

Patient-Centered Primary Care: Getting from Good to Great

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Faculty Disclosure

The presenter of this session currently has or has had the following relevant financial relationships during the past 12 months:

- Nothing to disclose

Learning Objectives

At the conclusion of this session, the participant will be able to:

1. Describe a group of multiply-disadvantaged patients and explain why they are so hard to engage in patient-centered care as it is usually practiced in the Patient-Centered Medical Home model.
2. Describe the changes in language used in notes and in conversations in front of patients that can make transparency possible so that patients can be partners in their care.
3. Describe routines of practice that enhance patients' experience of their strengths and abilities to participate meaningfully in their care and in self-care.

Conference Resources

- Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at:

http://www.cfha.net/?page=Resources_2019



Slides and handouts are also available on the mobile app.

The spread of the idea of “patient-centered” care

- Patient-centered care was called for in the “Crossing the Quality Chasm” report produced by the Institute of Medicine in 2001
- The IOM offered 10 rules to begin to fix healthcare :
 - some focused on a redesign of the delivery of care (e.g., practice patterns, data management)
 - some focused on a change in the relationship of the physician and other healthcare staff to the patient.
- IOM called for:
 - patients to be the “source of control” in planning their care
 - to have “unfettered access” to their own medical information
 - Later called for partnership between physicians and their patients

Changing care delivery processes is easier than than changing relationships.

- In early implementations of the PCMH, changing care delivery processes were stressful on doctors and patients, (satisfaction of both went down) but practice changes could be accomplished in 2-4 years.
- Changing the relationship of doctors and patients did not progress nearly as well.
- The evaluation of the National Demonstration Project on the Patient Centered Medical Home concluded that doctors needed to develop “new mental models” of care.
- The IOM’s call for the patient to be “the source of control” in their care was not being realized.
- By 2015, the IOM was calling for “explicit and partnered determination of goals and care options” between patients and health professionals. Frampton, et al. 2017.

Primary Care Doctors are “Under Siege”

- The struggles and inconsistencies of the health system as a whole seem to fall hardest on primary care:
 - Medicaid expansion – primary care should absorb the newly covered (low income, comparatively sicker) patients.
 - Patients can't or won't get behavioral health care elsewhere – primary care should provide it.
 - Need to “cross the quality chasm” – primary care should adopt the PCMH.
- Every new policy group and research team seems to want to change how primary care doctors practice. And the National Demonstration Project evaluators said they even need “new mental models of care.” How is a person supposed to achieve that?
- Low payment rates push primary care doctors to attenuate the main factor that attracted most of them to the field – relationships with patients.
- Still lowest salaries, high burn out and suicide rates
- Doctors need to be parts of a team that can take some of the tasks of primary care, leaving them to do what they do best, diagnose and treat disease.

“Complex” patients add stress for “patient-centered” approaches

These patients have been identified with various names:

- Complex Trauma victims
- Multiple chronic illnesses Heartsink patients
- High utilizers Somatizers
- Low health literacy. Underprivileged

“The over-serviced and underserved”

I call them “**multiply-disadvantaged**” patients.

Patients that have complex needs including BH problems, who don't seem to do their share of their chronic illness care, who are high utilizers, and who don't get better, can feel like “the last straw” to some physicians who are deciding whether primary care is a viable setting in which to practice.

Multiply-Disadvantaged Patients

- Described in literatures on “complex patients,” “disadvantaged patients,” and “trauma victims” with little acknowledgement of other literatures.
- Show low “patient activation.” They don’t take care of themselves.
- Unlike patients with higher activation, they tend to share many doctors’ expectations that in medical care, the doctor is in charge and the patient “complies.” They don’t expect care to be a “partnership” and they don’t feel the self-efficacy to participate.
- Many experience the interaction with a physician, not in terms of care or benevolence, but in terms of asymmetries of power.
- A setting in which they feel they have no power or control, such as a visit to a hospital or other medical setting, can trigger a re-experiencing trauma reactions.
- For these patients regaining a sense of control can involve making their own decisions about care. Unfortunately the medical professionals have already recommended the best approaches. To know it is their own decision, they often choose something else.

To successfully address complexities of new practice patterns and multiply-disadvantaged patients requires an enhanced team.

- Expecting more change of primary care doctors can just increase their stress.
- “High touch” care including care management and BH expertise has been shown to be necessary and cost effective for the highest utilizing patients (outside of the very elderly and the very sick).
- To support the doctor, reduce provider stress and better serve patients requires an enhanced team that provides:
 - more sorts of service (i.e., BH and care management)
 - more people to do tasks that don’t require a physician (e.g., scribing, patient monitoring and maintaining engagement, protocol based treatments)
 - a broader array of expertise sets to parse patients’ complex needs.

Getting from a Squad to a Team

- High-functioning teams are difficult to develop.
 - “The doctor is responsible for everything” training received by physicians and other staff makes it difficult to move to a team in which the doctor is facilitative leader of well trained team members (and in some situations, not the leader).
- Working with the same team members consistently (team structure) has been shown to improve physician and team cohesion (team culture).
- Cohesive team culture (communication, participation, mutual support, effort, shared objectives) lowers burnout and improves satisfaction for physicians and staff.
- High-functioning teams are associated with increased provider and patient satisfaction, lower error rates, better communication with patients, better adherence by patients, and better health outcomes.

Getting from “delivering care to patients” To “partnership with patients”

- Challenge of “professionalism” vs “partnership”.
 - Most of us were trained in professionalism and our various professional guilds support it. The person with the most knowledge and training should guide care.
 - In ambulatory care, doctors may determine what care choices are offered, but patients determine what treatments, health behaviors, and outcomes occur.
- Among current approaches to partnership:
 - *motivational interviewing*
 - *shared decision making*
 - *minimally disruptive medicine*
 - *addressing health literacy*
 - *relationship centered care*
 - *culturally informed care*
 - *coaching patients to assertively relate to their physicians*

Multiply-disadvantaged patients seem to do best in Trauma-Informed patient-centered care

Consider how the elements of trauma-informed care offer a pathway to partnership and embody the "rules" of the IOM:

- Safety – requires understanding the patients' experience of care
- Transparency and trustworthiness – patients have access to all information about their care
- Choice – meaningful choice in the direction and goals of care
- Collaboration and mutuality – shared decision making in pursuing goals
- Empowerment – interactions focus on patients' strengths and successes as much as possible.

The T.E.A.M. Way

- T – Transparent
- E – Empowering
- A – Activating
- M – Mutual

“T” is for Transparent

- Patients having access to all the notes about them is coming, if you don't have it yet.
 - Over 41,000,000 patients have Open Notes already (<https://opennotes.org>).
 - Multiply-disadvantaged patients are more positive about open notes than patients in general, if they are shown how to access them by smart phone.
- Those who write the notes need to learn a bit of new phrasing to take the blaming elements out of standard professional language.
 - E.g., “she is drinking again” becomes “currently she has lost her sobriety”
 - “He is not adherent to his medication” becomes “he has chosen not to take the prescribed medication.”
- As team members get more competent in patient-centered language, they can move discussions about patients from the hall into the exam room.
 - It saves time
 - Best way to involve new team member in the care (passing the relationship).
 - It is a real time enacting of the patient as part of their care planning team.

“E” is for Empowering

- Using the Trauma-Informed Care definition of “empowering” as care in which interactions focus on patients’ strengths and successes as much as possible.
- “Empowered” patients should not be confused with “enfranchised” patients, as medical professionals often use the term.
- Interviews highlight successes in patients’ caring for their own health and in coping with terrible adversities in their lives. These can be noticed by any member of the care team.
 - Exceptions to problem patterns in self-care: Studying times of sobriety, the times their A1c was lower, the small improvement in activity levels.
 - Noticing the problem events that didn’t happen: List of cigarettes not smoked, drinks not taken, failures to keep appointments that didn’t happen.
- Builds self-efficacy of multiply-disadvantaged patients, engaging them in their care.
- Builds health professionals’ experience of self-efficacy with this population, lowering stress and burnout potential.
- Making the change requires training and practicing empowering questioning by the whole team.

“A” is for Activating

- Patient activation for self-management of health, as measured by the Patient Activation Measure, correlates with income, education, assessment of one’s health status and self-efficacy in impacting one’s health. Multiply-disadvantaged patients show the lowest levels of activation. (Problem that the measure is a-contextual at lower levels of activation.)
- These patients tend to believe that the patient’s job in healthcare is to “do what the doctor tells you,” though they tend to fail or choose against that course of action.
- Their health self-efficacy can be built by impacting patients’ (and their doctors’) attributions about their commitment and abilities to improve their health and functioning.
- Empowering interviewing (last slide) can be directed toward changing both the patients’ and their doctors’ attributions about the patients’ impact on their health.
- An observation about the patient’s past success can be linked to a more general attribution about the patient’s commitment and likely future health improvement.

Attribution Generator: Pick one phrase from each column

A	B	C
It looks to me like...	...you are determined to...	...work on goals to make yourself healthier
I suspect that...	...you are learning to...	...prevent health problems down the road
I may be wrong, but I am thinking...	...your values are helping you to...	...be sure you get the information you need to maintain your health
I get the impression that...	...you are getting more confident that you can...	...follow through on treatments on your own
	...for your sake and for your family, you are going to...	...maintain the lifestyle changes you have made
	...you are getting back on track to...	...get your life back from the effects of your (illness)

“M” is for Mutual

- First large study of Open Notes found that patients liked having access to their notes, but they also wanted to have their thoughts about their care represented in their medical records. Doctors didn't like the idea.
- The “Patient-Centered Care Plan” provides a process for patients to finally have the sort of input in their care that the IOM originally envisioned. This makes “partnership” official.
- The structure of the plan has sections found commonly in care plans plus sections that can only be provided by the patient.
 - Who (outside of the professionals) can see my records or offer opinions about my care.
 - What professionals can do when I am overwhelmed or destabilized in a visit.
 - What I want my health team to know about me, my values, and my choices.
 - What I have chosen as my health goals.
- Several implementations in single practices and in large health systems tried: Generally the durability of the program depends on IS support so that all professionals in the health system who open the patients' records can see the plan. It is an “official” document on the system.
- The process is time consuming. Best to start with multiply-disadvantaged patients. They report that having a PCCP done with the health team tended to transform the patient/doctor/team relationship.

Following the T.E.A.M. Way

- It is a process better described as mutual growth rather than transformation.
- Several elements that support this growth:
 - Consistency of team membership
 - Adequate time for team discussion and learning
 - Flexibility of roles within the team. (e.g., Who can engage a particular patient best?)
 - Some coaching or training on appreciative inquiry within the team mirroring empowerment interviewing with patients
 - QI/PDSA as basic to the work of the team
- Retaining team members is crucial to consistency and to the maintenance of team expertise.
 - Career ladders of increasing responsibility and expertise within the team
 - Team as a training vehicle for the larger system. “Teaming” is a skill.



Let's talk more.

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Exhibit Hall at 12:15 today