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PC-MH Patient Activation, Engagement and Shared Decision Making Part II
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Learning is often the result of making mistakes and, rather than continuing to repeat the mistake, changing. Last week (March 5, 2015), we discussed the foundation of patient-centered medical home and shared-decision making. The following will explain how we learned from our mistake. Continuing the discussion of the case of the patient who wanted to lose weight but who needed to be treated for diabetes, the following was done.

> "Upon reviewing the patient's response to our care plan, I set up the following plan:
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> - "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."

In my review of the case, I realized that the patient wanted to lose weight and I had ignored that fact. I had substituted my desire for the patient's goal and as a result the patient ignored by instructions. I realized that I could easily have addressed the patient's weight concerns in the context of the important need to treat her undiagnosed diabetes.

Whereas I had remembered this as an excellent example of patient-centered care; it was in fact just the opposite. It was in fact an excellent example of the old and failed method of care. I

made every effort to contact this patient without success and can only hope that some day, I will meet this person again and can apply the new healthcare technologies formulated by PC-MH to this patient's care.

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

In 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 before.

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. Addressing the patient's goals allowed the provider to meet the patient's real goals while creating a bond between provider and patient which benefited both.

Conclusion: Unintentional Neglect of a Patient

After reviewing this patient's chart, all weekend, I thought and even dreamed about the patient. 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." and/or "neglect to participate in shared-decision making.."

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 this review, 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 been 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.