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VALUE BASED CARE and SHARED DECISION MAKING

Simin N Beg MD, MBA, FAAHPM, dip ACLM

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OBJECTIVES

- Discuss SHD and how it is related to VBC
- Identify barriers to providing VBC
- Discuss the “Three Questions” framework for SDM and VBC
- Discuss challenging situations and potential solutions

SHARED DECISION MAKING

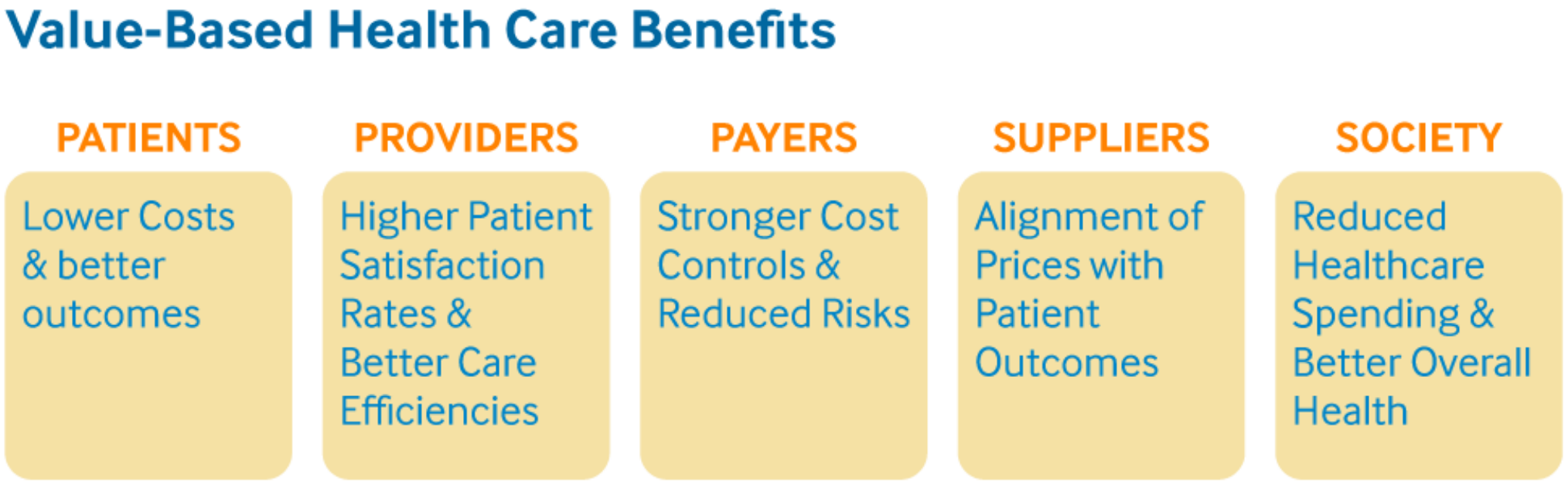
- Treatment plans that better reflect patients' goals
- Increase patient and physician satisfaction
- Improve patient-physician communication
- Have a positive effect on outcomes
- Often reduce costs

What is Value Based Care?

Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

Providers paid based on patient health outcomes.

VALUE BASED CARE



NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

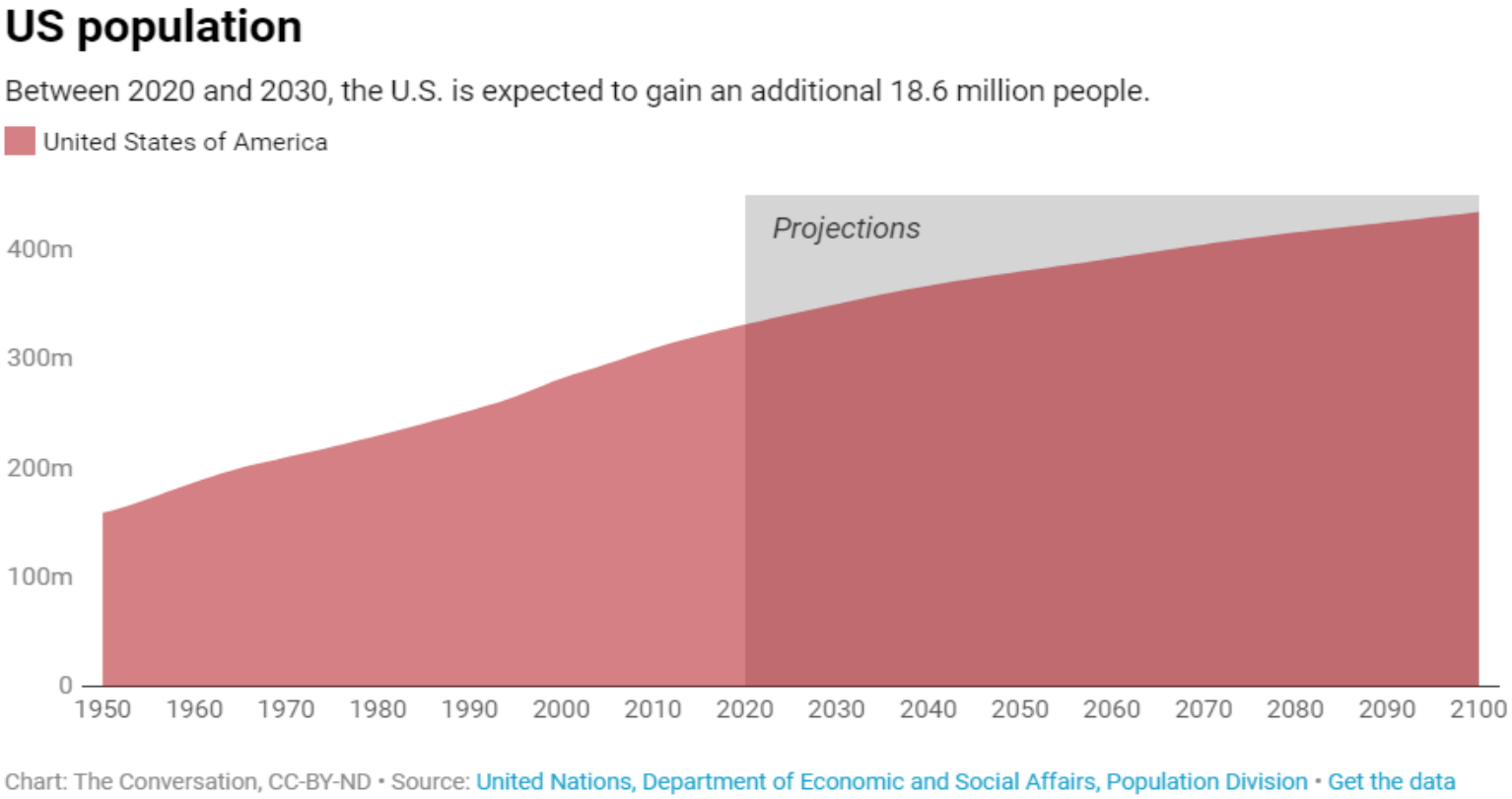
What is VALUE really?

- Beauty is in the eye of the beholder, and so is value
- Its not hard to make decisions once you know what your values are (same it true for our patients)

- *“Effective, patient-centered communication is key to quality care. Good communication is both an ethical imperative, necessary for informed consent and effective patient engagement, and a means to avoid errors, improve quality, save money and achieve better health outcomes.”*

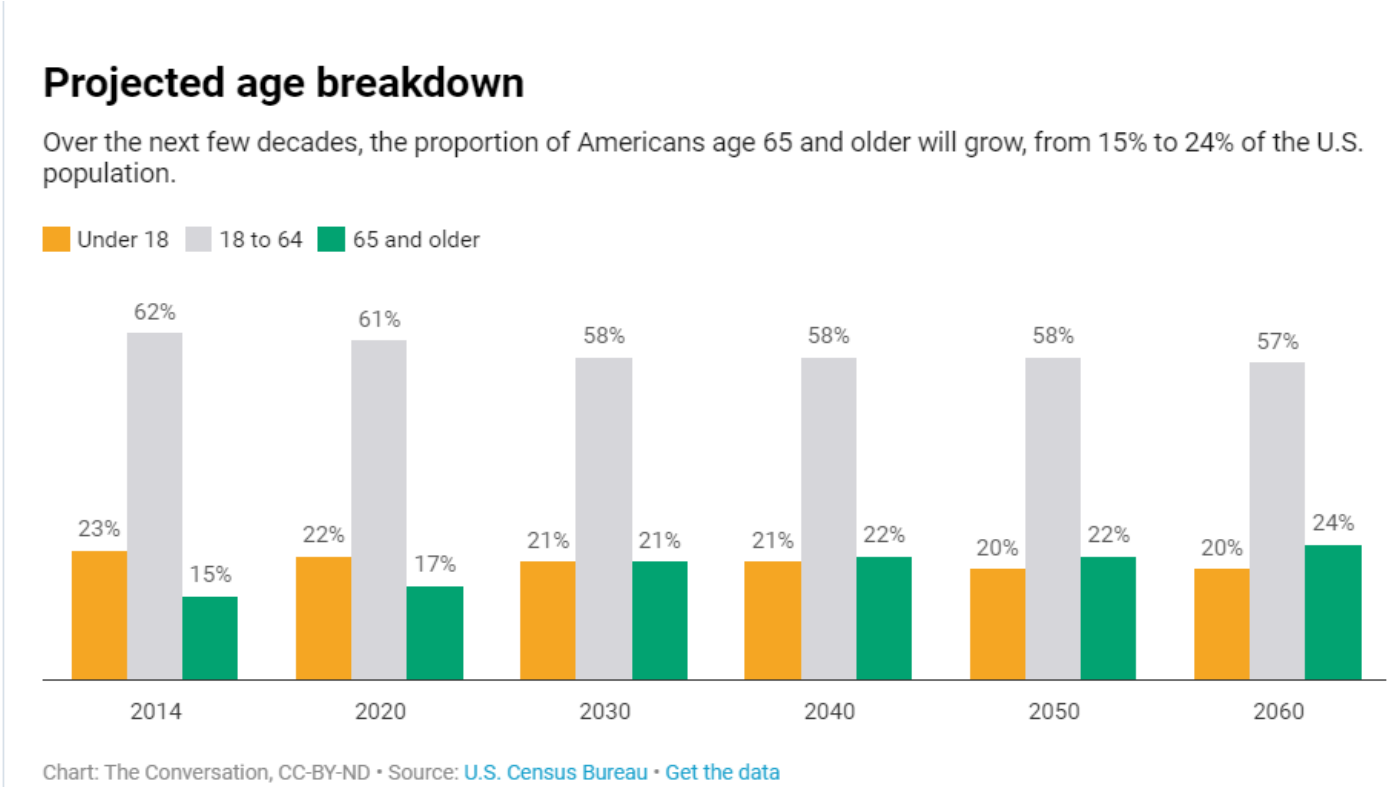
- American Medical Association. The ethical force program: C-CAT Patient-centered communication. [Last accessed on 2013a Oct 30].

There will be more of us



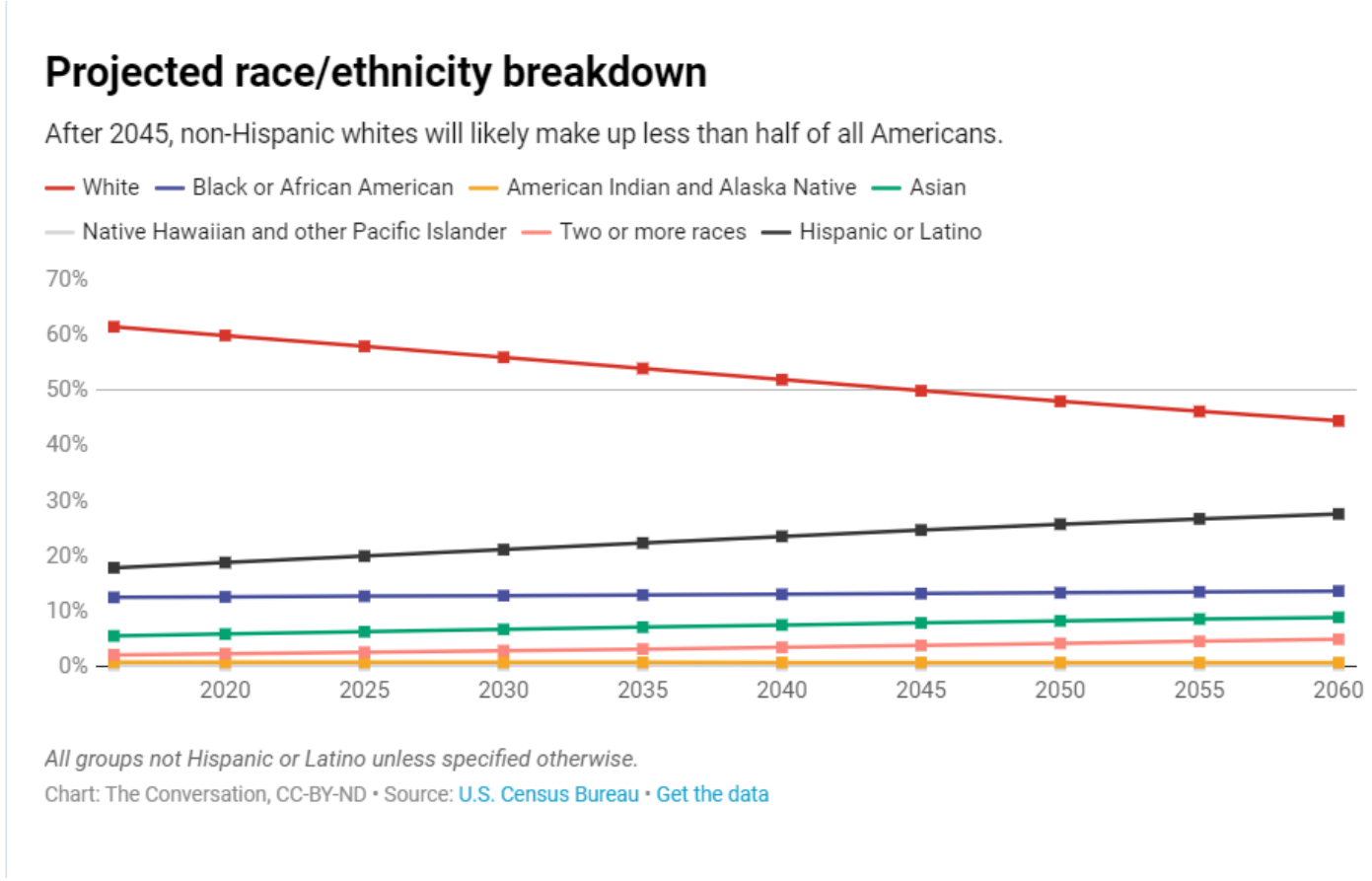
https://www.pbs.org/newshour/nation

Population will get Older



https://www.pbs.org/newshour/nation

Racial Proportions will shift



https://www.pbs.org/newshour/nation

Burn out in Health Care

- Prevalence is 52% for physicians
- Most common is DP and EE
- Increased incidence in females and BiPOC

Changes in Health Care

- The end of the public health emergency: What happens next?
- Technology, digital health and automation: Strategies to streamline, reach patients and goals.
- Hospital finances: Cutting expenses, where to save?
- The retail competition: Amazon, CVS, Walgreens, UnitedHealth move into primary care.
- Payers: Meeting the Transparency in Coverage rule that goes into effect January 1, 2023.
- Hospital at home checks the boxes: an aging demographic and a less expensive alternative.
- Medicare Advantage: Who's in, who's out?
- Telehealth: Fad or future?
- Mergers, acquisitions and partnerships.
- Interoperability for providers and payers.

Forward look at 2023

- Addressing costs; a top healthcare priority in 2023
- Addressing declining healthcare labor and staffing levels
- Drug costs and medical supplies are rising, too
- A focus on healthcare employee retention and training
- Emphasizing inclusion, growing the healthcare talent pipeline
- Addressing overall healthcare worker burnout
- Improving mental health access
- Exploring the role of integrated physical and behavioral health and technology
- People with chronic disease struggle to pay medical bills
- Understanding patients' needs beyond the doctors' office
- Addressing social determinants of health matters financially, too
- Estimating the high costs of health inequities
- Better understanding health and social factors
- Improvements in risk adjustments necessary
- A more prominent role for artificial intelligence in healthcare
- Consumers feel the impact of high healthcare costs, inflation

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All this to say……

What are Health Disparities?

- A higher burden of illness, injury, disability, or mortality experienced by one group relative to another.

- A complex and interrelated set of individual, provider, health system, societal, and environmental factors contribute to disparities in health and health care.

http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf

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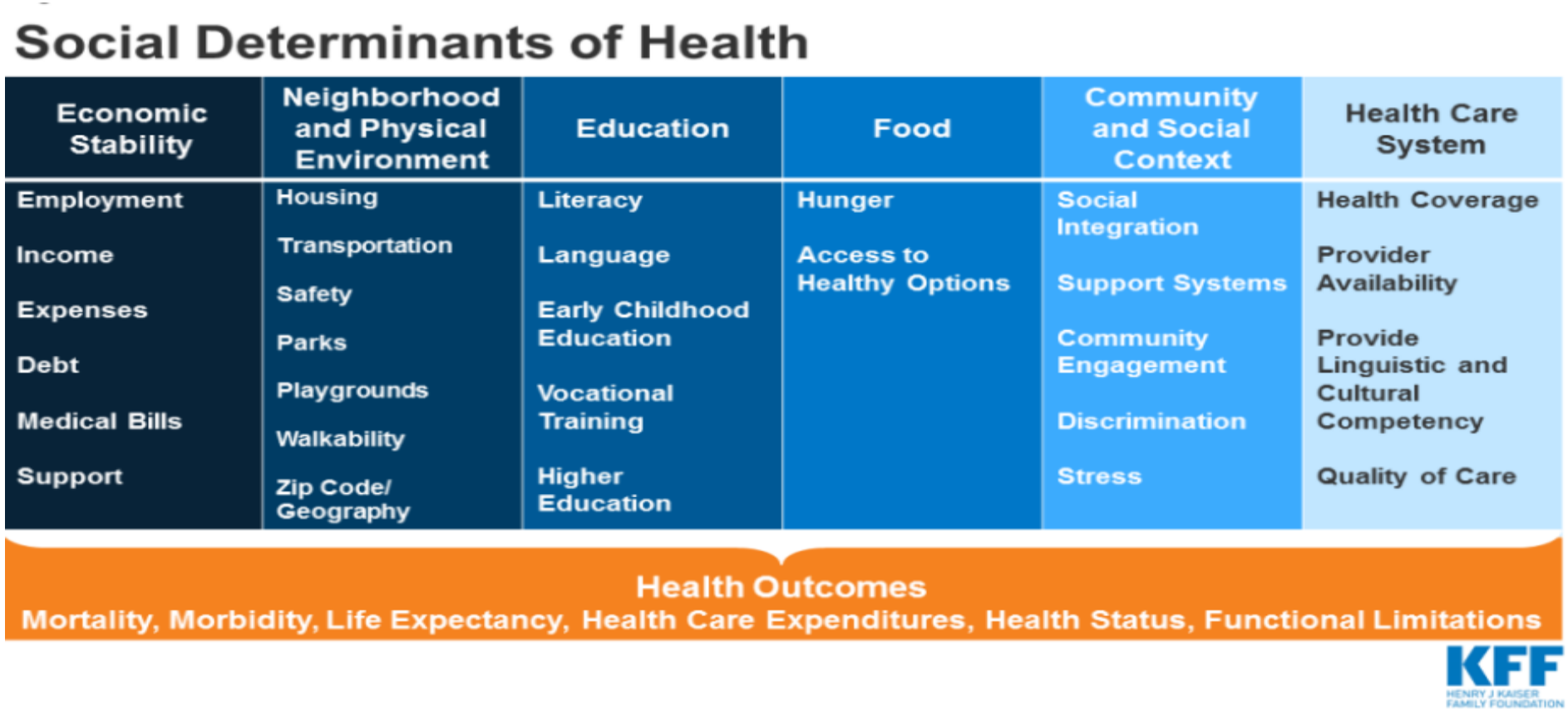
Social Determinants of Health



Health Disparities

People of color are less likely to receive preventive health services

Black and Hispanic patients are less likely to receive appropriate cardiac medication than other racial and ethnic groups, even taking into account insurance status, income, age and symptoms.

Black and Hispanic patients are more likely to follow medication instructions after they get treatment from someone of the same racial or ethnic background.

Elderly, Obese, non-English-speaking patients have poorer health outcomes

Hispanics are less likely to receive or use medications, especially for asthma, cardiovascular disease and other chronic illnesses

Patient-Centered Care: The Key to Cultural Competence

symposium article

Annals of Oncology 23 (Supplement 3): iii33–iii42, 2012
doi:10.1093/annonc/mds086

Patient-centered care: the key to cultural competence

D. E. Epner[1]* & W. F. Baile[2]

[1]*Department of General Oncology,* [2]*Department of Behavioral Science, MD Anderson Cancer Center, Houston, USA*

Much of the early literature on 'cultural competence' focuses on the 'categorical' or 'multicultural' approach, in which providers learn relevant attitudes, values, beliefs, and behaviors of certain cultural groups. In essence, this involves learning key 'dos and don'ts' for each group. Literature and educational materials of this kind focus on broad ethnic, racial, religious, or national groups, such as 'African American', 'Hispanic', or 'Asian'. The problem with this categorical or 'list of traits' approach to clinical cultural competence is that culture is multidimensional and dynamic. Culture comprises multiple variables, affecting all aspects of experience. Cultural processes frequently differ within the same ethnic or social group because of differences in age cohort, gender, political association, class, religion, ethnicity, and even personality. Culture is therefore a very elusive and nebulous concept, like art. The multicultural approach to cultural competence results in stereotypical thinking rather than clinical competence. A newer, cross cultural approach to

Conclusion

- The key to cultural competence is patient centeredness built on respect, sensitivity, composure, partnership, honesty, astuteness, curiosity, and tolerance.

All people really care about is being cared about!!

Patient Centered Care

"…care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions"

IOM. (2001). *Crossing the Quality Chasm: A new health system 21ˢ century.* Washington, DC: National Academy Press.

Importance of Trust

PLoS One. 2017 Feb 7;12(2):e0170988. doi: 10.1371/journal.pone.0170988. eCollection 2017.

Trust in the health care professional and health outcome: A meta-analysis.

Birkhäuer J[1], Gaab J[1], Kossowsky J[1,2,3], Hasler S[1], Krummenacher P[4], Werner C[1], Gerger H[1].

Author information

Abstract

OBJECTIVE: To examine whether patients' trust in the health care professional is associated with health outcomes.

STUDY SELECTION: We searched 4 major electronic databases for studies that reported quantitative data on the association between trust in the health care professional and health outcome. We screened the full-texts of 400 publications and included 47 studies in our meta-analysis.

DATA EXTRACTION AND DATA SYNTHESIS: We conducted random effects meta-analyses and meta-regressions and calculated correlation coefficients with corresponding 95% confidence intervals. Two interdependent researchers assessed the quality of the included studies using the Strengthening the Reporting of Observational Studies in Epidemiology guidelines.

RESULTS: Overall, we found a small to moderate correlation between trust and health outcomes (r = 0.24, 95% CI: 0.19-0.29). Subgroup analyses revealed a moderate correlation between trust and self-rated subjective health outcomes (r = 0.30, 0.24-0.35). Correlations between trust and objective (r = -0.02, -0.08-0.03) as well as observer-rated outcomes (r = 0.10, -0.16-0.36) were non-significant. Exploratory analyses showed a large correlation between trust and patient satisfaction and somewhat smaller correlations with health behaviours, quality of life and symptom severity. Heterogeneity was small to moderate across the analyses.

CONCLUSIONS: From a clinical perspective, patients reported more beneficial health behaviours, less symptoms and higher quality of life and to be more satisfied with treatment when they had higher trust in their health care professional. There was evidence for upward bias in the summarized results. Prospective studies are required to deepen our understanding of the complex interplay between trust and health outcomes.

Conclusion

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Cultural Humility vs Cultural Competency

Lifelong journey of self evaluation and critique

Recognizing power imbalances
Non paternalistic approach

Required historical awareness

Advocacy and partnerships on behalf of individuals and defined populations

Assumes the problem is lack of knowledge, skill and awareness.

Based on finite knowledge of a culture

Generalizations, monolithic

How??

There is not one right that fits all.

Are we asking the right questions?

Three (simple) Questions

1. What does your patient understand about disease process AND treatment options?

2. What do they hope for? Fear?

3. How can we align the two?

What the “Three Questions” really are

1: Health Literacy

2: Partnership with the patient

3: Individualized care plan

Question 1: (Health Literacy: “Head”)

- What is it really?
- The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

Who?

- 90 million Americans have low health literacy
- Lower socioeconomic status or education
- Elderly
- Low English proficiency (LEP) and/or who are non-native speakers of English
- Receiving publicly-financed health coverage or other socio-economic assistance.
- The burden of low health literacy **does not lie only on the individual**. Health care organizations must also be health literate to reduce the demands placed on individuals

Impact of Low Health Literacy

- Medication errors
- Low rates of treatment compliance due to poor communication between providers and patients
- Reduced use of preventive services and unnecessary emergency room visits
- Ineffective management of chronic conditions, due to inadequate self-care skills
- 2 day longer hospital stays and increased hospital re-admissions, 6% more hospital visits
- Poor responsiveness to public health emergencies
- Higher mortality
-

Partnership for Clear Health Communication at the National Patient Safety Foundation.

Question 2 (Doctor/patient relationship, “Heart”)

- Quality of the physician-patient relationship is positively associated with functional health by a correlation coefficient of between 0.05 and 0.08.

https://www.annfammed.org/content/18/5/422

ALL PEOPLE CARE ABOUT IS BEING CARED ABOUT!!

Question 3 (The Plan, “Hands”)

- Tangible, actionable steps
- Individualized
- Get creative and create new programs

  (virtual health, hospital at home, HBPC, HPC, RPM, EDK, etc)
- Use interdisciplinary team
- Create partnerships and SDH are addressed

HEAD, HEART, HANDS

Head	Heart	Hands
Health literacy	Know me, include me Autonomy	Plan of Action

Barriers to US doing this well

- Assumes we all have good communication skills and emotional intelligence
- Blind spots and bias must be identified and acknowledged
- EVERYONE already thinks they ask them
- Not a “one and done”
- Requires culture shift
- Takes practice
- Not just about end of life
- We expect too much too soon
- Biasing the conversation
- Cultural barriers
- This is not just for physicians; it applies to ALL of us!!!

SYSTEMIC BARRIERS

- Lack of time
- Reimbursement Model
- Culture of Medicine

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All you need is…..

Humosity

Steps to Cultural Humility

- Right intentions, right people, right knowledge
- Based on foundational communication skills and emotional intelligence
- Compassion (but no empathy)
- No stereotypes or on any "magic recipe“
- Recognize own biases and values
- Understand the impact of cultural congruence
- Recognize institutional barriers
- See mistakes as a part of the learning process
- Throw out the ‘golden rule’
- Equity is the goal

Benefits beyond Goals of Care

- Framework for Complex decision making
- Resolving ethical dilemmas
- Value based care
- Quintuple aim
- Best way for equity and to check bias

Language Matters

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Patient Centric Language

DEFCIT BASED	STRENGTH BASED
Addict	Person with substance use disorder
Frequent flyer	High utilizer of the medical system
Mentally ill	Person with mental illness
Homeless	Struggling with housing insecurity
Resistant	Not open to, not ready for
Non-compliant	Unable to adhere to medical plan because…..
Difficult patient	Difficult patient situation

LANGUAGE with NEGATIVE CONNOTATION

- Do you want everything done?
- Do you want to discontinue care?
- Do you want hospice?
- It’s time to stop aggressive treatments
- We will make sure he/she doesn’t suffer
- Nothing more can be done
- Maybe its time to stop fighting

LANGUAGE with POSITIVE CONNOTATION

- We will provide the best care possible until the very end
- We will concentrate on improving your quality of life
- We want to help you live meaningfully
- We want to make sure you get the treatment that you want
- Your comfort and dignity is our priority
- We will focus on treating your symptoms
- Let’s discuss what we can do to fulfill your wish to stay in your home

DANGER PHRASES

- They don’t want hospice
- Not on the hospice page
- They don’t get it
- They are not there yet
- Patient/family is difficult
- Non compliant

WHY USE THE THREE QUESTIONS?

a) Its the only way to provide Value based care

b) Studies show that patient directed GOC conversations reduces errors, improve quality, saves cost, enhances provider satisfaction

c) Best method to check biases and promote equity

d) We are lazy

e) Dr. Beg said so

In the END

- We CAN get it right, we MUST get it right
- Once we understand what matters to our patients, only then can we guide them in the care plan
- Hope is good, but it is not a plan and false hope is just plain cruel

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“We’ve been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being.”

•Atul Gawande, Being Mortal: Illness, Medicine and What Matters in the End


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