James L. Holly, M.D.

PC-MH Patient Activation, Engagement and Shared-Decision Making Part I
By James L. Holly, MD
Your Life Your Health
The Examiner
March 5, 2015

In 1999, four seminal events produced the foundation for SETMA's growth and the direction for our development (see May, 1999 -- Four Seminal Events in SETMA's History). Fourteen years later, in 2013, four different events converged to clarify a patient-centered-medical-home concept which had eluded me. There is a direct connection between both series of events in SETMA becoming a patient-centered medical home.

Shared-decision-making between patients and healthcare providers, collaboratively establishing the goals of care always seemed alien to me. Guided by evidenced-based, scientific literature, the goals of care seemed standardized and not subject to personal opinion, or patient desires. What was absent from this linear formula, i.e., diagnosis and prescription, was consistent, positive outcomes because often patients were not adherent, i.e., they did not follow the directions given by the healthcare provider. It should have been obvious. People often do not follow through on instructions given when they are a passive participant in the origination and development of those instructions.

Now that the concepts dictated by patient participation are clear, it may seem strange that it took so long for me to understand them, 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 *Health Affairs*. The February 28, 2013, Your *Life Your Health* resulted from 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," which added to that understanding, stated, "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 (ACO) requires delivery systems that participate in the Medicare Shared-Savings Program to engage in shared-decision making. This new patient-centered medical home "technology" was defined as:

> "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. 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 were much higher than that, but team members were doing tasks which had never been done before. There were ups and downs in the ratios but electronic patient records adopted in 1998 and the subsequent technology of electronic patient management adopted in 1999, 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 without the inefficiency of scheduling meetings with all team members in the same location. Monthly, we meet for a half day to discuss quality improvement, performance and issues which need resolving. Recently nineteen team members spent a day in a strategic planning meeting to look at the future and to plan for it. Daily electronic huddles directed by periodic strategic planning meetings 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 for the patient's privacy, I do not identify the patient's gender, age, 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. Yet, I was wrong.

I knew the facts of the patient's encounter well, but in preparation for a conference in which I wanted to relate the lessons learned in that experience, I looked up the patient's record. 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..who 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 diagnosis only 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; Medical Nutrition Therapy Education; and Diabetes Self Management Education.
>
> "I scheduled a Clinic follow-up call three days after the initial visit 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…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, education 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 education, 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.

In next week's column (March 12, 2015), we will discuss the plan of care which was given to this patient, which at the time was thought to be excellent but which turned out to contradict the concepts of patient-centered care.