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Continuous Professional Development:
Learning from a Convergence of Events
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During the week of February 17-22, 2013, four events converged to clarify a patient-centered-medical-home concept which had eluded me. Shared-decision-making with patients and a healthcare provider asking patients what their goals are always seemed alien to me. Guided by evidenced-based scientific literature, the goal of care seemed standardized and not subject to personal opinion, or patient desires. Now that the concept is clear, it may seem strange that it took so long for me to understand this but no matter how long it takes, the key is that ultimately and eventually, we do understand. As one reviewer of this article said, "We all still have much to learn - I will remember this story!"

1. *Health Affairs*: Activated, Engaged, Patient-Centric and Shared Decision Making

The first event was occasioned by my reading several articles in the February *Health Affairs*. The February 28th, Your *Life Your Health* resulted from my reading of one of those articles. Key concepts of patient activation, engagement and patient-centric care were discussed in *Health Affairs*. The article entitled, "*Patient and Family Engagement: a Framework for Understanding the Elements and Developing Interventions and Policies,*" provided insight into changing roles of patients and providers in the "new structures" of healthcare delivery. A second article, "*A Demonstration Of Shared Decision Making In Primary Care Highlights Barriers To Adoption And Potential Remedies,"* added to that understanding, stating,, "Providing patient-centered care is a key goal of health system improvement efforts. Shared decision making, in which patients and providers make health care decisions together, represents one approach to operationalizing patient-centeredness and is featured in new policies intended to improve the quality of care. For example, the final rule for Medicare accountable care organizations requires delivery systems that participate in the Medicare Shared Savings Program to engage in shared decision making.

"In shared decision making, providers and patients exchange important information: Providers help patients understand medical evidence about the decisions they are facing, and patients help providers understand their needs, values, and preferences concerning these decisions.[3,4] Then, ideally after allowing time for reflection, patients and providers decide together on a care plan consistent with medical science and personalized to each patient's needs, values, and preferences."

2. Care Management Ratios in Primary Care for High Risk Members

The second event was occasioned by a health leader asking the following question: "We are getting questions from provider groups on how they should consider their Care Management Ratio's in a Primary Care Setting for High Risk Members." My final contribution to this dialogue stated in part:

- I do not think that it is possible to have a formula of ratios. The work is too new. In the traditional medical practice, we can say that the ratio between provider and support team is 2.3 or some other number. When we began to transform SETMA and to expand our services that ratio went up to 7+ but team members were doing tasks which had never been done before. There were ups and downs. EMR adoption in 1998 enabled us to redefine roles and to benefit from economies of scale and function.
- Dialogue among all team members is imperative. Daily we use "electronic huddles" to stay in constant communication. Monthly, we meet for a half day to discuss quality improvement, performance and issues which need resolving. Recently a team of 19 team members spent a day in a strategic planning meeting to look at the future and to plan for it. These are the most important functions we perform daily, monthly and annually.

3. The Value of Remembering Past Experiences

During the above dialogue, I related the story of a patient whom I saw several years ago. (In an abundance of caution, I do not mention the patient's gender, age or ethnicity, or the precise date I saw the patient.) For the past three years, I have used this story to illustrate how we should respond to patents that do not follow our plan of care and our treatment plan. I have told this patient's story many times as an illustration of one of the aspects of patient-centered medical home.

I knew the facts of the patient's encounter well. It took me a little while to find the original, contemporaneous summary of the patient's post clinic summary of care. When I did find it and reread it; I was shocked to see that there was an element of the case which I had not remembered and it was THE key element. The following is the summary which was written the day following the patient's visit to my clinic:

> "I saw a patient on_____4,_____.. The patient sought care for weight reduction treatment and wanted Ionamin, Lasix and thyroid with which (the patient) had been treated previously by a non-SETMA provider.
>
> "On the 4th, I initiated a thorough history, physical and laboratory evaluation. On _____ 5,_____, upon review of her/his laboratory results, family history and evaluation, (the patient) was diagnosed with new onset diabetes. Normally, we would make that diagnosisonly after a second HgbA1c above 6.5, but (the patient's) father and two siblings had diabetes and (the patient) had uncontrolled hypertension which had been previously diagnosed and unsuccessfully treated.
>
> "On the 5th, I personally talked to the patient at 7:30 AM and started the patient on, the following medications which were e-prescribed:
>
> - Metformin 500 by mouth twice a day
> - Altace 5 mg by mouth once a day
> - Simvastatin by mouth once a day in the evening.
> - Ecotrin 81 mg by mouth once a day

“I also scheduled:

- Dilated eye exam
- MNT Education
- DSME Education

“I scheduled a Clinic follow-up call for the 7th because I suspected that the patient would not follow through. The following is the summary of Care Coordination’s contact with the patient on the 7th.

“Instructions and reason for telephone call given by MD -- **Any questions about the patient’s care and about my telephone call on .05. Has the patient gotten her/his medications -- make sure the patient is fasting when she returns**

“content of telephone call -- ***spoke with patient re: above...the patient stated the she/he **is not going to** take any meds, go to any classes or see any specialists for any illness diagnosed...the patient stated she/he wants to "do it the natural way"...with vitamins and diet...Instructed lab results and rationale for meds, ed and specialist referrals, but the patient stated she/he will not go to Dr._____as the patient **has an "eye doctor" at Walmart**, the patient said she/he won't go to nutritional or diabetic ed- as the patient has siblings who have diabetes and the patient can get information from them...The patient said she/he would continue Allegra, Ecotrin and go to see Dr._____for Allergy referral...the patient will also keep f/up appt. with Dr._____22___ (fasting)...The patient stated she/he takes iron, vitamins and B-12 po and that is all the patient intends to do..._____ _____ RN” (emphasis added)

“A **Diabetes Follow-Up Note and Treatment Plan and Plan of Care** was completed on the 5th and mailed to the patient.

“Upon reviewing the patient’s response to our care plan, I set up the following plan:

- “I will have our Care Coordinator call the patient and discuss the important issues of preventive care and treatment of her/his blood pressure, blood sugar and eye care.
- “At one time in my career, my impulse would be to refuse to see the patient if the patient refused to follow **MY** treatment plan, but Patient-Centered Medical Home does not allow for dictatorial mandates to a patient.
- “I will attempt to gain the patient’s confidence through further contact and will attempt to give the patient dietary counsel during office visits and will attempt to get agreement to participate in diabetes care.
- “Although I suspected that the patient would not follow the treatment plan she/he had agreed to in my telephone call, I was surprised at how totally the patient rejected it. At the next visit, I will attempt to understand why the patient feels the way she/he does about treatment. I wonder if it is because of some treatment failure with a bad outcome for members of her/his family or whether it has to do with a religious or philosophical conflict?”

4. **Discussion with Johnson & Johnson (J&J)**

On Friday, February 22, 2013, I met with three representatives of J&J about a research project to design an analytic tool for predictive modeling of diabetes complications. In that three-hour discussion, we reviewed the treatment of diabetes and the power of analytics in leveraging excellent care in diabetes population health. During that discussion, one of the J&J representatives commented on a project for the treatment of Schizophrenia fifteen years before. The care had been improved by asking the patients what their goals were. As I sat and listened, I kept remembering the patient I had seen several years ago.

The J&J scientist concluded by saying, "When we asked the patients what their goals were and when we helped them pursue their goals, they adhered to their medication regimen better and their outcomes improved." What were the goals of the patients with Schizophrenia? One said that he wanted to get married. Another just wanted to have a girlfriend. None of their goals had to do with the symptoms of their illness such as delusions, hearing voices, hallucinations, etc. Their goals were personal and social.

Conclusion: Unintentional Neglect of a Patient

All weekend, I thought and even dreamed about the patient I saw several years ago. Over and over and over, the words rang in my head, "I want to lose weight." I remembered well that once I had completed the patient's history and settled on treating her/his diabetes, I unintentionally ignored the patient's desires. I was certain that the patient had diabetes; which she/he did. And, I was determined to give the patient excellent care; which I didn't. Rather than explaining to the patient why I don't treat weight loss with Ionamin, thyroid and diuretics, I just ignored her/his goal.

Because I ignored the patient's goal; the patient ignored my plan. As I think of that patient and yesterday, as I and my staff tried to locate the patient without success, I realized that while I would have labeled the patient "non-compliant" using ICD-9, ICD-10 or SNOMED codes for that diagnoses; the real diagnosis should have been "failure to communicate," "non-patient-centric care," "failure to activate the patient," and/or "failure to engage the patient."

The fault was not the patient's; the fault was mine. What if I had engaged the patient in a conversation about weight reduction? What if I had discussed with the patient, the reasons why I don't prescribe Ionamin, thyroid medicine and diuretics for weight reduction? What if I had walked the patient through SETMA's Adult Weight Management program (see at www.jameslhollymd.com, under EPM Tools/Disease Management Tools/Adult Weight Management Tutorial)? What if I had said, "While we are helping you lose weight, we can also help you control your diabetes?"

Until last week, my memory of this patient's care was that of excellence and of the sad rejection of that care by the patient. Today, I remember this patient's care as my failure due to the hubris of "my thinking that I knew better." If my goal had benn to help this patient and it was and is,

then I should have met the patient's needs and expectations in order to gain the opportunity to meet the patient's real health needs. As it turns out, I have the opportunity to do neither.

The recognition of having made a mistake

Plutarch said, "To make no mistakes is not in the power of man; but from their errors and mistakes the wise and good learn wisdom for the future." My mistake can be forgiven if I learn from it. And, how will I evince that learning?

I think I shall never see a patient without asking the question, "What is your goal?" "What do you want to achieve in this visit and in the care you will receive from this clinic?" That question is partially answered when the patient-encounter record documents the patient's "chief complaint." But to make it more explicit, we are today adding a comment box to each disease management suite of templates and to each suite of templates. It will be labeled: "Patient Goal." It will be expressed in the patient's words." While we want to use structured data fields, this may be one case where structured data fields obscure the issue. As we have more experience with shared-decision making, we will clarify this data field more precisely. But, we will never ignore a patient's personal goal again. And, if the patient's goal is something which is inappropriate, or which can't or shouldn't be done, we will address that directly and frankly, rather than just by ignoring it.

Learning and Personal Mastery

We all do still have a great deal to learn, but if we are alert and attentive, if we are willing to be honest with ourselves, we can and we will learn. We will do this as we continue to pursue what Peter Senge's calls "personal mastery," which is "the discipline of continually clarifying and deepening our personal vision, of focusing our energies, of developing patience, and of seeing reality objectively which is the learning organization's spiritual foundation. (Senge, *The Fifth Discipline*, pp. 7-8)

People with a high level of personal mastery share several basic characteristics:

- "The have a special sense of purpose that lies behind their vision and goals. *For such a person, a vision is a calling rather than simply a good idea.*
- "They see current reality as an ally, not an enemy. They have learned how to perceive and work with forces of change rather than resist those forces.
- "They are deeply inquisitive, committed to continually seeing reality more and more accurately.
- "They feel connected to others and to life itself.
- "Yet, they sacrifice none of their uniqueness.
- "They feel as if they are part of a larger creative process, which they can influence but cannot unilaterally control.
- "Live in a continual learning mode.
- "They never ARRIVE!
- "(They) are acutely aware of their ignorance, their incompetence, their growth areas.
- "And they are deeply self-confident!" (IBID., (p. 142)

I hope I get to meet this patient again. And, if I don't, I shall see her/him in the face and eyes of every patient I see, as I focus upon their goals and desires in order to have the privilege and opportunity to meet their real health needs.