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Medical Home - Patient-Centric Care

Patient-Centric Care
link to a series of articles about medical home

Every practice which is or which desires to be a PC-MH must ask itself, "Do we simply have the structure of a medical home, or do we have both the structure and the dynamic. Being a

medical hoe has more to do with dynamic than it does with structure. Definitions and understanding of the concepts of this redesign are inextricably related. The authors stated: "Adding to the confusion, the term patient engagement is also used synonymously with patient activation and patient- and family-centered care. Although the concepts are related, they are not identical" If healthcare providers are going to be able to make the transition from expecting "compliance" on their clients part, to the experience of patients "adhering" to a mutually agreed upon healthcare plans of care, it is imperative that we understand the vocabulary.

1. "Patient activation-an individual's knowledge, skill, and confidence for managing his/her own health and health care -- is one aspect of an individual's capacity to engage in that care. But this term does not address the individual's external context, nor does it focus on behavior.

2. "Patient- and family-centered care is a broader term that conveys a vision for what health care should be: a partnership among practitioners, patients, and their families (when appropriate)' to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.

3. "...Patient and family engagement as patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system-direct care, organizational design and governance, and policy making-to improve health and health care. Although we use the term patient engagement for simplicity's sake, we recognize that those who engage and are engaged include patients, families, caregivers, and other consumers and citizens."

- **A Patient-Centric Experience in the hospital which parallels a patient-centric ambulatory experience measured by HCAHPS**

  HCAHPS an Imperative for Creating a Patent-Centered Experience

  The objective assessment of a patient's experience of care in the hospital (Hospital Consumer Assessment of Healthcare Provider and Systems) and in the ambulatory setting (Consumer Assessment Healthcare Provider and Systems) are critical to providers learning the dynamic of patient-centered medical home.

- **Patient Activation, Engagement and Shared Decision-making**

  This gives a definition of terms and how a guide to prepare patients to be a part of their medical home team.

- **Patient Engagement - *Health Affairs***

  SETMA 8.20.13 Provider Training -- Health Affairs 2.14.13 -- Patient Engagement

  "Patient engagement" is a broader concept that combines patient activation with interventions designed to increase activation and promote positive patient behavior, such as obtaining preventive care or exercising regularly. Patient engagement is one strategy to achieve the "triple aim" of improved health outcomes, better patient care, and lower costs.

- **Patient Centric Communication**

  What is patient-centered communication? Have you really addressed your patient's concerns?

  How to turn a medical office encounter into a medical home, patient-centric conversation

- **Conversation Project**

  The Conversation Project is a project of the Institute for Healthcare Improvement and is dedicated to helping people talk about their wishes for end-of-life care. We know that no guide and no single conversation can cover all the decisions that you and your family may face. What a conversation can do is provide a shared understanding of what matters most to you and your loved ones. This can make it easier to make decisions when the time comes.

- **Medical Home Transtheoretical Model Assessment Stages of Change Tutorial**

  In the Medical Home Model of healthcare, it is imperative that the patient participates in their own care. Terms like “activated,” “engaged,” and “shared decision making” are important descriptions of the dynamic of the patient participating in and actually “taking charge” of their own care. As part of this process, it is important that the patient’s preparation to change be sustained. In other tools, SETMA discusses the power of “What if Scenario,” which addresses the providers ability to quantify for the patient that fact that “if they make a change, that that change will make a difference in their health.” This is principally done through the Framingham Risk Scores and the ability to display the difference a change in behavior will make. That tool can be reviewed in either:

Risk Score

1. " SETMA's Disease management tools for Diabetes, Hypertension and Lipids used for patient activation and engagement via written plans of care and treatment plans."
2. Framingham Heart Study Risk Calculators Tutorial

The assessment of a patient's preparation to make a change can most effectively be done through the Transtheoretical Model Assessment of the Stages of Change which can measure the patient's preparation of making the changes recommended in SETMA's "What if Scenario." The following steps explain how to use SETMA's deployment of the Transtheoretical Model.

- **The Dynamic and the Structure of Patient-Centered Medical Home.**

1. Paternalism or Partnership: The Dynamic of the Patient-Centered Transformation

   This document contrasts the dynamic and the structure of the PC-MH.
2. Medical Home Series Two: Part I The Movie

   From a 1951 movie, *People Will Talk*, where the dynamic and principles of the patient-centered medical home are illustrated

3. Citadel - A 1937 Introduction to the Spirit of Patient-Centered Medical Home

   From a 1937 movie *Citadel* about a Scottish doctor who illustrates a physician following prey to entrepreneurism and loses and forgets his professionalism but regains his healthcare soul.

- **The Automated Team Tutorial**

In 1993, John Patrick set IBM on another course and changed the company's future. Reading his story made me wonder, is it possible for SETMA to set medicine on another course and to change the future. John did not want people to work "collaterally," side by side, maybe going in the same direction, maybe even having the same goal, but working independently and at best in a cooperative manner; he wanted people to work "collaboratively," synergistically, leveraging the generative power of a team in creating a new future which they partially envision but which even they could not control.

What can we do today in healthcare which would mirror the changes IBM experienced? How can we change "collaterallists" into "collaborativists"? How can we use the power of electronics, analytics, and informatic principles to energize radical change to create a

new future in healthcare? Testing and measurement is a science. In most industries, quality is determined by testing performance. But, in healthcare we are involved in a new kind of "testing." The tests used to measure the performance of healthcare providers are unique.

- **Medical-Home-Plan-of-Care-and-Treatment-Plan**

SETMA's Disease Management tools For Diabetes, Hypertension and Lipids Used for patient activation and engagement via written Plans of Care and Treatment Plans

Providing our patients a written, personalized Treatment Plan and Plan of Care is a critical aspect in patient activation and engagement. These documents serve as a "baton" which empowers the patient to care for themselves. The following poster which appears in all SETMA's examination rooms and a framed copy of which appears in all public places at SETMA symbolizes the "baton."

The Baton

Firmly in the providers hand
--The baton - the care and treatment plan
Must be confidently and securely grasped by the patient, If change is to make a difference
8,760 hours a year.

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.
5. That the imperative for the plan - the "baton" - is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.
6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.