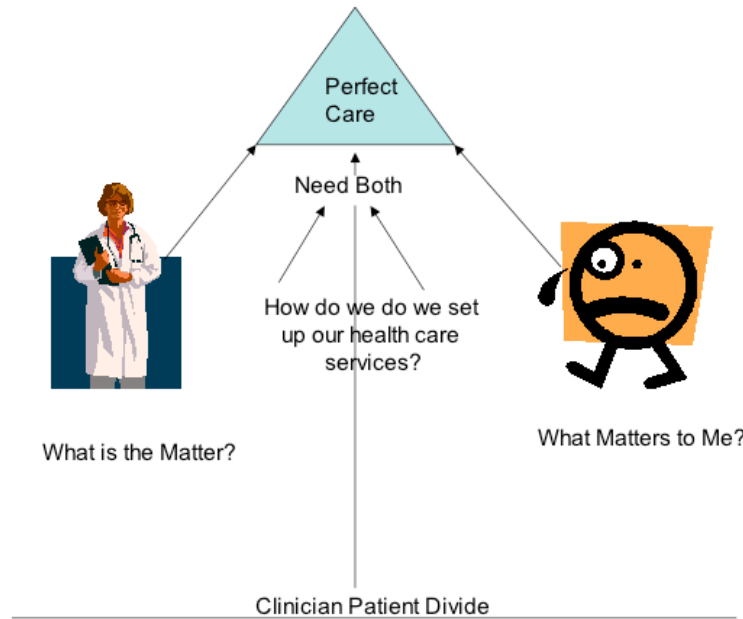
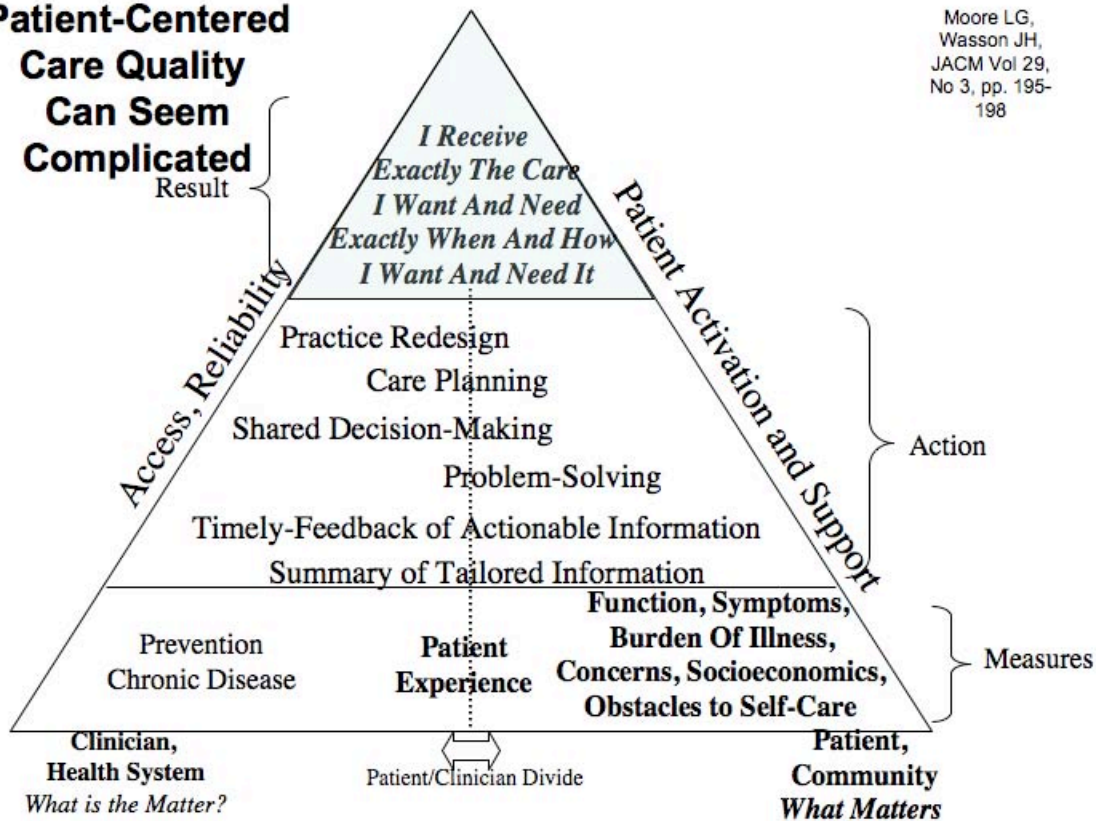


Patient-Centered Care in Practice



Patient-Centered Care Quality Can Seem Complicated
Result

Moore LG,
Wasson JH,
JACM Vol 29,
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Patient-Centered Care Quality Can Seem Complicated

"I Receive Exactly the Health Care
I Want and Need Exactly When and How
I Want and Need It"

	If Strongly Agree	If Disagree
Do you have:		
Continuity	95%	60%
Access	85%	10%
Efficiency	80%	20%
Information Quality	80%	20%
Confidence	75%	15%

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Access and Efficiency Overhead



Getting Focus Catching Your Breath

- Baseline Surveys
- ListServe
- Time Management

- Baseline Surveys
- Listserve
- Time Management
- Practice Flow



Collaborative Care Coaching

- Vital Signs
- Electronics
- Patient Segmentation
- Self-Management Confidence
- Problem-Solving
- Phone Coaching
- Refinements of Previous Techniques
- Referrals/Handoffs

**But the
Ideal Medical Practice
Method
Seems
Simple**



Confidence Working with Others

An Introduction to Technology for Patient-centered, Collaborative Care

L. Gordon Moore, MD; John H. Wasson, MD

Abstract: “Patient-centered, collaborative care” is healthcare jargon. But underlying the jargon is the principle that a patient who receives such care strongly agrees that “I receive exactly the healthcare I want and need exactly when and how I want and need it.” Currently only about 1 in 4 Americans who have adequate financial resources can make this claim. Think of a pyramid. At the apex is the highest level of “patient-centered, collaborative care.” At the base are measures about “what’s the matter” (from the clinical perspective) and “what matters” (from the patient perspective). As patients and clinicians act collaboratively on these measures, they climb closer to the apex of the pyramid. Given the realities of healthcare in the United States, should busy professionals take time to think about ways to climb pyramids? In this “Introduction” we describe why the answer to this rhetorical question ought to be “yes.” In the articles that comprise this issue, readers will learn how technology that supports patient-centered, collaborative care can help bridge the gap between desirable goals and limited time. All the authors understand technology (such as hardware and software), and the way humans use the technology (called *techne*) will not overcome the many obstacles to the attainment of patient-centered, collaborative care. Nevertheless, we are hopeful that the examples described in these articles suggest ways that significant progress toward patient-centered, collaborative care can be made. The articles are practical. The results are persuasive. It is worth the climb! **Key words:** *collaborative care, disease management, patient-centered care, practice improvement*

WHAT IS PATIENT-CENTERED, COLLABORATIVE CARE?

Healthcare produces jargon. The term *patient-centered* care seems to have its origins as a reaction to paternalistic “doctor-centered” health services (Davis et al., 2005; Wagner et al., 2005). “Collaborative care” results when doctors and members of the “healthcare team” actively engage patients in “evidence-based” decision making and management based on what matters to the

patients. Patients should become better “self-care managers” as a result of collaborative care. Collaborative care—almost synonymous with a “productive interaction”—is associated with improved patient outcomes (Bodenheimer et al., 2002; Renders et al., 2001; VonKorff et al., 1997; Wagner et al., 1996a, 1996b).

Regardless of jargon, patients who experience the best healthcare possible—the best “patient-centered, collaborative care” possible—should strongly agree that they are receiving “exactly the care they want and need exactly when and how they want and need it.” Only about 25% of adult Americans (and only 12% of low-income Americans) strongly agree that they have received “patient-centered, collaborative care” defined in this way.

What is it that differentiates those who strongly agree from those who disagree that their care is exactly what they want and need exactly when and how they want and need it?

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Table 1. "I receive exactly the care I want and need exactly when and how I want and need it"[™]

	25% of adult Americans who strongly agree, %	25% of adult Americans who disagree, %
I have one person I think of as my personal doctor or nurse	95	60
It is very easy for me to get medical care when I need it	85	10
Most of the time, when I visit my doctor's office, it is well organized, efficient, and does not waste my time	80	20
The information given to me about health problems is very good	80	25
I am confident that I can manage and control most of my health problems	75	15

*Respondents are aged 19-69 years, September 2005-April 2006. From HowsYourHealth.org.

Table 1 shows that no single attribute of care is uniquely associated with "patient-centered, collaborative care." There is no single thing a doctor, an office practice, or a healthcare system can do to guarantee patient-centered, collaborative care. Many things must be done well.

HOW IS PATIENT-CENTERED, COLLABORATIVE CARE ATTAINED?

This issue of the *Journal of Ambulatory Care Management* assumes that practice redesign is necessary for the attainment of patient-centered, collaborative care. But this is not the focus of the articles. Rather, the articles emphasize how emerging technologies and approaches based on technologies make patient-centered, collaborative care more easily attainable.

Figure 1 is a useful way to think about how an outstanding office practice might get to the top of the pyramid. . . that is how a practice can attain patient-centered, collaborative care.

To improve an office practice, it has to know how it is performing. Performance measures should include the "usual suspects" on which all clinician focus such as a blood glucose level in a diabetic or the third next avail-

able appointment. These measures of "what is the matter?" are located in the lower left-hand half (or the clinical side) of the pyramid.

But the practice should also know "what matters" to patients. For example, the utility of information they receive, their experiences with access to care, and their confidence to manage and control health problems? These measures are located in the lower right hand (the patient side) of the pyramid.

To attain the desired result of patient-centered, collaborative care, the patients and healthcare professionals need to take action. On the practice side of the pyramid, the final common pathway of all measurement should lead to practice redesign on the basis of a comprehensive model of care: 2 widely disseminated models are the "Chronic Care" and the "Idealized Design of Clinical Office Practice" models. The former is based on an analysis of evidence, the latter on an empiric distillation of experience in redesigning office practice.

But practices that emphasize a redesign that mechanistically delivers care independent of what matters to patients will never attain a high-level excellence. For example, easy access to services not focused on what matters to patients is neither patient-centered nor collaborative. It is access to what healthcare professionals want to deliver.

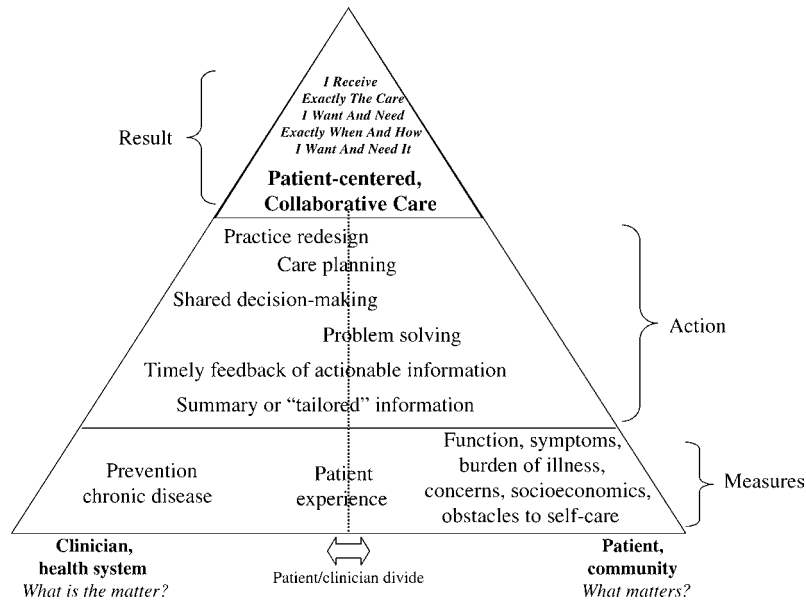


Figure 1. Schematic of measures and actions associated with patient-centered, collaborative care.

Examples of actions that ultimately embed what matters to patients into practice redesign are included in the figure. Many of the actions are greatly facilitated by technologies such as automated registries and patient portals. When clinicians take seriously what matters to patients and the patients receive information tailored to their needs, there is some improvement in care. The patients and clinicians are “on the same page.” When the patients are helped to use the information to better solve the problems that matter to them, their outcomes are improved. Together with the clinician, these “activated” patients are better able to engage in “shared decision making” and plan care. They are nearing the top of the pyramid.

THE ARTICLES IN THIS ISSUE

Patient-centered healthcare is a good thing. Collaborative healthcare is a good thing. Preventive, chronic, and acute healthcare services are all good things. Yet, estimates of the time a clinical practice might have to spend to deliver all these “good things” can easily consume most available hours of a 24-hour

day (Ostbye et al., 2005; Stange et al., 1998; Yarnall et al., 2003).

Something has to give. Unfortunately, the results of national polls in 2005 tell us what gives; for the first time in the history of such polls, more Americans felt negatively about healthcare than those who felt positively. And many clinicians do not seem to enjoy the work very much either (Sox, 2003).

This issue of the *Journal of Ambulatory Care Management* examines one partial solution to the dilemma of “so much good to do and so little time to do it.” In this issue, the authors describe how technology that supports patient-centered, collaborative care can help bridge the gap between desirable goals and limited time.

In the first article, the authors use a large national data set in which Americans report their needs and the services they have received. Using the same data source, the second article examines how a planned, step-care management approach for persons with chronic diseases is likely to be much more time-efficient and cost-efficient than current care.

The challenge for a clinical practice is to garner the insights from the first 2 articles and

make them operational in the day-to-day work. The third article in the series describes how a very low overhead, high technology practice seems to be attaining very high levels of patient-centered, collaborative care. A fourth article examines how patients and their doctors use technology to enhance communication, minimize waste, and even avoid some office visits.

Just as technology expands the opportunities for clinical practice, technology can also expand the boundary of clinical practice from the office or hospital to the community. In the final articles of this series, the authors describe how they are using assorted technologies for their employees (Engaging

Quad Graphics Employees in Improving Their Health and Healthcare) and the community (Employer-led Business Coalition Vision for Action).

All the authors understand all too well that technology (such as hardware and software) and the way humans use the technology (called *techne*) will not overcome the many obstacles to the attainment of patient-centered, collaborative care. The "Post Script" on health disparities emphasizes this point (Health Disparity and Collaborative Care). Nevertheless, we are hopeful that the examples described in these articles suggest ways that significant progress toward patient-centered, collaborative care can be made.

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