-world information about GLPs, a primary care practice recently completed four of this five step SAINTly process. The same questions the practice asked were also distributed nationally. The WMI risk categorization shown in the colored pies to the left, demonstrated that the practice's risk profile of obese and prescribed GLP patients and national data are similar. The black and grey bar charts demonstrated that its patients are faring comparably to others. It is observing in these early results a trend toward

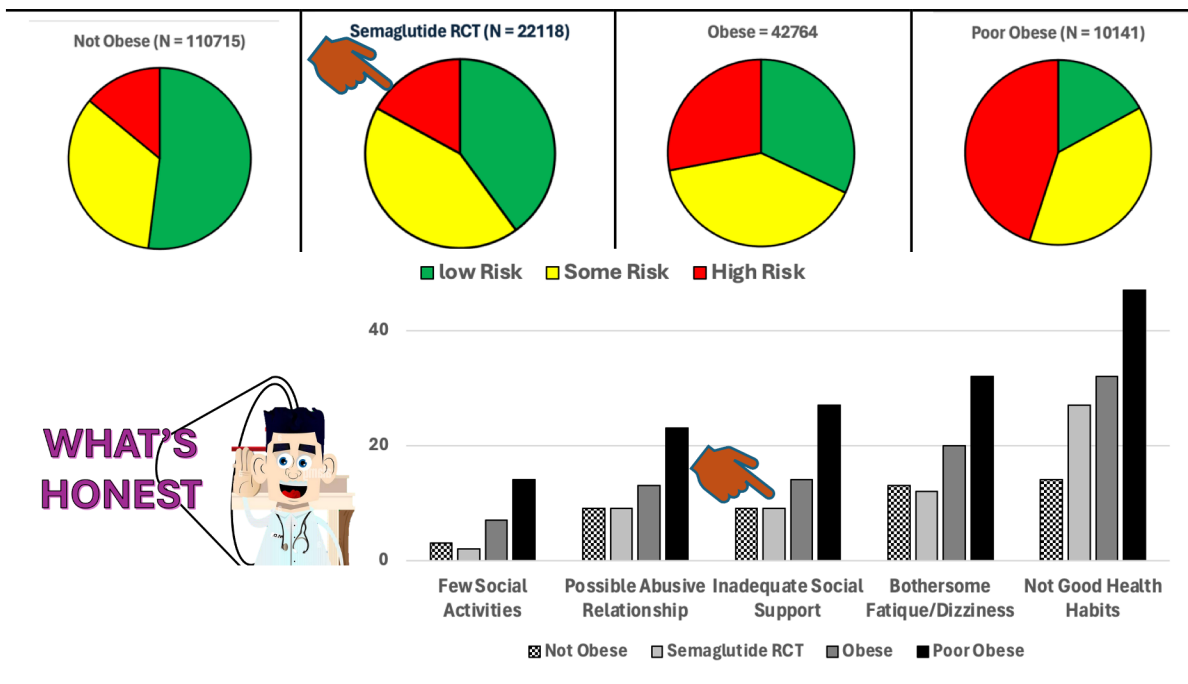
lower medication effectiveness for patients at higher risk for future costly care and lower quality of life. An observation the practice will keep in mind for subsequent investigation.

Although this preliminary proof of concept is based on a single practice and a few patients, after only a few weeks it has generated real-world GLP effectiveness estimates that can be honestly communicated to its patients.

Data gathering and hypothesis generation done in this way doesn't take years. It doesn't have high cost. It doesn't depend on finding a way to get an EMR vendor to change a template, and it doesn't nag the clinician to check boxes. A practice simply goes to the web, customizes the SAINT, and periodically discusses real world results with other practices. Patients do the rest and attain real-time benefits from SAINT feedback and standardized clinician actions for what matters.

A little more about the need for this type of patient powered data to enhance greater understanding of medical interventions.

The hand pointing to the pie illustrates the simulated risk characteristics of the obese patients enrolled in a very influential controlled trial of a GLP medicine called semaglutide. The pie to its left is the distribution of non-obese patients in typical US health settings, to the immediate right the obese and to the far right, the poor obese. The colored wedges of risk for semaglutide patients look more like non obese primary care patients (to the left) than obese patients seen by primary care clinicians (the pies to right). Bothersome problems are also lower in the semaglutide patients. The hand points to poor social support as just one of many examples.



Since bias like this is usually induced by constraints of controlled trials, generally accepted health information sources are likely to parrot misleading information. This is the type of problem that calls out the need for more relevant and honest real-world, patient-powered data.

In summary, instead of primary care continuing a glide-path down to extinction, this proof of concept demonstrates that routine use of existent, free, and well tested patient-powered SAINTs will boost reliable service delivery and provide a way for currently overwhelmed clinicians to be trusted sources for more honesty in health care.

However, to create the conditions for a patient-clinician-payer win-win-win a radical reduction of the sludge and waste oozing from administrative mandates and excessive measurement is needed. For example, a practice like the one demonstrating this proof of concept should have relief from waste and sludge and receive incentives when it actively and consistently participates in a PBRN devoted to the rapid betterment of service and the production of more honest information.

**To Remodel Primary Services and Restore Honesty in Health Care**

**THIS !**

😊 😎 😊  
Patient Payer Clinician

**Serve What Matters to Patients and Become Custodians for HONESTY**

**Reduce Waste and Sludge by**

- Using SAINT Output to Define Value
- Documenting Clinician Value in a Patient-Powered PBRN
- **Payer/Policy-Maker Partnering !!!**

Overhead  
Too Many Measures  
Administrative Stuff  
EMR Check-Boxes, PREMS, PROMS, SDHs, etc.  
**NOT THIS**

We hope that this presentation has illustrated why it is in the self-interest of all stakeholders to convert this proof of concept into a proof of value. For example, imagine how quickly and efficiently a greater number of primary care clinicians in a learning collaborative could prospectively examine large amounts of real-world data to identify which GLPs are likely to be more effective for different patients.

In fact, if this SAINTly approach is productized by PBRNs, Payers, and/or EHR Vendors, its data could also be monetized for the benefit of a common good.

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A website called HonestyInHealthCare.org, will be available in October to further scientific thinking about how patient-powered SAINTs eventually will remodel primary care. Included on that website is an interactive data base for more than 100,000 adults that can produce output like that we have displayed for this GLP-1 example.

We hope that you will investigate it, envision SAINTly power when it is taken to scale, and add your insights and comments as we increase user friendliness and utility.

**GO TO**  
**HonestyInHealthCare.org**

**HowsYourHealth.org**  
**HealthConfidence.org**

- **This Presentation**
- **Relevant Footnotes**
- **Article about SAINTs with Many References**
- **WMI Validations Illustrated**
- **Query Function for 100,000 Adults' Responses to HowsYourHealth.org**
- **Updated Information and New Tools**

**What are better opportunities for enhancing the interconnections of PRTNs and PRTNs in clinical practice?**

**A Patient-Powered Quality Improvement Technology Will Remodel Primary Services and Restore Honesty in Health Care**  
(Proof of Concept Using GLP-1 Agents)

John H. Messeri MD  
Adam Schwarz MD and Eliza Hearst, BA

**Standardized assessment, information, and networking technologies (SAINTs) Systems from three decades of development and testing**

**Illustrations of WMI Validations**

**HowsYourHealth.org Primary Care Data Base**  
Use for all 100,000 adults aged 18-65 by criteria, age, gender, and a WMI level.

**Criteria** Specify "OR" Sort Criteria

**Sort:**  Last Patient Status

**Filter:**  Aspiration

**Gender:**  Male

**Age:**  18-24

**Diagnosis:**  Diabetes

**Medication:**  Insulin

**Healthcare:**  Hospital Care

**WMI:**  WMI = 0

**Age:**  Age 18-49

**WMI High:**  WMI High 10-21

**SUBMIT**