Person-Centered Care: a 21st century model for transforming lives, systems and the delivery of care

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Colleen Doak, PhD
Nicole Carkner, MBA
Cheryl True, MD
Goals for Today’s Session

- **Broaden and Deepen the Understanding and Practice of PCC** - Melissa
- How research and practice can support improved person centered training and outcomes - Colleen
- Understanding the important role and practice of cross-sector community collaboration - Nicole
- How person centered care is as important to physicians and providers as it is to patients - Cheryl
How two social workers were schooled in Person-Centered Care
Melissa Sharer and Julie Solomon, MBA, MSW

- Participatory Action
- Social Determinants of Health

When you know better you do better.
Maya Angelou
Frame of the Institute for Person-Centered Care

- Workforce Development-
  - "Known Known"
- Continuing Education-
  - "Known Unknown"
- Building the Evidence Base-
  - "Unknown Unknown"
Changing Trends in Health & Behavioral Health Care

- A fundamental shift in the way health services are:
  - Funded (Value Based)
  - Managed (with, not to) and
  - Delivered (technology, home, community)
- Quadruple AIM: Better Care, Better Health, Lower Cost, Better Job Satisfaction
- Upstream: Shift away from institutions/disease, toward people/health.
The known known: Multiple Definitions of Person-Centered Care

-Institute for Health-Care Improvement (IHI)
-National Academy of Medicine (NAM)
-The American Geriatric Society
-World Health Organization (WHO)
One “Known” Definition

-WHO (2016)
“integrated...putting the comprehensive needs of people and communities, not only the diseases, at the centre of health systems...empowering people to have an active role in their own health”
Essential “Known” Elements

- Dignity and Respect
- Information Sharing-Open Notes
- Participation-co-creation
- Collaboration-Interdisciplinary
- Performance measurement
- Continuous quality improvement
Planetree™ One “Known” Model

Planetree Model - Components of Care

- Human Interaction
- Family, Friends, & Social Support
- Architecture & Interior Design
- Spirituality
- Complementary Therapies
- Information & Education
- Nutritional & Nurturing Aspects of Food
- Arts & Entertainment
- Human Touch
- Healthy Communities

StAmbrose University
THE INSTITUTE FOR PERSON-CENTERED CARE
Alternative Frame for IPCC

● What is the Known Known?
  ○ Interprofessional Toolkit

● What is the Known Unknown?
  ○ Save the Date: Oct 1, 2019: Health Innovations

● What is the Unknown Unknown?
  ○ Implementation Science=Community Based Participatory Research
“Never believe that a few caring people can’t change the world. For indeed, that’s all who ever have.” Margaret Mead
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Evidence Based Public Health & Person Centeredness

Colleen Doak, PhD
Evidence Based Public Health: The Example of BMI

- BMI has been used to improve public health
- BMI has helped to identify emerging global trends
- BMI has been used to identify individual and community risks
- BMI has been used to identify interventions that are (are not) effective
BMI as a Clinical Cutoff: Is it Person Centered?

- Labels of underweight/overweight/obesity (based on BMI measures) can be experienced as stigmatizing
- The cutoff may not be appropriate for some people (muscular adults, children)
- Ethnic differences in body composition are documented but not well understood
- Monitoring based on change in BMI may give misleading results as compared to more direct measures (e.g. skinfolds)
In 1823 Adolph Quetelet observed that from infancy to adulthood height and weight do not increase proportionately.

In adults, weight fits a normal Gaussian curve when divided by height in meters squared.

Quetelet’s index: Weight in kilograms $\div$ meters$^2$
Quetelet describes weight/stature\(^2\) as an index of body mass in **adults**

Keys reports Quetelet’s BMI to be the best proxy for body fat % in **adults**

WHO defines **adult** overweight as BMI \(\geq 25\) and obesity as BMI \(\geq 30\)

Rohrer introduces the ponderal index (weight/stature\(^3\)) for **infants**

Must et al publishes BMI percentiles for **6-74 years old**

WHO publishes definitions using BMI z-score:

- For **children** 0-5 & 5-18 years
  - 18.5
  - 25 & 30
- For children 2-18 years
  - 18.5

**1823**

**1921**

**1974**

**1991**

**1995**

**2000**

**2007**

**2010**
Ethnic differences: Risk related to BMI differs

- The source data for the cutoffs BMI 18.5, 25, 30
- The finding that these cutoffs do not reflect risk for some African population (example, S. African women)
- The finding that these cutoffs do not reflect risk for Asian populations (Yajnik/Yudkin example)
Meaning of BMI differs by population: Yudkin-Yajnik paradox
Population prevalences may be distorted by differences in:

- Height (correcting for height differences in populations improves comparability of BMI)
- Age at puberty
- Body composition (bone and muscle mass)
- Nutrition status (related to height)
BMI is Faulty; The Epidemic is Real

- Children are developing type 2 diabetes
- Rising incidence and prevalence of diet related diseases, hypertension, cancer..
- Need for medical equipment, airplane seating etc. that can accommodate the population changes in weight/size
- Need to discuss the risks related to the physiological effects of increasing body fat without body shaming or stigmatizing
Discussing the Obesity Epidemic

- Public Health need for person centered research & training
- Can the public discussion of the obesity epidemic be person centered?
  - Could we use the term BMI instead of categories, underweight, overweight, obesity?
  - Can we adopt better measures (skinfolds, waist circumference) that are more directly related to health risk?
  - Can we focus on healthy behaviors rather than weight?
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The Quad City Health Initiative

-Nicole Carkner, MBA
Our Mission
The Quad City Health Initiative exists to create a healthy community.

Vision
QCHI will be our community’s recognized leader for creating collaborative action on health.

Value Proposition
Because of QCHI, entities with aligned goals are able to sustain work across organizational boundaries and geographic borders and thus improve our community’s health status and quality of life.
Collective Impact for a Community Aligned with Person-Centered Care Elements

- **Common Agenda**
  - Individualized, goal-oriented care plan based on the person’s preferences.

- **Shared Measurement Systems**
  - Performance Measurement and Quality Improvement using feedback from the person and caregivers.

- **Mutually Reinforcing Activities**
  - Active coordination among all care and support service providers.

- **Continuous Communication**
  - Ongoing review of the person’s goals and care plan.
  - Continual information sharing and integrated communication.
  - Education and training for providers and, when appropriate, the person and those important to the person.

- **Backbone Support Organizations**
  - Care supported by an inter-professional team in which the person is an integral team member.
  - One primary or lead point of contact on the care team.

QCHI In Practice

- Clear Vision Statements/Objectives
- Community Health Assessments/Indicators
- Cross-Sector Project Teams
- Communication with Stakeholders and Entire Community
- Project Management Support

Community Health Assessment

- 2018 Assessment was joint effort of QCHI, Genesis Health System, UnityPoint Health-Trinity, Rock Island County Health Department, Scott County Health Department, Muscatine County Board of Health and Community Health Care, Inc.

- Community Engagement via MAPP framework including community health survey and qualitative input from community stakeholders
Project Example: Be Healthy QC

We want to increase the % of adults and children who are at a healthy weight by encouraging physical activity and healthy eating.

Shared Vision: All sectors of our bi-state community align and work together on program, policy, systems and environmental changes in order to create a "culture of wellness" that supports healthy eating and active living.

QCTrails.org
Workplace Wellness
Be Healthy QC Educational Campaign
Access to Healthy Foods (Information Sharing)
Community Health Improvement with a Person-Centered Lens

- Community engagement/collaboration in visioning, assessment, issue prioritization and project teams
- Conversations about social determinants of health and policies that create healthy communities
- Cross-sector consideration of person-centered care elements
  - What does it mean to be person-centered in a school, workplace, community?
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The physician, the patient, the herd of elephants in the room and the need for Person-Centered Care.

-Cheryl True, MD
“Burnout is specialty blind, and spares no one. ”

–Kimberly Bercher MD
400 physicians die by suicide each year, a rate more than 2X that of the general population (American & Swenson, 2015).

24% of ICU nurses tested positive for symptoms of post-traumatic stress disorder (Mealer et al., 2007).

Physician rates of depression remain alarmingly high at 39% (Ihacovsky, 2015).

23-31% Prevalence of emotional exhaustion among primary care nurses (Gomez-Urgoico et al., 2016).

How can we protect the health of the people who protect our own?

National Academy of Medicine
Action Collaborative on Clinician Well-Being and Resilience

Learn more at nam.edu/ClinicianWellBeing

@theNAMedicine
Burnout Among Health Care Professionals:
A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care

A National Academy of Medicine Discussion Paper

Between 2011 and 2014, the prevalence of burnout increased by 9% among physicians while remaining stable in other U.S. workers. (Kroenke et al., 2015)

Burnout is nearly 2 times as prevalent among physicians as U.S. workers in other fields after controlling for work hours and other factors. (Bakker et al., 2012)

Suicide rates among female physicians are 130% higher than that of other females in the population. (Kroenke et al., 2015)

Suicide rates among male physicians are 40% higher than that of other males in the population. (Kroenke et al., 2015)

In a study of 1,171 registered in-patient nurses, 18% had depression versus a national prevalence of approximately 9%. (Kroenke et al., 2015)

35% of hospital nurses have a high degree of emotional exhaustion. (Monger et al., 2015)

Health care professional burnout represents real suffering among people dedicated to preventing and relieving the suffering of others. The high prevalence of burnout among health care professionals is cause for concern because it appears to be affecting quality, safety, and health care system performance. Efforts are needed to address this growing problem. (Dyrbye et al., 2017)

Read more and download the full discussion paper: nam.edu/Perspectives

#ClinicianWellBeing
How “epidemic” is it?
Prevalence of Burnout Among Iowa Physicians

Rate yourself relative to the statement: “I am experiencing professional burnout”

- Not At All: 31.1%
- Somewhat: 24.8%
- Moderate: 17.7%
- Significant: 20.6%
- Total: 5.7%

Source: 2015 Iowa Physician Survey
Figure 1 | Clinician EHR Systems/Tools | Source: Ommaya et al., “Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout,” National Academy of Medicine.
FACTORS AFFECTING CLINICIAN WELL-BEING AND RESILIENCE

This conceptual model depicts the factors associated with clinician well-being and resilience; applies these factors across all health care professions, specialties, settings, and career stages; and emphasizes the link between clinician well-being and outcomes for clinicians, patients, and the health system. The model should be used to understand well-being, rather than as a diagnostic or assessment tool. The model will be revised as the field develops and more information becomes available. Subsequent layers of the model, and an interactive version of the model, are in development in conjunction with the Action Collaborative’s other working groups and will be made available shortly.

EXTERNAL FACTORS

SOCIO-CULTURAL FACTORS
- Alignments of societal expectations and - Clinician role
- Culture of safety and transparency
- Discrimination and overt and unconscious bias
- Media portrayal
- Patient behaviors and expectations
- Political and economic climates
- Social determinants of health
- Stigmatization of mental illness

REGULATORY, BUSINESS, & PAYER ENVIRONMENT
- Accreditation, high-stakes assessments, and published quality ratings
- Documentation and reporting requirements
- HR policies and compensation issues
- Initial license and certification
- Insurance company policies
- Litigation risk
- Maintaining balance and certification
- National and state policies and practice
- Remuneration structure
- Shifting of systems of care and administrative requirements

ORGANIZATIONAL FACTORS
- Bureaucracy
- Congruent organizational mission and values
- Culture, leadership, and staff engagement
- Data collection requirements
- Diversity and inclusion
- Level of support for all healthcare team members
- Professional development opportunities
- Scope of practice
- Workload, performance compensation, and value attributed to work elements
- Measurement and discrimination
- Power dynamics

LEARNING/PRACTICE ENVIRONMENT
- Authority
- Collaborative vs. competitive environment
- Curriculum
- Health IT interoperability and usability/Electronic health records
- Learning and practice-setting
- Mentorship
- Physical learning and practice conditions
- Professional relationships
- Student affairs policies
- Student-centered and patient-centered focus
- Team structures and functionally
- Workplace safety and violence

INDIVIDUAL FACTORS

HEALTH CARE ROLE
- Accountability and responsibility
- Alignment of responsibility and authority
- Clinical responsibilities
- Learning/career stage
- Patient population
- Specialty and specialty issues
- Student/faculty responsibilities
- Teaching and research responsibilities

PERSONAL FACTORS
- Inclusion and connectivity
- Family dynamics
- Financial stress/economic vitality
- Flexibility and ability to respond to change
- Level of engagement/connection to meaning and purpose in work
- Personality traits
- Personal values, ethics, and morals
- Physical, mental, and spiritual well-being
- Parliamentarianism and social support
- Sense of meaning
- Social integration

SKILLS AND ABILITIES
- Clinical Competency: performance
- Communication skills
- Coping skills
- Delegation
- Empathy
- Management and leadership
- Mastering new technologies or proficient use of technology
- Mentoring
- Optimizing workflow
- Organizational skills
- Resilience
- Teamwork skills
Implementing Optimal Team-Based Care to Reduce Clinician Burnout

Person-centered medicine - at the intersection of science, ethics and humanism
Andrew Miles

Person Centered Medical Education: North American Approaches
Ted Epperly

National Academy of Medicine
Action Collaborative on Clinician Well-Being and Resilience

THE INTERNATIONAL JOURNAL OF PERSON CENTERED MEDICINE

American College of Lifestyle Medicine
EUROPEAN JOURNAL FOR PERSON CENTERED HEALTHCARE

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CALL TO ACTION and RESOURCES

Sign up for the following e-newsletters:

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2. Institute for Healthcare Improvement [www.ihi.org/Topics/PFCC/Pages/default.aspx](http://www.ihi.org/Topics/PFCC/Pages/default.aspx)
3. World Health Organization: [https://youtu.be/pj-AvT0dk2Q](https://youtu.be/pj-AvT0dk2Q)
4. SAU-Institute for Person Centered Care [www.sau.edu/institute-for-person-centered-care](http://www.sau.edu/institute-for-person-centered-care)

- Review the tangible practices of PCC and as an organization, identify some areas you can begin to put them into practice
- Cultivate conversation based on what you are learning from the national resources
Question & Answer

THANK YOU!