EDUCATORS FOR EXCELLENCE . UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

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"Patient Centered Care: How do we teach it? How do we practice it?"

Dr. Shorey's Key Questions and Reflections:

- ***What is the source of deep commitment to "patient centered care"*** at our academic medical centers and health professions colleges?
- ***How is the patient woven into the fabric of team based care***? Are they at the center of the team? Tangential to it? Missing entirely?
- How steep is the hierarchy of the team in team-based care? Is it so steep that there is no true "team work" or ***is the hierarchy flat enough that it enables and facilitates true engagement*** and participation?

Dr. Shorey commented. In my fellowship, "we wouldn't think of missing team meetings because they were so much fun…we took care of each other; we took care of the patients. The team was diverse. ***This team was the cradle for learning patient centered care and the nuances of care that mattered.***"

Now once again, perhaps forces are beginning to align so that we can reinvigorate our thinking and practice of patient centered care.

It feels like the right time and the right thing to do, but the question remains, "how do we get there from where we are today?" We use HCAPS scores and other benchmarks for patient satisfaction and quality of care. We think about the big three issues:

1) improving the individual patient experience,
2) improving population health, and
3) bending the cost curve.

But, most of those are ***trailing indicators.*** *What can we use and what should we be using as our* ***leading indicators*** of patient centered care and patient centered teaching?

Roundtable discussion questions:

1. Do you buy-in? Is having a patient and family centered focus the right thing to do in our academic health centers?
2. How would you advise us re: building a sense of urgency? What is the "burning platform" that will facilitate us as faculty to adopt a patient-centered clinical care approach?

Round robin summary notes re: Buy-in & Sense of Urgency:

- Yes, we buy in. And the work has to start with the teachers' time (take it! {will pay it back}) – model what you think is right
- Complex systems in which we practice must have buy in from top admin – what is supported (4), do things like "the computer" really support PFCC
- Mirrors learner – centered education and works best with learners who are ready to set their goals. Some patients will be more ready to engage and set goals for engagement as part of the patient centered team than others. How do we discern? How do we initiate that conversation and follow-through appropriately?
- Question of readiness on part of patient and family. Patients with complex, or lifelong conditions such as having a child or family member with a disability, may be more prepared to engage because they are the hub for all the information, treatment, advice from every health professional encounter. They are probably surprised that we are fragmented and not coordinating an integrated care encounter. Some patients want the physician to lead and you hear, "just tell me what to do doc!" these patients may not be ready or may need a different kind of preparation to engage as part of the team.
- "Consumer convert" can we integrate high tech + high touch? Paradigm shift needed: Technology must actually help (e.g., not demand more provider time – rather less) to allow provider patient time (the high touch part). As a generation of providers we may not yet see technology as helpful. And it is clear that some of the ways in which technology has been implemented in health care, the "computer" can become the divider between the patient and the physician/practitioner. We need to use technology to enhance our being side-by-side with the patient—not my back is to you because I must type this note while you're speaking. In the absence of that opportunity for eye-contact and

connection, the physician may not be able to read the nuances of a patient having difficulty bringing a problem or concern forward. Technology must enhance our capacity to engage the patient, not diminish it.

- EMR must truly contain the "long" story patient medical history (pmh)/med list/ problem list/lab hx organized so provider can find the needed info fast

- "Frontline" consultation with all staff & patients (e.g. multiple stacks of same forms) about the key needs in order to truly practice PFCC. We waste a lot of time and energy, and create frustrations for practitioner, patient and patient family by redundancies that make no sense to anyone in the encounter.

- Granular – shape space: attend to the layout of furniture and equipment in exam rooms and consultation rooms. Do that facilitate good engagement between the physician and the patient, or do they present uncomfortable barriers?

- 30 thousand foot view of Pts: Practice has changed - Sr. Faculty are old! Back-log of modeling. We need to adopt new techniques for modeling/teaching the patient encounter in this contemporary setting

- Dental School built "case for change":
    - Small group studied and crafted "the case"
    - Distributed to all faculty
    - Discussed in small groups at faculty retreat
    - Shifted attitudes
    - Started with general " willingness to change survey"
    - 80% of faculty were resistant to the change

- Use technology to inform patient & family of when to expect M.D. will "round"/ appointment timeliness so family members will know when to assure they are at the patient's bedside. Respectful not to keep the family waiting "all day" without a clue as to when the doctor and/or team may appear.

Summary

If academic medical centers are going to survive, they need to provide clinical care that patients will seek and value. Today's discussions affirmed the rightness and importance of teaching both our students and our faculty how to practice in ways that respect the core values of patient and family centered care. Successful adoption of patient and family centered care by a health care system requires absolute commitment from the top administrative leaders because our systems of operation must change to put the service of the patient and family as the top priority, rather than the convenience of healthcare providers. Additionally the physical structure of spaces wherein care is delivered and technology infrastructure (especially the Electronic Health Record) must support providers and patients to maximize high-quality time for patient-provider interactions. Today's discussions confirmed that all providers must be brought into active participation within a health system's adoption of the practices of patient and family centered care. Many approaches are likely necessary to accomplish the challenge.

Recommended Follow-up Reading

Institute of Patient and Family Centered Care

- ❑ IPFCC Core concepts (PDF)
- ❑ IPFCC Frequently Asked Questions (web)
- ❑ IPFCC Bibliographies and Supporting Evidence (web)