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Executive Dialogue

Patient-Centered Care

Overcoming barriers and identifying success

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Accelerating Patient-Centered Care

Patient-centered care has been and will continue to be a top priority for hospitals and health systems. The delivery of patient-centered care is linked to improved outcomes and reduced costs. However, many organizations struggle with understanding what patient-centered care really means and what it looks like. Health Forum convened a panel of health care executives and industry experts May 7 in Tucson, Ariz., to discuss ways organizations can accelerate the transformation to patient-centered care. Health Forum would like to thank all of the participants for the open and candid discussion, as well as Siemens Healthcare for sponsoring this event.

MODERATOR (Maulik Joshi, Health Research & Educational Trust): How do you define patient-centered care? A common definition that we typically talk about is "nothing about me, without me" care that's centered around the patient. How do you define patient-centered care as it relates to your organization?

GARY YATES, M.D. (Sentara Healthcare): We like to think of care as beginning with the patient, taking into account their needs and desires. So, it is trying to meet the Institute of Medicine's Six Aims and also realizing it isn't just about hospitals, it's about the continuum of care. Some patients are asking us to help them be as healthy as they can be. Patient-centered care is really trying to get a deep understanding of that and then being able to build a care system to help patients achieve their highest level of health.

MAUREEN GAFFNEY, R.N. (Winthrop University Hospital): That's the definition we use as well. The challenge is having everybody understand that we're all moving toward the same goal. This discussion is important because if you talk to six different providers, you will probably get six different definitions. They all will have a slightly different interpretation of what patient-centered care means. That's a challenge for us, especially since our entire health care delivery system has not been patient-centered. Until now, it has been provider- and organization-centric.

I'm also not sure whether our patients will be ready. We are reaching the patient engagement piece for meaningful use now, which addresses patient portal utilization. Getting patients and physicians comfortable with an open dialogue electronically is going to be a big hurdle for us.

MODERATOR: Don, you've got a variety of organizations within your system. Are you seeing similarities across the hospitals?

DON PAULSON (University Hospitals): Good question. We do have many distinct organizations serving inner-city communities and the Amish in Geauga County [Ohio], for example. The revenue cycle is usually one of the first and last interactions people have with a hospital. We deal with patients as they come in the door, when they are often very anxious. At the end of the process, after the bills are sent out, we sometimes have to go back to them and collect balances. We did not centralize the revenue cycle across the organization. Rather, we brought structure and common practices to the organizations so they are able to reflect and serve the local community.

JOHN GLASER (Siemens Healthcare): One way to define it is through analogues. Health care is not unique. Take banking, for example. A customer-centered bank has different types of customers with different needs. The bank has to figure out what the retiree needs and wants versus the young couple just starting out. In health care, we have to have a set of services that reflect what our patients need and want from us. And we can look for examples on how to serve our varied customer base outside of health care.

GAFFNEY: There are lessons to be learned from other environments. But the difference in health care is that we're dealing with patients' lives and we're dealing with a whole host of emo-

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tional components and contributors, as well as family. We're more than patient-centered, we are patient-, family- and community-centered. For us to be truly patient-centered, each and every component within the organization has to be patient-centered. That's a challenge.

PAULSON: That's correct. One of the challenges is that the payer system in the United States forces us to look at care on a transactional basis. What we have to do then is turn those outcomes back into patient-centered communication with the patients. These are pure transactions from a financial standpoint where we're dealing with nothing but computers and systems and contracts. After that, we have to go back to the patient and often explain everything. Hopefully, we can invest more in financial counseling, customer service and other front-end services.

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Don Paulson

DEBORAH DAHL (Banner Health): From Banner's perspective, we've been an acute care system for about 13 years. Every transaction should be an excellent exchange with the patient. It doesn't matter whether it's environmental services, food service or nursing. As we move into an accountable care organization model, it has changed our focus of patient-centeredness from what happens at each transaction or at the bedside to the full continuum of care. How do we make sure there's continuity for those folks? What does a patient-centered medical home look like? Because we're new, we have the opportunity to say our patient-centered medical home will be a standard model. Yes, each individual has the opportunity to participate in shared decision-making to build the model they want to work with but, overall, it's a franchise model.

We're focusing on reduction of variation and improvement in outcomes. And we're rolling out to about 167 individual medical practices a standardized patient-centered medical home. That's a daunting thing to do. And it makes our rollout of the EHR look like a trivial detail. But this way we're changing what the primary care physician is doing, the specialist's role and we're adding nurse practitioners.

GAFFNEY: Part of our challenge, too, is that we're really emphasizing the patient's experience, moving away from task-oriented types of behavior. It's very hard, especially since we have so many external and regulatory pressures that really force us into that type of task-oriented, check-off-the-box type of behavior. I think the personalities that are entering into health care have changed over the years. Younger generations want balance in their lives. They want to do their jobs and hand them off to other caregivers. They truly want to help people, but that ownership of a patient's life has changed a bit. How do we design our processes to engage the true meaning of what those tasks are for the patient and not just to check the box?

MISTRETTA: It's interesting. We've been doing this probably for about seven years. We have a very diverse patient population. Our approach is to develop a continuity of care record. We have an advantage of being the dominant player in our market, so there are not a lot of others to compete with or to have an exchange with. The challenge that we have is the patient engagement piece. I'm not sure the U.S. population is prepared, willing or interested in patient engagement right now. As we talk about patient-centered care, that's got to be a critical piece that comes to play. If patients don't want to be engaged, it doesn't really work.

GLASER: It shows how we're at cross-purposes sometimes. We often equate a clinical-centered model with a patient-centered care model. Under the patient-centered care model, we support the patient's decision whether or not we believe it is best from a clinical perspective. If a patient has a body mass index of 40 and is content with that, then we support that decision. Under the clinical-centered model, it's more paternalistic. We acknowledge the patient's perspective, but we continue to try to convince the patient to see otherwise. So we shift our centricity all the time.

GAFFNEY: Absolutely. And we're being measured for that. A perfect example is the patient with the elevated BMI. We're being measured as practitioners and as an organization if we don't send them for a nutritional consult. But, then again, we are supposed to acknowledge and respond to their wishes.

MODERATOR: So what does this mean for patient-centered care? We're accountable for care and patient health, yet we're also accountable for keeping the patient at the center of care.

MISTRETTA: Transactions need to be invisible to the patient at the end of the day. We can look at care from a transactional perspective so we can do our billing and other administrative work. But we've made a real, concerted effort to make sure those activities are invisible. It's patient experience, it's not a transaction.

PAULSON: Mike, you bring up one of the great debates that we deal with in revenue cycle. Access to care is often a challenge. The payer system often makes it difficult for patients to see a doctor, to see a specialist. It's unfriendly. So, we are now looking at ways patients can reserve services. We're not actually scheduling services because we don't have the diagnosis and course of treatment yet, but we can schedule something. We need to allow people greater access. We've kept the patient completely out of the transaction and tried to do it all ourselves. At the end, the patient would get an explanation of benefits and have no idea

Panelists

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Deborah Dahl

or understanding of what it all means. We still do that, we still try to shield them from what's going on. But now, we are thinking of ways to re-engage the patients, keeping them informed of what's going on. That may take more effort; it may take better communication than we have today. But we think that it leads to letting patients know what's happening in a controlled fashion. We don't want to overwhelm them.

MODERATOR: What does patient-centered care mean when you think about accountable care organizations or other models in which payment and delivery are at risk together?

GAFFNEY: Part of the challenge is there's no communication between the payer and the customer. We're the middle man trying to explain the coordination of benefits. Payers seem to have a lot of control over and input into the care process due to our contracts. Yet, what are they contributing to help us with patient-centered care?

DAHL: The payer piece makes me nuts. We need to be cautious not to make health care a full-time job for our patients. Some bills are so complex it takes a specialist to interpret them. But then some of the other measures we need to meet forces the patient to follow a whole set of rules and a regime that might not interest them. My colonoscopy may be overdue and it looks bad for my primary care physician. There should be an easier way. We are trying to make our patients adjust to our system instead of us moving into their model.

MISTRETTA: The other issue that we have in our community, as well as in other communities, is a lack of primary care. If we have a severe deficit of primary care physicians, how does this model work?

GAFFNEY: And for the primary care physicians who are in place, the reimbursement model does not allow hem to be more involved with their patients.

MISTRETTA: That's changing, though, because if you look at employment models for primary care, their salary ranges in the last five years have gone up considerably. The reimbursement models are catching up from the physicians' perspective. I don't think that's going to be as big an issue as it was before. It's a numbers game at the end of the day.

YATES: My sense is we probably need more primary care physicians, but we also need to embrace a redesigned care model. As a family physician, many of the tenets of the patient-centered medical home fit integrally into how we were trained. A number of physicians are concerned about letting others do things they've always done themselves. But we are beginning to think of the primary care physician as the leader of the team and we're the folks on the team. That's going to be the key to moving forward.

A starting point for patient-centered care is realizing that we are the visitors in patients' lives. And there's some really excellent work being done about measuring patient activity and using that as a starting point for engagement and motivational interviewing. We all need to learn more in that area if we're going to be successful.

MODERATOR: Do you think one of our challenges is that we don't have the right way to evaluate, whether it's the patient activation measure or other care coordination measures, to really get at patient-centered care? Is that one of the challenges? And, if so, what can be done about it?

YATES: That is one of the challenges. There's some excellent research coming out that suggests we can use patient information measures and others more broadly, having a better understanding of its correlation. We respond to what we're incentivized for, so I think around the table we agree that patient-centeredness is more than Hospital Consumer Assessment of Healthcare Providers and Systems scores. How do we move toward the right measurement to incentivize progress on the journey?

GLASER: There are a number of things at a fairly fundamental level that make this really, really hard. One is, obviously, that those who pay are different from those who consume.

And another is that people tend to view hospitals and health systems differently from other businesses. There are poor-performing organizations in terms of HCAHPS scores and they're still around. A restaurant or burger joint with a terrible reputation for service would close up shop.

MODERATOR: I'd like to further explore where we are today with patient engagement. As has been mentioned, it is a challenge. What are you doing in your organization to try to change that?

GAFFNEY: Let's use palliative care as an example. At Winthrop, one of our geriatricians is a leader in palliative medicine. And yet, I've been slow in getting people to understand the value of palliative care outside of just end-of-life care. We're so quick to move to the emotional aspect of end of life, but it comes down to what is the right way to achieve the goals of care. How do we have that conversation? You'll quickly learn whether you are in alignment with the patient and patient's family.

This is going to be a very slow-moving process. We're seeing an increase in palliative care consultation. We're seeing fewer end-of-life decisions being made in an ICU setting, but it's taken us five years to get there. When it comes to patient engagement, even some families and patients don't want to talk about it. And again, that's true patient-centeredness. They shouldn't have to, if that's what they want.

DAHL: I'm hoping the patient-centered medical home will help generate that discussion while the patient is still somewhat healthy, so it won't be necessary to have it when they're in a crisis.

GAFFNEY: That's a huge cultural shift in this country.

MODERATOR: So we're talking patient-centered care. And now we're talking about education, more upstream. What's the role of the hospitals as we transition to new care delivery models?

MISTRETTA: For us, it comes down to the availability of primary care physicians. We try to facilitate getting patients to the best place that we can based upon their needs. Our social workers and case managers are working harder than ever trying to figure out where the patient should go following discharge. The big fear in our market is that providers will opt out of Medicaid. If that happens, it's going to make things a lot worse at the end of the day.

GAFFNEY: We've invested a lot in our case managers, because navigating the system we've created is a challenge. Not only do they help the patient, but they help the organization move the patient through the system as quickly as possible, Their work supports our quality initiatives, as well as our cost-effectiveness and cost-reduction strategies.

MISTRETTA: It also removes some of the burden from physicians. They want to take care of the patient. They want to practice medicine. They don't want to practice insurance negotiation and all of those other things. That's a huge distraction. The case management team has to determine what's the right level of care for the patient through the continuum. But so much of what patients are eligible for is dictated by the payer. The insurance company often dictates the course of care and we become the bad guys when we have to tell patients that certain treatments are not covered.

GLASER: Education will be a significant part of patient-centered care, as will care coordination. There also will be a greater emphasis on prevention and wellness. It will be a challenging decade for the delivery of care. And it's not so much because we're going to be patient-centered, as it is the shift in reimbursement.

MODERATOR: We definitely have some barriers and impediments to this work. In the hospital, today, people talk about various patient engagement practices, open visiting hours and conducting change-of-shift reports at the bedside with patient and families involved, among other things. We know, though, that these things are not happening consistently in hospitals. So what are some of the barriers? Is it cultural?

GAFFNEY: Well, at Winthrop it's a challenge. As with many organizations, each patient floor has a different personality, a different patient population and a different physician and caregiver population. We have attempted multidisciplinary rounds, and on some units it works very well and on others it doesn't. We have to find what works because, at the end of the day, what matters is good communication, accurate information and an understanding of the patients' and families' goals of care.

GLASER: Change is hard, period. One of the challenges around patient-centered care is that it asks clinicians to do some things that are not inherently natural to their training. That doesn't

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Maureen Gaffney, R.N.

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John Glaser

mean they can't change, but it's a difficult change process.

YATES: When my mother-in-law was ill, she received excellent care. But the little things, like bedside rapport, made a big difference. We can't underestimate the opportunity to connect with the patient. What's interesting is that there were two driving questions during her stay: Where will I go after discharge? And when is the physician going to come by? There's an opportunity for us on a number of fronts.

GAFFNEY: We can't underestimate the power of the nurse at the bedside. Unfortunately, the nurse has become less engaged, in part, because of external influences and regulatory pressures. We have to start designing systems to draw in the patient and the care provider. It's those nurse-driven encounters that really drive the patient's experiences.

As part of our patient experience program, we're trying to build in reminders to our caregivers as to why they entered the field in the first place. They want to ease suffering. If we get everybody thinking about that, then maybe we can make a difference. But until we change the processes that drive clinicians into task-oriented behavior, we've made it hard to do otherwise. I believe technology can play a big role. We need systems that generate more interaction between the patient and the caregiver.

GLASER: That's absolutely correct. The human touch — the relationship with nurses — is essential. The relationship helps to empower patients because they feel they have an advocate on their behalf, someone who understands their situation and is pulling for them. It reduces the feeling of helplessness because someone is by the patient's side.

MISTRETTA: We're also focusing on giving the patient a greater sense of control. One of the things we do is provide patients with a daily activity report. It outlines the care plan for the day. That communication is essential in engaging patients in their care. Patients and families receive an update every morning.

GAFFNEY: We're trying to do that as well. But the challenge is that the schedule is always changing.

MISTRETTA: There will always be changes in the schedule. That's unavoidable. But it does provide patients an idea of what is in store for the day. They will receive an MRI. They will meet with a dietitian. Our biggest challenge is communicating the medications they will receive and the potential side effects. We list all of the medications and have to explain them to the patient and the family.

GAFFNEY: That's a great safety measure.

DAHL: Perhaps it could be communicated in blocks of time, mid-morning, early afternoon, etc.?

GAFFNEY: I would love to just say, 'You're getting an X-ray today,' but in a teaching organization, those things change all the time.

PAULSON: In our environment, we are fortunate because organizations are adopting process

Key Findings

- Patient-centered care requires significant cultural change among clinicians, patients and family members. As organizations strive to become more patient-centered, it's important to realize that not all patients and families will want to be actively engaged in the care process.
- Technology plays an important role in patient-centered care, particularly in facilitating the exchange of patient information among caregivers along the continuum of care.
- Hospitals must continue to make the billing process more transparent and make it easierfor patients to view and pay their bills electronically.

improvement initiatives such as Six Sigma and Lean. Resources then can be redeployed into patient communication. We can put more people in financial counseling to walk patients and families through the process. We need them to see that we value them as individuals and not simply as a payment. Technology can assist with this as well. It can help to streamline processes so caregivers can direct more time to the patient.

Again, with billing, there are many opportunities for improvement. Once a patient returns home, he receives multiple bills from laboratory services, physician specialists, the hospital, etc. I'm always asked why it can't all go on the same bill. And it's hard to explain to patients why it can't all go on one bill.

Ideally, we have to move away from the transactional basis and start putting bills online in one place so patients can see everything in their entirety. Patients can schedule their payments online as well, but that transition will take some time. The shift to electronic formats gets quite expensive, and it will require some adjustment in workflow. And we'll have to retain all of our old processes for people who don't want to access their accounts online. It's complicated, too, by the fact that their payment is mostly determined by a third-party payer. We have to find better ways to communicate the billing process to them. We have to move away from those models where we're in charge of everything, and start taking some risk in letting the patient get involved with this process.

GAFFNEY: I believe the financial piece is just as important as what we do in the hospital at the bedside. As Don mentioned, finance is often one of the first and last encounters of every patient stay. It goes back to what we were talking about at the beginning; every single part of the organization and continuum has to be patient-centered.

My mother lives with us and she's a traditional Medicare patient. She came to our hospital and she was beside herself because she received a bill she thought she had already paid. But it was a physician's bill. She had paid the bill for her scan. She was very confused. We do need to learn to speak the patient's language.

PAULSON: I completely understand. My dad is 85 and he brings all of his bills to me to review. I have to sit and explain them to him. It makes me realize how far off we are in communicating the financial piece to patients.

MODERATOR: Let's talk more about the role of technology. John, what role can technology play in accelerating patient-centered care?

GLASER: You could argue sometimes that health care is behind in the technology. You can also argue that it is a messy, complex domain. The field is still learning how to apply technology because it's hard and complicated. There's a lot that technology can do to support patient-centered care. But there are challenges as well. The incentive system too often is not aligned with service excellence. As Don mentioned, there are benefits to providing billing information online, but it comes at a cost and there is no economic reward to do it.

The second challenge is the phenomenal fragmentation of the industry and the interdependence between the parts. As patients move between systems, their information does not necessarily go with them. A third challenge, one may argue, is that there is no domain of knowledge messier and more volatile than that of medicine. Change is constant and clinicians need to stay on top of new practices and knowledge.

Some of these aspects that get in the way are tractable. Hard, but tractable. I guess this is a long-winded way of saying that I think the technology fundamentally exists. There are limits to it, currently, but it will get better.

YATES: There are some pieces of technology that are quite ready. Take, for example, the patient portal. At Sentara, we have more than 100,000 patients signed up who use that as a form of communication. And as the technology improves, we'll be able to connect even better with those individuals. It's a good starting point.

GAFFNEY: Let's talk about the providers. The only way they're going to take the extra step to get that information is if the information has value. But the information only has value if it's all there. If you don't have everybody participating, there are big gaps in the data and big gaps in the information about that patient. So then, how reliable is it? If you have a patient who tends to stay within the Winthrop network, it works well. But in our metropolitan area, we

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Mike Mistretta

To be successful, we need to build a culture of patient-centeredness.

Gary Yates, M.D.

cross worlds all the time and we need to have a majority of the providers participating. It takes money and time.

MODERATOR: What are some of the areas where you've seen success?

PAULSON: There's a big change in the patient's mentality. One of the things we've been focusing on is primary care access. It's a real problem in our emergency departments as it is at many places. Even if patients have a primary care physician, they don't have access to specialists so they go to the ED. We've been advocating, strongly, to do medical screening at the front end and have a contiguous primary care setting, hopefully a medical home.

GAFFNEY: We're looking to start an urgent care center to help offset some of those medical cases, as well as after-hours primary care availability for our patients. It's not only more cost-effective, it's better for our patients. They're not sitting in the waiting room for long periods of time because they're lower on the triage list. And it helps us with our ED congestion. Winthrop University Hospital is a 590-bed academic medical center. We're not part of a large health system, although we serve a large community in Nassau County. How do we continue to build our patient-centered medical homes, which we're starting to do in our pediatric area? We're trying to engage patients and nonaffiliated physicians to send their patients to us. That's part of our challenge. And as Don suggested, where does the cash go? How do we develop payment models that encourage family physicians to send patients to chronic disease management specialists, if needed. How do they get credit for it? We are struggling with that. We're looking at those different care delivery models.

We are trying to tie the whole continuum together. We have our own home health care agency. And we're engaged with our partners, although not necessarily in a true accountable care organization model. It comes down to making sure that all of the information transitions with the patient and that it is consistent and reliable. That's where technology really helps us.

MISTRETTA: We need to be conscious, though, of the unintended consequences of how fast we're moving forward with technology. I'd like to challenge the engineers and the designers of the technology to help us, because what I'm seeing in our organization is a dependency on the technology to make decisions regarding patient care. How can we design systems going forward to facilitate more of a partnership with patients that's also not a replacement for critical thinking? I've challenged my informatics group to start looking at ways to design screens and processes that give providers the information they need but not hand them everything. We want technology to assist the critical-thinking process, not replace it.

GAFFNEY: That's more critical now than ever given the incentives for physicians and organizations to adopt electronic health records. I'm fearful that there's going to be a rapid- cycle implementation without true clinical conscience in the design. This is where the vendors need to take some responsibility. I'm also worried that technology is going to get a bad rap over the next few years because there's going to be some unintended consequences to that rapid-cycle implementation.

YATES: We put our innovation efforts under the moniker of transformation of care, primary care redesign, chronic care coordination and learning to be accountable. I'm optimistic about some of these innovations, especially primary care redesign, including the patient-centered medical home. It really can move care forward. We need to think about the specialists and how they will fit into the medical home model. We need to be looking at physicians who aren't employed by the system. How do we engage those independent physicians? We are beginning to look at connectivity and bringing everyone together. And rather than just doing it as a system, we're working with other health systems in our marketplace to try to develop a communitywide approach.

MODERATOR: What's your advice to the field in terms of moving forward on patient-centered care, based on your experience?

PAULSON: We try to find those things that we can break down into predictable outcomes, predictable transactions and make those things as efficient as possible. We then redeploy our resources into the patient communication envi-

ronment. That's what has to be done. We've gotten so good at certain things. We need to continue to find ways to reallocate resources to help patients through the billing process, among other things. So that's my advice. Try to get those things you can down to the simplest, most repeatable level, but then redeploy those resources in the areas that are untouched.

GLASER: Twenty-five years ago, I was a new chief information officer at the Brigham and Women's Hospital. And the CEO at the time always advised me to do what's best for the patient. He was absolutely right. We need to have that foremost in our minds. As we go through all kinds of complicated decisions, technical and otherwise, there won't always be an easy answer. But if we do what's right for the patient, we're on the right path.

GAFFNEY: Every decision that we make has to be about the patient. And part of my responsibility at Winthrop is the patient experience program. The program is built on the tenet that every single thing we do has to be about the patient. To get there, we also had to make sure that our staff are happy and able to provide the care that they want to provide. We focus on mutual respect in the workplace, as well as creating a healing environment. We feel that without those two pieces within our organization, we will not be able to truly influence change across some of the more complex environments, such as workflows, process and clinical excellence. We're going to build a better patient experience, in part, by identifying the barriers that clinicians experience in their work.

MISTRETTA: Every meeting that we have basically starts with: What's in this for the patient? That's what it's about. That wasn't necessarily true five years ago.

DAHL: Banner's mission is: We make a difference in peoples' lives through excellent patient care. It's not unlike what the rest of you have said. I would add that leadership from the board and the CEO is crucial. And that means, among other things, holding people accountable for their work. If a physician or employee is disruptive, that's not acceptable. If they don't change their behavior, they are not the right fit for the organization. That's just one way that we keep the focus on clinical quality. I appreciate Banner's focus on the leadership aspect to make that patient care happen.

YATES: In a complex environment, it's important to use simple rules. Putting the patient at the center of care is an excellent rule as we go forward. That means trying to understand where they're coming from and anticipating their wants and needs. To be successful, we need to build a culture of patient-centeredness. My advice to others: Don't be afraid to embrace some of the promising new models that are coming along and to think across silos. ✱

Thanks

Health Forum would like to thank the panelists for taking part in "Accelerating Patient-Centered Care," with special thanks to our sponsor:

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