Whole Person Orientation in Primary Care: Understanding Priorities and Assessing Performance

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Whole Person Orientation in Primary Care

Understanding Priorities and Assessing Performance
Aims

Use a participatory method to develop a framework for understanding the concept of whole-person orientation in primary care.

Use that framework to develop pilot items for a primary care practice self-assessment tool.
Evaluations of the PCMH Model

+ · Improvements in appropriate utilization of services
  · Increases in patient satisfaction
  · Increases in use of preventive services
  · Less provider burnout

− · No significant changes in clinical outcomes
  · No significant changes in cost
  · Decreases in patient satisfaction
  · More provider turnover
Implementation of PCMH Model

Joint Principles of the Patient Centered Medical Home

NCQA Patient Centered Medical Home Recognition Standards

Outcomes
Joint Principles

• Personal physician
• Physician directed medical practice
• Whole person orientation
• Care coordination
• Quality & Safety
• Enhanced access
• Payment

NCQA Standards

• Access & Continuity
• Identify and manage patient populations
• Plan and Manage Care
• Provide Self-Care Support
• Track and Coordinate Care
• Measure and Improve Performance
## Existing Recommendations

| Stange et al. | “Measure the changes in practice operations and the co-evolving healthcare and payment systems that are hypothesized to provide added value to the PCMH” | “Measure quality and function of relationships with patients, and healthcare system and community partners” | “Avoid unintended negative consequences from emphasizing more easily measured instrumental aspects of the PCMH over the complexly interacting relationship aspects that are likely to provide much of its value” |

Existing Recommendations

Commonwealth Fund

| “Include qualitative and quantitative data that capture how and why implementation strategies change” | “Capture details concerning how different PCMH components interact with each other over time” | “Measure resources required for initiating and sustaining innovations” |

### Existing Recommendations

<table>
<thead>
<tr>
<th><strong>AHRQ</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Focus on quality, cost, and experience”</td>
</tr>
<tr>
<td>“Recognize that PCMH is a practice-level intervention”</td>
</tr>
<tr>
<td>“Be strategic in identifying right samples of patients”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Source</th>
<th>Domain Name</th>
<th>Domain Description</th>
<th># Items</th>
<th>Availability</th>
<th>Citation (Development/Validation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation Care Measure (CCM)</td>
<td>Patient/Consumer</td>
<td>Quality, Personal Physician, Patient Centeredness</td>
<td>It measures patients’ perceptions of patient-centered care during the last visit with a family physician. The instrument has 5 subscales: communication and partnership (11 items), personal relationship (3 items), health promotion (2 items), positive and clear approach to the problem (3 items), and interest in effect on life (2 items) and uses a 4-point Likert scale ranging from very strongly agree to neutral/disagree.</td>
<td>21</td>
<td></td>
<td>Little P, Everett H, Williamson I, et al. Observational study of effect of patient centeredness and positive approach on outcomes of general practice consultations. BMJ. 2001;323(7318):908–911.</td>
</tr>
</tbody>
</table>

Examined over 50 tools
<table>
<thead>
<tr>
<th></th>
<th>Peer reviewed Tools</th>
<th>Used in a peer-reviewed publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Medical Home-ness”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Physician</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>Physician-Directed Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole-Person Orientation</td>
<td></td>
<td></td>
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<tr>
<td>Care Coordination</td>
<td></td>
<td></td>
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<tr>
<td>Enhanced Access</td>
<td></td>
<td></td>
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<tr>
<td>Payment</td>
<td></td>
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</tbody>
</table>
New evaluation tool

- Developed before 2007
- No patient input
- No framework for concept
- Lack of relevant tools
- Opportunity to address SDH
Methods: Concept Mapping

- Preparation
- Idea Generation
- Utilize Maps
- Compute Maps
- Structure Ideas
Participatory

Provides clear guidance

Demonstrates relationships

Equal consideration
Preparation

Question Stem:

What does having whole person orientation in primary care mean?

- All settings, experiences
- Procedures, physical features, interactions with clinicians/staff
- New and existing ideas
Idea Generation: Brainstorming Sessions

66 statements

PFAC

DFCM

JFMA
Structure Ideas

• Sorting
• Rating
  – Feasibility Rating
  – Impact Rating
Compute Maps: Analysis
Point Map
Compute Maps: Analysis
Cluster Map

1. Personal Connections
2. Providers
3. Emotional Health
4. Whole Person Orientation
5. Clinic Flow
6. Community
7. Patient Education
8. Healthy Lifestyle
Compute Maps: Analysis
Cluster Rating Map - Feasibility

Cluster Legend
Layer  Value
1  3.63 to 3.75
2  3.75 to 3.86
3  3.86 to 3.98
4  3.98 to 4.10
5  4.10 to 4.22

1. Personal Connections
2. Providers
3. Emotional Health
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1 | 3.63 to 3.75
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Compute Maps: Analysis
Pattern Match

Feasibility

Impact

patient education
emotional health
Providers
Healthy Lifestyle
Clinic flow
Whole Person Orientation
Personal Connections
Community

r = 0.04
Utilize Maps

Personal Connections – 8 items

“Provide culturally competent care”

“Focusing on patient and not medical record during visit”

“Identify what patient and his or her family want to gain from the encounter”

“Involve family more often through encouragement and communication”
Utilize Maps

Providers- 8 items
Build healthcare teams that know each other and communicate well
Coordinate with specialists
Integrate mental and social services
Provide the right services, at the right time, at the right place
Increase 1:1 contact with patients
Utilize Maps

Emotional Health- 7 items
Focus on the connections among spirit, mind and body
Address stress in the patient’s environment
Ask patients about emotional health, including things that they might want to change
Ask patients about how their condition is affecting their life
Utilize Maps

Whole Person Orientation- 9 items
Address more than underlying disease
Address relationship health
Address financial stability
Identify individual motivating factors for each patient
Utilize Maps

Clinic Flow – 14 Items

• Have a staff member dedicated to managing referrals, providing education and advocating on behalf of patients
• Have one set of comprehensive medical records
• Provide quick responses to questions, inquiries, requests
• Send text message reminds about appointments
• Check in with patients regularly between appointments
• Help patients arrange transportation
Utilize Maps

Community- 10 items

• Help patients navigate insurance
• Offer more services at home
• Provide referrals to community or religious organizations
• Consider solutions that do not require insurance
• Provide nutrition services on site
Utilize Maps

Patient Education- 5 items

Educate patients about healthy eating
Provide parenting education
Help patients to understand health news, changing science
Utilize materials that are at the appropriate health literacy level
Utilize Maps

Healthy Lifestyle - 5 items
Offer alternative solutions to drug therapies, such as lifestyle changes
Suggest techniques for alleviating stress
Incentivize good lifestyle choices
Find and suggest more alternatives to standard therapies, like medication
## Item Development

### Level of Implementation Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>D</th>
<th>C</th>
<th>B</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternatives to drug therapies</td>
<td>Are not offered.</td>
<td>are offered, but on an ad hoc basis in response to specific requests.</td>
<td>are integrated into care protocols and reminders, but only for limited disease states.</td>
<td>are integrated into care protocols and reminders across a comprehensive set of diseases and risk states.</td>
</tr>
</tbody>
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