Patient Centered Care

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Which country’s workers work the most hours?

- Canada
- Cyprus
- Denmark
- Iceland
- Japan
- New Zealand
- Singapore
- South Korea
- Spain
- Taiwan
- United Kingdom
- United States

PPCM=PGCM=GCM=CM
GLOBAL WAGE REPORT 2009: HARDEST WORKING PEOPLE

Answer: Singapore
Happy Planet Index

- Life Expectancy
- Experienced Well-being
- Ecological Footprint

Singapore # 90
US # 105
Costa Rica # 1

Out of 151 countries rated
Figure 1:
YOUNG CHILDREN AND OLDER PEOPLE AS A PERCENTAGE OF GLOBAL POPULATION

An Aging World

Huge Demographic Change

By 2050, there are projected to be 2 billion people in the world over age 60

80 percent of them will be in developing countries
Figure 5:
PROJECTED INCREASE IN GLOBAL POPULATION BETWEEN 2005 AND 2030, BY AGE

Figure 7:
PROJECTED POPULATION DECLINE BETWEEN 2006 AND 2030 (IN MILLIONS)

Russia: -18.0
Japan: -11.1
Ukraine: -7.1
South Africa: -5.8
Germany: -2.9
Italy: -2.8
Poland: -2.0
Romania: -1.5
Bulgaria: -1.4
Spain: -1.4

Source: U.S. Census Bureau International Data Base. Available at:
WHO

Ageing Society 7-14% > age 65
   (US and Singapore)

Aged Society >14% > age 65
   (Japan and France)
Background & Status

International Comparison of the Speed of Aging

- France: 14% of population age 65+ at 115 years
- Sweden: 14% at 80 years
- U.K./Germany: 14% at 45 years
- U.S.A: 14% at 65 years
- Japan: 26% at 25 years
- Taiwan: 29% at 26 years
- China: 29% at 26 years
THE INCREASING BURDEN OF CHRONIC NONCOMMUNICABLE DISEASES: 2002–2030

Low- and Middle-Income Countries

2002: 44% Communicable, maternal, perinatal, and nutritional conditions, 12% Noncommunicable diseases, 44% Injuries

2030: 54% Communicable, maternal, perinatal, and nutritional conditions, 14% Noncommunicable diseases, 32% Injuries

High-Income Countries

2002: 85% Noncommunicable diseases, 9% Injuries, 6% Communicable, maternal, perinatal, and nutritional conditions

2030: 89% Noncommunicable diseases, 7% Injuries, 3% Communicable, maternal, perinatal, and nutritional conditions

Singapore Population Statistics

- Population 4.5 million
- Age structure
  - 0-14 16%
  - 15-64 75.9%
  - 65+ 8.1%
- Life expectancy (at birth, 2005 est.)
  - Total 81.6 years
  - Male 79.0 years
  - Female 84.4 years

Gender Gap Increases with Age

Number of Older Men Per 100 Women (By Age Group)

Women

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>81</td>
</tr>
<tr>
<td>70-74</td>
<td>72</td>
</tr>
<tr>
<td>75-79</td>
<td>63</td>
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<tr>
<td>80-84</td>
<td>53</td>
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<tr>
<td>85-89</td>
<td>43</td>
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<tr>
<td>90-94</td>
<td>36</td>
</tr>
<tr>
<td>95-99</td>
<td>34</td>
</tr>
<tr>
<td>100+</td>
<td>30</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau
Patient-Centered Care

Definition:
Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.

Ref: Institute of Medicine
Patient – Centered Care, 4 key Attributes

• Whole Person care

• Coordination and Communication

• Patient Support and Empowerment

• Ready Access

• Ref: Institute of Medicine
Patient-Centered Communication in Cancer Care

**Figure 1.1** Clinicians, patients, relationships (clinical and social), and health services are all integral to patient-centered care. The interactions among these elements are complex and deficits in any one area can significantly decrease the quality of patient care.

Improving Communication

**Improved Health Outcomes**

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Epstein RM, Street RL. Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering. NCI.
### Table 1.2 Examples of Active Patient Communication Behaviors

**Asking questions**
- Communicating assertively
  - Offering opinions
  - Stating preferences
  - Interrupting, if necessary
  - Sharing beliefs about health
  - Introducing topics for discussion

**Expressing concerns and feelings**
- Expressing emotions
- Disclosing fears and worries
- Noting frustration

**Telling one’s health “story” in the context of everyday life**

Ref: Epstein
# Table 1.1 Examples of Patient-Centered Clinician Behaviors

### Nonverbal Behaviors
- Maintaining eye contact
- Forward lean to indicate attentiveness
- Nodding to indicate understanding
- Absence of distracting movements (e.g., fidgeting)

### Verbal Behaviors
- Avoiding interruptions
- Establishing purpose of the visit
- Encouraging patient participation
- Soliciting the patient’s beliefs, values, and preferences
- Eliciting and validating the patient’s emotions
- Asking about family and social context
- Providing sufficient information
- Providing clear, jargon-free explanations
- Checking for patient understanding
- Offering reassurance
- Offering encouragement and support

Ref: Epstein
### Communication Outcomes

**Table 1.3 Outcomes of Effective Communication**

<table>
<thead>
<tr>
<th>Communication outcomes</th>
<th>Health outcomes</th>
<th>Societal outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strong patient/family-clinician relationships (trust, rapport, respect, involvement of family and caregivers)</td>
<td>• Improved adherence, health habits, and self-care</td>
<td>• Cost-effective utilization of health services</td>
</tr>
<tr>
<td>• Effective information exchange (recall of information, feeling known and understood)</td>
<td>• Access to care and effective use of the health care system</td>
<td>• Reduction in disparities in health and health care</td>
</tr>
<tr>
<td>• Validation of emotions (e.g., empathy)</td>
<td></td>
<td>• Ethical practice (e.g., informed consent)</td>
</tr>
<tr>
<td>• Acknowledgment, understanding, and tolerance of uncertainty</td>
<td><strong>Health outcomes</strong></td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Patient participation in decision-making</td>
<td>• Survival and disease-free survival</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Coordination of care</td>
<td>• Prevention and early detection of cancer</td>
<td>-------------------------------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>• Accurate diagnosis and completion of evidence-based treatment</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Maintenance of remission</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Intermediate outcomes</strong></td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Strong therapeutic alliances</td>
<td>• Health-related quality of life</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Patient knowledge and understanding</td>
<td>• Functioning: cognitive, physical, mental, social, and role</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Emotional self-management</td>
<td>• Well-being: physical, emotional</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• High-quality medical decisions (informed by clinical evidence, concordant with patient values, and mutually endorsed)</td>
<td>• Health perceptions</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Family/social support and advocacy</td>
<td></td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Patient self-efficacy, empowerment, and enablement</td>
<td></td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

Ref: Epstein
Change

Change, often = Fear

The Devil you know ...
The Myths of providing Patient-Centered Care (PCC)

Providing PCC is too costly
   attitude, kindness, compassion, empathy
      Free

Providing PCC is the job of Nurses
   is the job of all at every tier of an organization, clinical and non-clinical;
   requires complete transformation of organizational culture

Will have to increase staffing ratios to provide PCC
   # of experiences in hospitals demonstrate nursing time can actually decrease

Ref: Frampton
Myths -- continued

• PCC can only truly be effective in a small hospital
  – Many examples of success in large institutions and health systems

• No evidence exists showing the benefits of PCC
  – Increasing research evidence demonstrating effectiveness

Ref: Frampton
Myths -- continued

• First step in becoming PCC is renovation or construction
  music, artwork, pet visits, humor – not expensive and
don’t require renovation

• PCC is a “Magic Bullet” – fixes and cures everything
  requires long term commitment, “walking the talk”
goal: not to reach the destination, but to continue approaching it

– Ref: Frampton
Myths -- continued

We’ve already received a number of quality awards, so we must be Patient Centered

Our patients aren’t complaining, so we must be meeting all their needs

Ref: Frampton
Patient-Centered Care

PCC is not a checklist, a dashboard or an action plan.

It requires a buy-in and engagement from all levels of an organization, it requires a long-term commitment, and a willingness to routinely challenge the “that’s the way we’ve always done it” mentality.

Ref: Frampton
PCC

PCC is not simply a goal to be achieved in order to move on to the next initiative. The true test is its sustainability and its ability to endure even in the face of high census days, staffing shortages, demanding patients and leadership turnover.

Ref: Frampton
Communication – Advice for Health Care Personnel and Patients

Communication is Key

Information: give and receive information and cues (verbal and non-verbal)

Dialogue: listen, watch and speak
Electronic Medical Record (EMR)

• The good news: legible, organized, available from multiple sites

• The bad news, from patient-centered perspective: you, the patient, are not the “center”, the computer is.

• Little eye contact, less interpersonal dialogue, lots of boxes to check, non-verbal cues missed
The “Good” Patient

The one that doesn’t bother you

The one who adhered to medications and was respectful

The one who didn’t try to second guess

(The “good” baby, the “good” child, the “good” student)

Barriers Between Doctors and Patients

Psychological

Social

Economic

Cultural

  Some do too little
  Some do too much (try too hard)

The Goal – Detached Concern (Renee Fox): to be simultaneously concerned, and, in order to be objective, somewhat detached

Ref.: Klitzman
Experience of Being Ill

The experience of being ill inspired many physicians to strive to reduce the barriers between themselves and their patients.

Doctors now reassessed the doctor-patient relationship, seeing it less as “us versus them” and more as “we’re all in this together” – would not have happened if they hadn’t been sick.

Ref.: Klitzman
A physician, in describing his experiences overcoming cancer and how “that recognition of vulnerability ... makes me a better doctor today”.

But, he also states “I’m not sure that I would be better prepared if I had to relive it again. No amount of doctoring can prepare you for being a patient”.

Ref. Klitzman
My experiences

Waiting for surgery – arrive 6 am ...

Office (Derm) – wait and wait – just take 30 seconds and tell pt how long ...
The colder the x-ray table, the more of your body is required to be on it.

- Steven Wright
"Full day, Frank! First to the Radiology Department, then the Urology Department, then down to the Witchcraft Department..."
The Truly Good/Vigilant Patient Helps Prevent Errors – Sometimes Serious, and, Unfortunately, Not Uncommon

Tests repeated unnecessarily
Data misread
Information misplaced

This is a real life example of an eminent physician’s wife at a highly respected U.S. academic health care hospital in spite of his presence and efforts.

Things weren’t just slipping through the cracks: the cracks were so big, there was no solid ground

Ref.: Time, 4/06
Truly the GOOD Patient

Be respectful BUT appropriately firm and demanding; be your own advocate, and have family or friend(s) as advocates also

Please, what is the indication for this x-ray, blood test, procedure?

Please, why am I being given this medication?

Is there a good reason I have to stay in bed/get out of bed?

How much longer do you think I will need this urinary catheter/IV/oxygen/feeding tube?
Potential Complications of Bed Rest in the Elderly

• Pressure sores
• Bone resorption
• Postural hypotension
• Pneumonia
• Thrombophlebitis and thromboembolism
• Urinary incontinence
• Constipation and fecal impaction
• Contractures
RISKS FOR HAZARDS OF HOSPITALIZATION *

- Restraints
- Immobility
- Unfamiliar Environment
- Isolation
- Malnutrition/N.P.O.
- Sensory Deprivation
- Polypharmacy
- Incontinence
- Insomnia

* MSSM Geriatric Consult Beeper: 917-506-4540

FALLS
DEPRESSION
DELIRIUM
INFECTION
ULCERS
DECONDITIONING
INCONTINENCE
IMMObILITY

Fernandez H. Mount Sinai School of Medicine
NO CULTURE IS MONOLITHIC

– The cultural information in this presentation is accurately described *in general*

– Beliefs, traditions, customs, and preferences of the individuals in a cultural group vary widely

– Clinicians must never assume that any person’s cultural background dictates his or her health choices or behavior

– Ref. GRS, 7th ed.
Team

Patients come to understand the value of an interdisciplinary Team approach to their care
Teams include many players...

- Patient
- Family Member/Caregiver
- Physician
- Registered nurse
- Social worker
- Dietician
- PT/OT
- Pharmacist
- Physician assistant
- Nurse practitioner
- Chaplain
- Others......

And perspectives...

Ref: Howe
Team Intervention

- Focuses on discharge planning, starting with day 1
- Assess and focus on patient/caregiver preferences
- Re-designs of the discharge plan according to changing in medical status, preferences, etc.
- Incorporates the input of the SW regarding system regulations, limitations
- Assures ongoing medication reconciliation
- Assures proper follow-up
- Acts as the first emergency back-up system for any post-discharge issue identified by the GNP or SW

Ref: Howe
Patient-Centered Care = Patient Satisfaction??

Both are necessary but they are not the same thing

Ref: Kupfer JM, JAMA
Patients/Patience

• Patients pay, patience usually doesn’t

• Answering questions, giving explanations, educating – these are more time-consuming and less lucrative than doing tests and writing prescriptions

• Patients are partly at fault here as well – often want tests, antibiotics, the “latest” new test

Need to understand that more is not always better, and can be harmful (and expensive)
Good Doctor

• Smart, technically excellent (eg. surgeon)

• Nice, empathetic, personable

• Why does one have to choose? Doctor shouldn’t be just one or the other – should be both
Patient/Family Responsibilities

• Respect for nurses’, doctors’ time and obligations
• Respectful communication
• Questions – write them down ahead of time if possible
• One designated family member or friend to speak for patient, ask questions, call (except for family meetings)
• Contract (Denmark)
What Is A “Patient-Centered Medical Home”?

A patient-centered medical home is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has a relationship with a primary care clinician who leads a team that takes collective responsibility for patient care, providing for the patient’s health care needs and arranging for appropriate care with other qualified clinicians.
What Is A “Patient-Centered Medical Home”? (cont’d)

A medical home achieves these goals through a high level of accessibility, providing excellent communication among patients, clinicians and staff and taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.

Reference: NCQA
The medical home is intended to result in more personalized, coordinated, effective and efficient care.

Reference: NCQA
Tool D: Cleveland Clinic’s Respond with H.E.A.R.T. Badge

RESPOND WITH
H.E.A.R.T.

Hear the Story
Listen attentively

Empathize
“I can hear/see that you are upset.”

Apologize
“I’m sorry you were disappointed.”

Respond to the Problem
“What can I do to help?”

Thank Them
“Thank you for taking the time to talk with me about this.”
Northern Westchester Hospital

Just Ask!

IF YOU’RE THINKING IT... ASK IT

For example:
- May I request a different meal selection?
- Can my vital signs and blood work be drawn at a more convenient time for me?
- What medications are you giving me and what are they for?
- How can I arrange for a complementary relaxation session?

Please ask, so that we can better meet your needs and make your stay more comfortable.

Ref: Frampton; Planetree
After You've Had Your Baby

This chart will help you know what to expect during your stay and when you and your baby can safely go home.

What to Expect During Your Stay
- Physical care by your name
- Use "Please Do Not Disturb" sign as needed
- Assistance with feeding your baby
- Pain assessment/management
- Education about self and baby care
- Visit the car seat display
- Fill out the Birth Certificate form
- Visit by your provider (doctor or midwife)

What to Expect During Your Baby's Stay
- Nursing care
- Screening blood tests
- Hearing test
- Hepatitis B vaccine
- Daily check-in by Pediatric or Family Medicine

When Can Your Baby Safely Go Home?
- Your bleeding is normal
- You have no active infection
- Your pain is controlled
- Your high-risk complications are under control
- You are committed to eating, drinking, and walk around
- Your questions about health care have been answered
- Your follow-up care has been discussed with you
- You and your baby have started to figure out the basics of feeding and know who to call if you have questions once you are home
- Your baby has been evaluated for jaundice
- Your baby has normal breathing, sleep, pooping, and temperature
- Your baby has normal lab tests
- Your questions about baby care have been answered
- You have a safe car seat
- Your baby’s follow-up care has been discussed with you

If your baby is in the Progressive Care Nursery (PCN) or Neonatal Intensive Care Unit (NICU), speak with your nurses and pediatricians about what to expect.

University of Washington Medical Center
On Medicine

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July and August

• Unless it’s an emergency, stay out of the hospital (if it’s an academic/teaching hospital)

• Why – new trainees, just out of medical school

• 4% jump in risk adjusted mortality in major teaching hospitals in July and August (ref: National Bureau of Economic Research)
Try not to work for a person who has more problems than you do.
A person who is nice to you, but rude to the waiter, is not a nice person.

- Dave Barry
Never go to a doctor whose office plants have died

• Erma Bombeck
References

References (cont’d)


8) Kuehn, BM. Hospital at Home Program Cuts Costs, Improves Patient Health and Satisfaction. JAMA 308: 2: 122.

9) Kupfer JM, Bond EU. Patient satisfaction and patient-centered care: necessary but not equal. JAMA 308; 2.

References (cont’d)


12) Patient-Centered Care As Organizational Culture Change. 2008 by Planetree (www.planetree.org) and Picker Institute (www-pickerinstitute.org)


References (cont’d)

PPCM slides – special thanks to Sheila Fallik

Team slides – special thanks to Judy Howe