

The Emerging Quality Imperative – Patient-Centered Care

Introduction

A systematic shift is underway in healthcare, one that is directed at transforming the way patients and clinicians interact and share accountabilities. Traditionally, medicine has been organized around the clinician and disease, with a primarily episodic and reactive pattern of treatments. Recently, however, professional, policy, and healthcare market leaders have begun advocating for a move toward “patient-centered care”—a model that elevates the patient’s involvement, preferences, and needs, and reorients the system around the patient.

The call for patient-centeredness has emerged from a nexus of healthcare trends. Patients and their families are more motivated than ever to become active partners in their care and take part in the decision-making process. In addition, the growing trend of pay for performance is leading physician practices to focus on the need for improved quality of care in order to compete in an increasingly transparent marketplace. And the reimbursement systems currently utilized by Medicare and other payers are in grave need of revision to better reflect ongoing changes in healthcare delivery.

At the same time, more patients are being diagnosed with chronic conditions, treatment alternatives are multiplying, clinical decisions are becoming more

complex, and relevant evidence is less available. Patients are likely to be seen by multiple clinicians and take multiple medications, leading to an increasingly fragmented web of providers and treatments, rather than a centralized hub. Clearly, quality improvement requires a new delivery system model, according to many industry and policy leaders.

Reports by a growing number of healthcare leaders confirm that patient-centered practice delivers differentially effective care. As early as 2001, the Institute of Medicine (IOM) identified patient-centered care as one of its six aims for clinical quality improvement. More recently, the American College of Physicians’ 2007 annual report on *The State of the Nation’s Health Care* proposed a patient-centered model as the solution to the looming healthcare crisis, stating, “The personal physician practicing under this model is the patient’s ally in facilitating treatment that is patient-centered, coordinated, and of high quality, and in navigating our complex system of care” (Kirshner). Likewise, the National Committee for Quality Assurance’s (NCQA) 2007 Back Pain Recognition Program advocates that clinicians receive recognition based on their demonstrated ability to provide high-value, patient-centered care, a model that the NCQA says “represents the future of the healthcare quality movement” (Stanton). Such statements

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Why Patient-Centeredness Matters

It has been suggested that patient-centeredness can be defined by what it is not: technology-centered, doctor-centered, hospital-centered, and disease-centered care (Irwin). The IOM defines patient-centered care as “healthcare 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.” It asserts

that effective care of the chronically ill involves:

- The definition of clinical problems in terms that both patients and providers understand;
- Joint development of a care plan with goals, targets, and implementation strategies;
- Provision of self-management training and support services; and
- Active, sustained follow-up visits, telephone calls, email, and web-based monitoring and decision support programs (IOM).

These attributes coincide with additional facets of quality patient care, including shared decision making, patient engagement, patient experience and

NCQA Back Pain Recognition Program Criteria

Structural Standards	Criteria	Points
1. Patient Education	<i>Structural standard</i>	6.5
2. Post-Surgical Outcomes** MUST PASS	<i>Structural standard</i>	8.5
3. Evaluation of Patient Experience	<i>Structural standard</i>	3.5
Clinical Measures	Criteria	Points
1. Initial Visit	50% of patients in sample	8.0
2. Physical Exam MUST PASS	50% of patients in sample	9.5
3. Mental Health Assessment	72% of patients in sample	5.0
4. Appropriate Imaging for Acute Back Pain*	50% of patients in sample	7.5
5. Repeat Imaging Studies*	<i>Data collection only - Will not be scored</i>	<i>No Score</i>
6. Medical Assessment with Smoking Cessation	76% of patients in sample	3.5
7. Advice for Normal Activities	48% of patients in sample	8.5
8. Advice Against Bed Rest	48% of patients in sample	7.5
9. Recommendation for Exercise	71% of patients in sample	5.6
10. Appropriate Unit of Epidural Steroid Injections*	10% of patients in sample	6.5
11. Surgical Timing**	5% of patients in sample	8.5
12. Patient Reassessment	25% of patients in sample	5.0
13. Shared Decision Making**	50% of patients in sample	6.5

*Overuse: Lower is better
 **Surgeons only

Total points 100.0
Points needed for Recognition 40.0

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satisfaction, and continuity of care. Such concepts are increasingly being used as measures of high-value care on clinician “scorecards” and other rating systems and are crucial to differentiation and success as the healthcare market continues to become transparent.

Advocates of patient-centered care cite a substantial body of research supporting the ability of patient-centeredness to create impressive, measurable results for patients and practices alike. A recent editorial published in the *Journal of the American Medical Association* describes this evidence base as “robust and supported by clinical trials that have demonstrated the desired outcomes” (Bergeson). Multiple studies indicate that patient-centered care produces better clinical outcomes, greater patient and clinician satisfaction, reduced malpractice claims and greater patient loyalty to the clinician (Meryn, Roter, Lewin, Stewart). Other research demonstrates that patient-centered care can reduce the likelihood of unnecessary testing, increase patient compliance, and improve patients’ symptom burden (Knebel, JCAHO).

Also, research shows that patients are increasingly requesting a positive, patient-centered approach and are more satisfied when they receive it. One study reported that patients are particularly dissatisfied with the amount of medical information they are receiving from their physicians (Irwin). Higher patient satisfaction leads to benefits for clinicians: Results of patient-centered care in hospitals include improved public perception and increased market share — crucial advantages in an increasingly competitive healthcare marketplace (JCAHO).

Professional Autonomy through Shared Decision Making

Many clinicians decry the movement toward “cookbook medicine” that has occurred over the past 20 years. Critics of protocol-driven medicine argue that real-world complexities are not effectively captured by most clinical guidelines. However, in the absence of clinical evidence warranting the selection of a particular treatment approach that varies from guidelines or documentation of particular circumstances related to an individual pa-

Pulmonary Patients with Unmet Needs*

Percentage of Patients with Unmet Needs

Need Clusters/Items	Primary Practitioner (n=121)	Specialist (n=72)	Overall (n=193)
More Information			
About written information about asthma/COPD	50	57	52
About results from diagnostic tests	47	50	48
About causes	43	45	44
About prognosis	31	39	34
About long-term use of medication	25	41	31
Treatment	31	32	31
More patient participation in treatment decisions			
More frequent physical examination	30	28	29
Organization	44	42	43
More continuity of care provider			
Less waiting time	25	21	24

*Adapted from Koning et al.

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tient, providers are left with little recourse in supporting their choice of treatment.

Since the decline of managed care's pre-authorization gatekeepers, the vast majority of community-based clinical providers have not been assessed for their usage of particular medical or surgical services. This seems unlikely to continue, however, as purchasers intent on managing medical spending and improving value (including Medicare) are embarking on initiatives to measure and compensate based on quality and efficiency measures, including analyses of variations in care.

Wennberg and colleagues at Dartmouth Medical School's Center for the Evaluative Clinical Sciences have amassed and reported a multitude of studies and conclude that care intensity (essentially service utilization) is not correlated with the quality of outcomes and is, in fact, often inversely related to quality. The Center has raised broad market awareness regarding the U.S. healthcare system's ubiquitous problem of unwarranted variations in care, which Wennberg defines as "variation not explained by illness, patient preference, or the dictates of evidence-based medicine." Many health plans are now employing a variety of programs targeting control of unwarranted variations. For example, health plans are contracting with nurse coaches who contact patients to discuss treatment alternatives for so-called preference-sensitive care conditions (treatments involving significant quality-of-life trade-offs and clinical evidence that does not clearly favor one approach).

Given these developments, specialist clinicians may find that the best way to justify their usage patterns may rest in partnering and sharing decisions with patients, thereby demonstrating that treatment approaches are in their patients' best interests and that high quality, patient-centered care is being delivered. In this way, 21st century medicine's professional independence may be based in auto-

nous clinician-patient teams, versus the traditional self-governing, stand-alone clinician model.

IT Systems and Patient-Centered Care

Depending on their design, application, and implementation, clinical information technology (IT) systems can either be a requirement, a facilitator, or a hindrance to adopting patient-centered care. Weiner and Biondich argue that since information flow is central to the clinical encounter process, and because the way information is collected, shared, and analyzed impacts physician-patient relations, IT strategies will determine the extent of patient centeredness achieved. "Relationships and information are closely intertwined in healthcare," they write.

Types of IT systems that researchers have cited as promoters of patient-centered care include:

- Web applications that provide patient access to accurate, current, pertinent clinical information before and after office encounters. These promote patient engagement, the ability to dialogue with the clinician, and shared decision making;
- Electronic, asynchronous, secure communications between patient and clinician. Studies indicate that these channels can enhance the physician-patient relationship by increasing dialogue frequency and encouraging communications regarding sensitive issues;
- Physician practice web portals that enable electronic collection of the patient's medical information outside of the clinical encounter. This provides efficiencies that can improve the quality of the encounter, since precious face-to-face encounter time is not spent documenting background and historical information. Research-

Web Portal Applications for Patient-Centered Care

		Facilitation of Patient-Centered Care Approach	Other Provider Benefits
Portal Applications	General health, patient preference questionnaires	Patient issues incorporated into care decisions	Documentation for treatment decisions
	Previsit medical history, medications	Documenting before encounter means more high quality face-to-face time	Process and administrative efficiencies, fewer data errors
	Conditions, tests and treatment specific information	Informed patient can better participate	Improved patient experiences, potential liability risk reduction
	Patient decision aids	Enables shared decision making	Stronger informed consent, patient loyalty
	Treatment plan instructions and report	Better engagement, adherence to plan, outcomes	Pay for performance benefits
	Guidance on relevant behavior change	Supports better quality outcomes	Pay for performance benefits
	Follow-up monitoring	Better patient engagement and accountability	Patient retention, additional revenues
	Patient reported outcomes	Informs provider's knowledge regarding intervention	Develop practice-generated evidence base/specific clinical expertise

ers have also found that this improves data integrity; and

- Physician web portals that also can be used to deliver patient questionnaires regarding patient preferences, concerns, and questions in a manner that efficiently promotes shared decision making.

Other clinical IT systems have been reported to be problematic for patient-centered care and detrimental to physician-patient relationships. For example, many electronic medical record systems (EMRs) require the clinician to perform extensive data entry during the encounter, which can be distracting and interfere with communications. One study found that physicians using computers in exam

rooms were less likely to make eye contact with patients (Coiera). Weiner and Biondich assert that “electronic medical records have been established that seem to serve everyone except the patient and physician, as physicians are required to spend more time entering data manually but have few tools for automating manipulation or interpretation of the same data.”

Patient-centered IT applications, on the other hand, have the potential to help defray practice financial IT costs through monthly service fees paid by patients. A number of market research reports have indicated that a substantial share of patients are willing to pay their providers for electronic services such as email communication and reminders, access to personal health records, and access to other Internet-based patient engagement tools. These payments could help offset the additional personnel, physician time, information technology, and office system costs that would be required to deliver patient-centered services (Davis).

Conclusion

Market forces are driving patients to become more financially responsible, engaged participants in their healthcare. Moreover, patient-centeredness — care that addresses the patient’s needs and desires — is a key aspect of the industry trend toward clinical quality improvement. Given these dynamics, patient-centered care is emerging as a critical provider strategy in responding to purchasers’ concerns regarding quality and value, and their calls for transparency of provider performance.

Practice web portals that engage patients in treatment decisions may be the most viable way for specialists to efficiently employ a patient-centered care model. “High performance in patient-centered care seems to be an achievable goal,” writes Audet. “With the right knowledge, tools, and practice environment, and in partnership with their patients, physicians should

be well positioned to provide the services and care that their patients want and have the right to expect.”

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