

Person-Centered Care

What we can learn from caring from the most complex patients to transform primary care



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- No reported conflicts of interest

Behavioral Learning Objectives

- Identify features and principles of a person-centered versus provider centered primary care practice.
- Use tools that can identify and measure progress towards person-centered goals.
- Create a plan to implement a person-centered care team for the highest need patients in their practices.

Who are complex patients?

- Meet several of our patients:
- By payer mix:
 - Medicare—high medical complexity
 - Medicaid—high BH complexity
 - Uninsured –high social complexity

What do they have in common?

- The traditional primary care model doesn't work for them. They need:
 - open access
 - immediate communication
 - a trusting therapeutic relationship
 - social support
 - assistance with basic life services and skills
 - care outside the clinic walls.

If we're going to serve these patients we'll need an expanded model of primary care

Should we try to serve this population in primary care?



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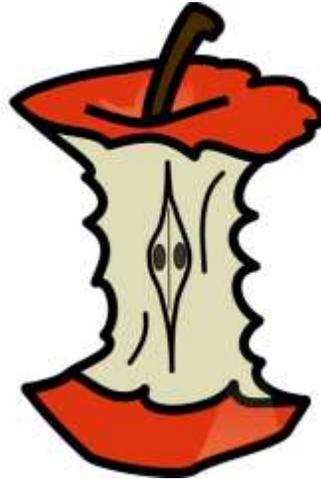
Why does it matter?

- “This is where the money is”
- Value-based health care
 - Triple aim: Improved outcomes, experience of care, lower overall cost.
- Opportunities for value
 - Standardizing chronic/preventive care
 - Reducing diagnostic errors/improved safety
 - High utilizer care—1% drives 50% of the cost
 - High risk/under-utilizer—“ticking time-bombs”

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We should be all over this

- Returning a broader scope of practice back to family medicine.
- Relationship-based care.
- Highly rewarding (personally, and to health systems/payers)
- If we don't do, someone else will.



What we did

- Bridges to Health (BTH)
- Project 1300
- Caring 4 You (C4U)
- Appalachian Mountain Community Health Center (AMCHC)

Bridges to Health

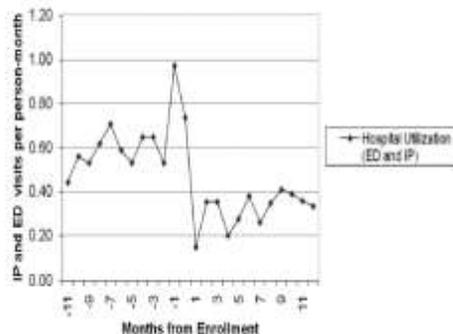
- DIGMA for high risk, uninsured, and Medicaid high-utilizers—6th year.
- Integrated care—RN CM, BH specialist, patient advocate/peer support specialist, occupational therapist
- 3 groups a week, two settings (Free Clinic, FQHC).
- Immediate cell-phone access to CM 6 days a week.
- First year enrolled 45 patients; \$55,000 budget

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BTH Outcomes

- 125 concurrent enrollees.
- PMPM hospital utilization dropped 45%.
- First year savings \$250,000
- Improved PHQ9 scores
- 1/3 marked life changes

Figure 1. Hospital use (emergency department [ED] and inpatient [IP]).



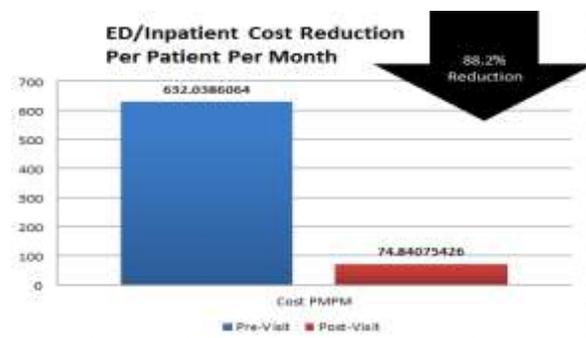
Project 1300

- Outreach and open access clinic for homeless, uninsured high-utilizers—2nd year.
- Integrated care: LCSW/CAS, RN CM, peer support specialist, FNP, Care manager assistant, eligibility specialist (SOAR), PCP, psychiatrist, transportation van.
- First year 550 enrollees, \$500,000 first year budget

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Project 1300 Outcomes

- PMPM of enrolled patients dropped from \$632 to \$75 (88%).
- Annualized per person savings of \$6686
- Cost savings to hospital \$4.5 M



C4U Outcomes

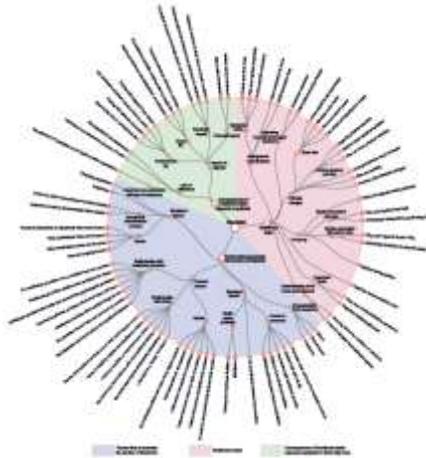
- High utilizers
- “Ticking time bombs”



So what did we learn?

- Relationships matter!
- Communities and culture matter!
- All patients have a care plan—usually not the one you lay out for them.
- Patients are far more resilient than assumed.
- Face a myriad of barriers, many created by us.

The complexity of patient barriers



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Engagement: Start with the two key questions

- “What is important to YOU?”
- What is important FOR you?””

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The other key question

- “What happened to you?”
 - More than 70% of our younger high risk patients have very high ACE scores.
 - Centering exercises (CRM); counseling

The 5 questions of engagement

1. “ I felt that we talked about things that were important to me.”
2. “This clinician and I were working toward my goals.”
3. “I felt that the clinician and I were working well together.”
4. “I understand and agree with how we are approaching my concerns”
5. “I felt that the clinician understood and respected me.”

What if we asked every patient these questions at the end of every encounter?

What if patient engagement really mattered?



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The 5 questions of engagement

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2. This clinician and I were working toward **my goals**.
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What is person-centered care?

- Each person is the expert in their own health and about how disease and treatment impacts their lives.
- Health conditions are addressed in the physical, social, and cultural context of a person's life.
- Comprehensive and highly focused services are available to address the full spectrum of needs.
- Services are carefully planned and delivered to eliminate redundancy and duplication.

Provider Culture Matters!

- Establishing the nurturing culture
 - Promoting person-centered care principles.
 - Recruiting the right people
 - Involve patients
- Reinforcing
 - Involving the whole care team in planning
 - Sharing successes; problem-solving together
 - Make all work meaningful
- Measuring
 - “What does it mean to be patient-centered”

Measuring Patient-centeredness

- If you don't measure it, it isn't important.
- This isn't something outside entities care about (yet): PCMH, ACO, MU2 (3).
- Culture is hard to measure—but not impossible
- The key elements:
 - Relationship: Access, communication, continuity, time
 - Patient engagement

Specific Measures

- Access=>time to next 3rd appointment
- Communication=>Time to PCP query response
- Continuity=>% clinic visits with PCP
- Perceived time with PCP=>listening
 - Quality of therapeutic relationship
 - 5 Questions

How can this model improve care for all of our patients?

- Listening first
- Patient-centered goal setting
- Mindfulness—patient, clinicians
- New models of care:
 - Accommodating walk-ins; modified open access schedule; “fast-pass”; care-portal; advanced medical assistant training; DIGMAs for DM, chronic pain, high social need.

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Why does this matter?

Because someday all of us will be patients. How do you want to be cared for?



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Moving toward patient-centered practice

- Establish a patient-centered culture
 - Language matters—ban use of “non-compliant”; start with personalized care descriptors (“fun factoids”)
 - Patient goal at the top of a “problem list”; key resources AND barriers in social history.
 - Know something important about EVERY patient.

Learning from failure

“Conclusion: WISE (self-management support) was not embedded because of **the perceived lack of relevance and fit to the ethos** and existing work.

Enacting SMS within primary care practice was **not viewed as a legitimate activity or a professional priority.**

There was failure to, in principle, engage with and identify patients’ support needs.”

Appalachian Mountain Community Health Center

- New CHC integrating complex patient care model and primary care clinic—3 months
- Patient panel—250 “complex”, 1000 “usual FQHC patients”
 - Open access clinic
 - Chronic care DIGMAs
 - RN CM “air traffic controller”
 - CHWs/care manager assistants (MA)
 - Integrated team

Changing the change paradigm

- Approach every “quality” improvement with key questions: “How will this improve the relationship with our patients? How does this help patients manage their care?”
 - Involve patients (not just the “good ones”) in redesign
 - Start measuring therapeutic relationship
 - Empower small teams to experiment with improved care models.

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During the break...

- Discuss / think about how you might implement the information you just heard.
- Fill out a session evaluation.

Questions?

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