

Making Patient-Centered Care Real: The Road to Implementation

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What does it take to make patient-centered care (PCC) real? Because PCC is a cultural change, it takes more than aspiration. The envisioned change affects the entire system, but most profoundly, the relationship between providers and patients. Changing provider culture is a huge and complex enterprise, involving how they are chosen, educated, socialized, evaluated, and rewarded. The subject of this paper is patients, which here means the public (since we are all prospective patients). How do we begin to equip patients with the knowledge, authority, and tools to do their part in achieving the desired change?

The Challenge

The way patients and providers (and the system as a whole) interact is a product of history, circumstance, psychology, social norms, identities, and other factors that together define the nature of the relationship. All patients are different and there are varying capacities to participate in and influence the care process. The theory of patient-centered care is straightforward; implementation is not. The specific challenges are:

1. On many levels the nature of the relationships is inherently unequal. Patients are by definition dependent on their providers for help (otherwise they wouldn't need to see them). Providers have more knowledge (most of the time).
2. Much of the time, patients are in some degree of pain, discomfort, or anxiety. They are not at their peak; they are vulnerable. In such circumstances they often have reduced capacity to assert themselves and take control of their care.
3. Status and other hierarchies come into play. Often providers are more highly educated than patients, particularly older generations. There is a tendency to defer to credentials and the other attributes of status that accrue to providers, notably but not exclusively doctors.
4. Providers – again, physicians in particular – are not inculcated with a culture of service. They see patients as fundamentally different from customers. They view their own time as a precious commodity (which it is) and organize their practices around its most efficient deployment. Their basic question is not, “what does the patient need to have a good experience,” but rather “what do I need to do to cope with demands.”
5. It is difficult to imagine a system fundamentally different from the one we know. Our behavior is conditioned by our expectations, which are conditioned by how things are and have been. It is even more difficult to change when one does not know what is possible.

6. There are risks (real or perceived) inherent in trying to change power relationships and modes of communication and behavior. Alienating a provider on whom one depends is obviously problematic. Where the relationship is intermittent, it may not be worth risking even if there is some dissatisfaction with what one has.
7. Providers can signal that any change in the relationship is unacceptable and even offensive.

Empowering Patients: More Than A Toolkit

Patient-centered care is major behaviour change, and major behaviour change requires a great deal more than exhortation and education. By and large, we have anchored our theory of change in health care around these concepts:

1. The linear education model: make good information available to people and they will make informed, “rational” decisions, whether they are providers or users of care. The classic forms were clinical practice guidelines for practitioners, and public service announcements for consumers. Both assume an independent and widespread demand for high-quality information and the capacity to use it. This approach is a proven failure.
2. The intermittent, targeted marketing model: this is a more engaged “push” strategy, with some engagement of the target audiences and a more active dissemination strategy. It could involve meetings, joint planning, etc. for providers, and public service announcements and partnerships with educators for consumers. Its impact is limited.
3. The incentive model: current forms include pay for performance for practitioners, and taxation policies that privilege certain activities for consumers. The assumption is that financial reward will change behaviour. While the basic idea seems unassailable, the problem is in execution. It is difficult to design a system aligned with the complexities of care, immune to gaming, and compatible with accurate measurement of performance. As an example, English GPs get almost all of the bonus money available for what should be considered ordinary (rather than remarkable) performance.
4. The QI model: adopt quality and efficiency processes from other industries, create opportunities for sustained engagement, measure and feed back results, and over time culture will change. This has proven successful at sub-system levels, but not system-wide. And it is not clear whether the main influence on change is the QI apparatus itself, or the development of a

shared insight that the status quo is unacceptable and it is essential to change (plus the leadership to bring it about).

These approaches (which are oversimplified) constitute an evolutionary path. It is now recognized that behaviour change is complex, and that “rationality” is layered and nuanced. What appears to make no sense from the broad perspective of a system may have its own internal logic at the organizational or individual level. Even where people recognize that the status quo is deficient, the combination of their context and their personal history and attributes may be formidable barriers to change. Major system change is inevitably multi-level, and inattention to important dimensions may torpedo the entire change agenda.

People change because they perceive – explicitly or implicitly – that doing so is preferable to the status quo. Social marketing experts have observed that the most effective campaigns persuade people that the desired behaviour change creates benefits that outweigh the costs.

This reality affects both patients and providers (and for that matter, managers and policy-makers). Hence it is important to understand the cost-benefit structure that underlies both current realities and anticipated future states. In each case there are assets and liabilities. For instance, patients may highly value the familiarity with how the system works and their relationship with their providers as an asset, and count poor communication and inconvenience as offsetting liabilities. They may also consider a different, patient-centered alternative vision to be a valuable asset, but with concerns about the price of acquiring it (in terms of discomfort, anxiety, disruption, fear of failure, uncertainty, etc.). In short, their propensity to change their expectations and behaviour ultimately depends on their overall satisfaction with what exists (i.e., what’s good about it minus what’s bad about it), and their perception of the vision for and likelihood of achieving a better state. For providers, the basic calculus is the same: what do I get (and what do I not get) from the status quo, and how will a different approach meet my needs.

How does this work in practice? Consider the example of a program to persuade young adults in Wisconsin not to drink and drive. A purely negative campaign – “drinking and driving kills” – had very modest effects. So the state, in conjunction with social marketing experts and a first-class ad agency, pursued a different approach. They asked young people what they would be willing to pay for an alternative ride program that would either take them home, or take them from bar to bar. The responses: \$5 for a ride home, \$10 for an evening pass, with no more than 5 to 10 minute waits. The state designed the program accordingly, and promoted the service with ads with two messages: not

having to drive is liberating, and the party keeps going in the car. It worked – after one year alcohol-related traffic injuries were down 17%.

Clearly, psychology, social norms, and price considerations¹ come into play in effecting behaviour change. There is a difference between a beer campaign and a public health campaign, and a purely commercial marketing mentality does not really care whether the message is “true”. The point is not to treat patient-centered care like Pepsi; it is to recognize that education by itself is insufficient, and the techniques of social marketing are essential to success. Handing out pocket cards describing patient-centered care or a list of core questions patients should ask is unlikely to achieve much on its own.

A further lesson is that the developmental strategy must be participatory and ongoing, with the central parties to health care transactions – patients and providers – as co-producers. There will have to be market segmentation: different groups of patients will have different needs, expectations, and capacities, as will providers. The first step is to understand fully what moves various groups to change; the second is to provide the tools and supports for action.

The other main dimension is incentives. Once the elements of patient-centered care have been defined and adopted, it should be possible to develop an indicator set that measures performance. This in turn should create possibilities for incentive systems that reward patient-centered care and build momentum for its widespread adoption.

Beginning the Change Process

Given these challenges, it requires a strategy to succeed, and it will be a long haul. How the strategy is developed is at least as important as the content. Core elements to consider might include:

1. The strategy should be collaborative, with providers central to (but not dominant in) its development. They have to own the goals and the means of achieving them. They have to signal to their patients that it is not only permissible, but desirable to turn the system upside down (or inside out). The provider-patient dyad is, in most cases, unequal. It is unrealistic to expect most patients to demand patient-centered care if providers signal their discomfort or disapproval. Success will depend, among other things, on:
 - a. Ownership of the concept by professional associations, individually and in concert;

¹ Price can be monetary, or another perceived cost, such as risk, anxiety, discomfort, inconvenience, etc.

- b. Support for exposing practitioners to PCC concepts and experiences, analogous to the efforts to support QI in the province;
 - c. The creation of on-the-ground opportunities for the public/patients and providers to interact, share perspectives, and where necessary debate directions from a position of equality, in a safe and open environment;
 - d. Introducing techniques such as simulation as a vehicle for reshaping the culture.
2. It must be coordinated. Government, providers, educators, health care organizations, and the public and patients have to share goals and their actions have to be mutually reinforcing.
 3. It must be supported by intelligence, i.e., good indicators, appropriately and frequently measured and transparently reported; the sound application of behaviour change methods.
 4. It must be sustained – cultural change requires repeated, consistent messaging and a supportive environment.
 5. It must be incubated – there must be innovation centres and experimental sites.
 6. It must be rewarded by incentive systems.
 7. It must have a highly visible focal point to signal that it is an important priority.

This suggests a series of steps that will both clarify what PCC means, and increase the prospects for its achievement. Among steps to consider:

1. Develop a patients' charter of rights and expectations that define core elements of PCC, e.g.:
 - a. Timeliness of care
 - b. Convenience of care
 - c. The right to be heard and listened to
 - d. Courtesy and respect throughout the process
 - e. An efficient care process that minimizes disruption
 - f. Outstanding communication with patients and among providers
 - g. The ability to play a central role throughout the care process
 - h. The right to designate family members and others as advocates and partners.
2. Mandate a review of the educational measures needed to support PCC, including:
 - a. A review of all health science education program curricula
 - b. Continuing education opportunities for providers
 - c. The characteristics of PCC-friendly sites in which to apprentice.

3. Encourage regulatory bodies, accreditation agencies, and professional associations to incorporate PCC into their core expectations, codes of ethics, etc. Ideas to consider might include:
 - a. Require primary care practices to “read patients their Miranda rights” as part of their initial communications processes, indicating what PCC means and what patients have a right to expect
 - b. Require health care organizations to develop and pursue multi-dimensional PCC implementation plans, including measurement of and public reporting on performance
 - c. Have patients and providers sign “contracts” (not legal documents but hard copy symbols of commitment) that outline PCC principles and processes
 - d. Require periodic patient surveys to track PCC performance on various dimensions
 - e. Include PCC knowledge and observation in licensure exams.
4. Develop PCC continuing education programs for managers, practitioners, case coordinators, volunteers, and the public, using multi-faceted techniques such as simulation, to expand capacity and spread the concept.
5. Develop organization and practice-specific PCC indicators and certification programs that would be important and visible signs of commitment to the concept and create healthy competition. Imagine a prominent “this is a patient-centered care organization” sign at the entrance to a doctors’ office or hospital.
6. Develop a sustained communications strategy for promoting PCC, with elements such as:
 - a. Videos and films that show what it is and how it differs from what now exists
 - b. Public media campaigns (radio, TV, newspapers)
 - c. Presentations and workshops at professional meetings, conferences, newsletters
 - d. Patient-friendly materials widely available in health care facilities
7. Create a network of paid and volunteer patient navigators trained in patient-centered care concepts and empowered to advocate, educate, and coordinate.
8. Set up a multi-stakeholder PCC Commission, led by and with majority public representation. PCC is an important but elusive concept. It is less tangible than wait times or technical excellence, even if it is more fundamental. It needs a profile and a highly public voice. A Commission signals that PCC is important both as an aspiration and as an accountability mechanism. It would be a sustained centre of advocacy for culture change, supported by

sufficient resources to engage the public and media, and change what we mean by performance. Its mandate might include:

- a. Develop and refine PCC concepts and models on a continuous basis
- b. Promote PCC to the public, patients, providers, managers, and policy-makers
- c. Partner with other organizations to inculcate PCC into mission statements, mandates, principles, contracts, standards, certification, etc.
- d. Evaluate and report on PCC performance and issues at multiple levels (patient, organizational, policy)
- e. Develop a comprehensive social marketing strategy to advance PCC uptake and performance
- f. Hold high-profile PCC events;
- g. Develop and implement PCC certification programs for individuals and organizations, along the IHI and other models;
- h. Partner with other organizations (HQC, regulatory bodies, health regions) to incorporate PCC into broader system goals and performance measures (e.g., quality improvement).

Learn by Doing

Above all, the province must be open to supporting both providers and patients interested in embracing PCC and doing things differently. Be willing to:

1. Send motivated clinicians to PCC environments where they can see it in action and acquire new ways of doing things.
 2. Design a PCC collaborative that includes patients.
 3. Conduct focus groups, make videos, hold webcasts where people can discuss PCC and learn to listen to their customers.
 4. Create checklists and reminders for both providers and patients.
 5. Bring home care and long term residential care into the centre of the conversation – these are areas with unsung PCC achievements.
 6. Create awards for achievements in PCC based on empirical evidence.
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