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National Quality Forum and Care Coordination Part II
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A Dialogue versus Two Simultaneous Monologues

Last week, we began a discussion of Care Coordination as defined and described by the National Quality Forum (NQF) in 2010. Because the Plan of Care is an important element of Care Coordination, NQF added the following comment to that discussion: "Integrated with the plan of care, but distinct from it, is the critical role of the 'feedback loop' in coordinated care."

The "feedback loop" includes communication but communication with an open dialogue between the provider, the healthcare team, the patient and their family. A "dialogue" is by definition "a discussion." Often in human relationships people carry on two simultaneous monologues without ever really communicating. Perhaps no human enterprise has been more filled with monologues than healthcare. However, when both provider and patient are listening to one another with respect and interest, it is possible to create understanding and in the case where a healthcare action has to result from the conversation, a plan of care can result.

Medical Ethics and Patient Rights

An illustration of the value and power of a dialogue between patient and provider occurred in my practice twenty-five years ago. A patient I was caring for had been admitted to the hospital. He needed a blood transfusion but explained to me that his deeply-held religious convictions prevented him from receiving human blood. After stating this, he began to explain to me why he believed that. I interrupted him and said, "You have the right to your belief and I respect that right. You are competent to make the decision which you have made, and you understand and accept the potential consequences of your choice. We have two choices, we can leave the conversation where it is and I will respect your choice, or you can continue to explain to me why you believe as you do and I will expect equal time to explain to you why I don't believe that."

He smiled and said, "Let's leave it where it is." This patient and I had a long and mutually satisfying relationship even though we both knew that we disagreed with each other. The key here is that it is not necessary for a patient to justify, or explain their preferences in treatments. If a patient is mentally and legally competent to make choices, patient-centered, care coordination requires the healthcare provider to respect the patient's choice and decisions. In addition, after making certain that the patient understands and accepts the risks of their choices, it is incumbent upon the healthcare provider to support those choices in a non-judgmental and positive manner.

However, consistent with medical ethics, if the healthcare provider feels that he/she cannot or should not provide the care which the patient wants, and which care is legal, then the provider can transfer the patient's care to another provider. Either way, the patient has the right to make choices, even if the choice made is personally objected to by the healthcare provider.

Content of a Dialogue

For a dialogue to be effective, all parties to the conversation must have the same information such as in "consultation notes, progress reports, sharing decision making and maintaining privacy with access to information." Communication, which is the intent of this dialogue, must "involve health literacy, translators, and expert panels as appropriate and should be culturally competent" (NQF, *Quality Connections*, "Care Coordination," p. 3, 2010)

As healthcare providers encourage their patients to have a personal health record (PHR) and as providers help facilitate patients' ability to have such through web portals, it is important to affirm that the patient has the right to access to everything that is in his/her medical record. Some of the means to that end are:

1. The patient should receive a printed copy of his/her encounter record at each visit with his/her healthcare provider.
2. The patient should have electronic access to part of his/her health record – medications, laboratory tests, procedure summaries, etc. – through a web portal.
3. The patient should be able to obtain a reusable, electronic version of his/her health record upon request.
4. The patient should know what his/her treatment goals are and how those goals are measured.
5. The patient's agreement must be sought and obtained if the ultimate value of this transparency is to be achieved.

This level of transparency between the patient and the healthcare provider is a new concept in healthcare structurally, but has always been a part of creative, dynamic healthcare relationships, which create trust and confidence in the provider. This level of transparency will also increase the collaboration of patients in their care. In this case concurrence is both a part of the process and of the desired outcome.

Interrogatives: An Effective Part of Dialogue

One of the most effect means of assessing the effectiveness of patient-provider communication is "teach back," where the provider asks the patient to teach the provider what he/she has just learned in the patient-provider encounter.

In the book, *The Influencer*, the author examined a school in which certain teachers routinely had excellent results and where others routinely had poor results. The difference turned out to be the difference between a monologue and a dialogue. The teachers who routinely had poor results

lectured to their students without any interaction or dialogue. The teachers who routinely had excellent results combined lecture with questioning of the students. The questioning reinforced the lecture and the dialogue allowed the students to test their knowledge. It turned out that the "feed back" from the students not only helped the students learn but it also helped the teachers teach.

None of this should be surprising because healthcare providers and patients learn in the same way. Recently, I made presentations to three national organizations concerned with continuing medical education (Society for Academic CME; National Institute for Quality Improvement and Education, and The National Task Force on CME/Provider/Industry Collaboration). All of the participants understood that lectures were among the poorer teaching methods. In one of my presentations, I said, "A *dialectic* approach – a dialogue -- is substituted for the traditional *didactic* – pedagogical – CME method. As Medical Home engages the patient in a discussion about their health, Joslin engages providers in a discussion about evidence-based medicine."

This was illustrated by a humorous story which I was told by a friend. An elderly gentleman was driving around town at 2 AM. He could barely see over the steering wheel. The police observed him for a while and then stopped him and asked where he was going at that hour. He said, "To a lecture." Incredulous, the police said, "What kind of lecture?" The elderly gentleman said, "A lecture on alcohol, tobacco and sleep depravation." "Who is giving such a lecture at this hour, the officer asked? The old man, smiled and said, "That would be my wife."

It is probable that the old man was not going to profit from the lecture he was going to receive. And, it is probable that our patients are going to benefit more from a conversation with us than they will a lecture. Dialogue, dialectic, teach-back, and interrogative -- whatever term you want to use, the principle is that successful communication will be the result of a dynamic exchange between a healthcare provider and a patient. And, the patient is more likely to carry out a plan of care which they have helped develop and to which plan they have agreed.

Plan of Care: Reviewing Elements of Plan

The great value of a written plan of care and treatment plan is to provide the patient and the patient's family with a means of reviewing what they learned during the visit to the clinic. Without the written plan of care which is identified on each page with the patient's name and which has the patient's personal laboratory and procedure results, little will be accomplished, as in a very short time, humans forget 90% of what they have heard. And, what a person remembers of what he/she only received audibly is not accurately what was said. With a written plan of care to review, the probability of real learning taking place is greatly enhanced.

Furthermore, as healthcare providers we are committed to life-time learning, we want our patients to become students. The more the patient learns, the more they participate effectively in their own care. Having had a dialogue with their healthcare provider and having received a

printed copy of their plan of care, the patient is prepared to accept responsibility for their own care 8,760 hours a year.

This principle was illustrated for SETMA twelve years ago. A mother brought her five-year-old child to the pediatrician at SETMA. At SETMA, every patient is given a **LESS Initiative**. The Agency for Healthcare Research and Quality which is a part of Health and Human Services has published SETMA's **Less Initiative** on their Innovation Exchange. The Initiative encourages each patient to Lose Weight if needed, Exercise and Stop Smoking. It consists of a weight management assessment for each patient, in which patients are given their BMI, BMR, and Body Fat content, with explanations of each and with a plan for how to increase the BMR in order to achieve improved weight. Each patient is given a personalized exercise prescription with an explanation of his/her personal maximum heart weight and how to start an exercise program which includes stretching, strengthening and aerobic conditioning. Finally, the **Initiative** includes an assessment of smoking and in the case of children, passive, second hand, or environmental smoke exposure.

When the mother returned home, she left the **Less Initiative** on the truck seat. Shortly after their return, the father got into the truck to go buy another pack of cigarettes. He saw the paper with his son's name on each page. He began to read. Forty-five minutes later, the father walked back into the house having never left the drive. His eyes were red because he had been crying for forty-five minutes. In alarm, his wife asked what was wrong. He responded that he had never realized what his smoking was doing to his son. If a person does not smoke, but is exposed to second-hand smoke, the **LESS** presents evidence of the harm that smoke is doing. The father has not smoked since. The dialogue with the pediatrician and the personalized document dramatically impacted this family.

Example of Feedback Loop

Few things are as new; it seems, to the "medical home" model of care, as is this concept of a "feedback loop." Most physicians were trained to have a monologue with patients: telling them what they have; how it is to be treated; and, what they are to do until their next visit.

In September, 2010, I saw a patient for the first time whose father, mother, sister and two brothers had diabetes. I thought, "Aha, I wonder if she has diabetes?" Upon testing, diabetes was proved. The day following the clinic visit, I called the patient and reviewed the diagnosis, condition and plan of care and treatment plan with the patient, which included medication, further evaluation with ophthalmology, endocrinology and diabetes self-management education and medical nutrition therapy.

The patient agreed to all of the plans, but as I hung up, I thought to myself, "This patient is not buying any of it." Using SETMA's Clinic Follow-up Call template, I scheduled a call from our Care Coordination Department for three days hence. The call was made and I received the

report: the patient appreciated the visit and the call, but was not going to do the education, take the medication or have any of the other evaluations. In this case the "feedback loop" was disappointing but demonstrated the work needed in order to get this patient to accept treatment. That was a year ago; at present, the patient has been unwilling to pursue a treatment plan which is appropriate. Tragically, this can be done for ten or more years but then the complications set in and they are irreversible. We don't always win with our patients but effective communication will increase our win/lose ratio and when we do lose, it is because of a conscious, informed, and documented decision by the patient.

Communications between Healthcare Team Members

NQF states, "Communication among primary care providers, hospital providers, specialist and nonclinical resources in the community is critically important to optimal care. Communication has become a vehicle of many hospital programs to improve transitions and reduce medical errors and re-hospitalizations." SETMA's Care Transitions program which includes post hospital calls has resulted in decreased readmissions and improved patient safety and satisfaction. (See Patient-Centered Medical Home and Care Transitions: Part I April 21, 2011 and Patient-Centered Medical Home and Care Transitions: Part II April 28, 2011 at www.jameslhollymd.com under Your Life Your Health) Also, SETMA's program design, which includes the principle that the last act of the post-hospital transition of care is the patient being seen in the clinic by their primary care provider, has "closed the loop" on hospital care transition.

This element of communication is increasingly important as more and more hospitals are employing hospitalists who take care of indigent and unassigned patients admitted to the hospital. Many of the hospitalists work for larger companies most of whom do not have a clear plan for care transitions making the patient seen by them vulnerable at the time of transition to ambulatory care. This is an important area for work to be done to improve patient safety, continuity of care and care coordination.