FOR INTERNAL USE ONLY

Modern Healthcare

Providers work to re-establish bonds with patients

https://www.modernhealthcare.com/safety-quality/providers-work-re-establish-bonds-patients

By Maria Castellucci

June 22, 2019

Building trust takes time, concern and consistency. As some healthcare systems are finding out, achieving the right mix to do so isn't easy.

Recent data shows patient trust in the healthcare industry is declining and there are many reasons for the drop, experts say. The abundance of online health information, pressure on clinicians to shorten office visits, the rise in out-of-pocket healthcare costs and more awareness about surprise medical bills and physician conflicts of interest are among the likely contributors to the downward trend.

"Physicians have a steeper hill to climb in establishing trust," said Dr. Richard Baron, CEO of the American Board of Internal Medicine and the ABIM Foundation. "They are confronting more skepticism."

And given the strong body of evidence that shows mistrust leads to patient dissatisfaction and lower compliance with recommended treatment, health systems are encouraged to address the problem. "Providers are going to do better on quality metrics in environments that have trust," Baron said.

The ABIM Foundation has decided to raise awareness about the issue through a provider-focused initiative launched last year that includes as a major component the solicitation and sharing of implemented practices that have led to increases in trust with patients and even their own employees.

Four of the participants in the foundation's initiative, called the Trust Practice Challenge<https://abimfoundation.org/what-we-do/rebuilding-trust-in-health-care/trust-practice-challenge>, agreed to discuss how their efforts established better trust with patients. While the health systems didn't address many of the root causes of patient mistrust like rising out-of-pocket costs, which is hard for them to solve, they were able to foster trust by improving the patient's relationship with providers.

And, as Baron said, "It's the relationship that glues this all together."

The EHR as a tool

Dr. Lolita Alkureishi, a pediatrician at UChicago Medicine, was assigned the role of a superuser in 2010 when the system was transitioning to a new electronic health record system.

In that role, Alkureishi advised her colleagues on the best ways to use the technology, and she noticed troublesome habits begin that never went away. "I saw some of my colleagues who are amazing communicators and skilled providers just going nuts," she said. "They were focusing so much on the computer and the patient was just sitting there."

Interested in learning how the EHR was impacting patient care, Alkureishi partnered with UChicago's internal medicine team to review the literature and found the negative effects it can have on satisfaction and the patient-physician relationship.

As a result, Alkureishi and the internal medicine team, which had similar concerns, began to work on a solution. They landed, perhaps unexpectedly, on comics.

In health education studies, comics have proven to be an effective tool to quickly convey information. "It's great for diverse populations because it's visual," she said.

The UChicago comic, called "Computers in the Clinic: Your Role," depicts a patient feeling left out because the provider is looking at a computer screen instead of the patient. The comic then encourages patients to ask to see the screen; review their records and ask questions; and call for the doctor's full attention, especially when something is important to them.

The comics were handed out to patients in the pediatric and internal medicine clinics starting in early 2018.

Clinical staff were informed, and there was no pushback. "Everyone wanted to hear what patients had to say," Alkureishi said.

Separate posters were also hung in work stations, depicting ideal interactions providers should have using the EHR.

Results from a survey indicated that the comics helped improve the patient-physician relationship. Of the 144 adult patients surveyed, 55% said they were satisfied with their relationship with their physician because of how they used the EHR with them. Furthermore, 55% of parents said they understand their child's treatment plan better because of how the provider used the EHR.

Alkureishi said given the positive results, UChicago is currently exploring ways to scale the comics across the system.

In addition to trying to keep EHRs from being a distraction, UChicago officials want clinicians to use EHRs to enhance care. Alkureishi said the EHR can be more than just a medical record; it can be a computer with a variety of resources doctors can share with patients, such as educational videos or handouts, to help them better understand their condition.

The approach shouldn't take extra time, either, something already in short supply among physicians. "It's just involving the patient with what you're already doing," she said. "When I see a patient, I already have to review their medicine allergies, their prognosis. This is a great opportunity for discussion and clarification and they are helping me get my job done as well."

Segmenting care

Similar to many hospitals across the country, Dell Seton Medical Center at the University of Texas often failed to appropriately treat patients with opioid use disorder during their inpatient stay.

Treatment focused on the medical condition that brought the patient to the Austin hospital, like sepsis or a heart infection, and didn't offer resources to help them address their opioid addiction. The oversight was causing these patients to return to the hospital again and again.

Not only was it frustrating for physicians, but it destroyed patient trust, said Dr. Chris Moriates, assistant dean for healthcare value at Dell Medical School, the hospital's affiliated medical school. "It's like pumping up a flat tire without ever looking for the nail that caused the problem in the first place. You can imagine how that erodes trust," Moriates said.

Two years ago, Dell Seton established what it calls the B-team, a group of clinicians that offer patients who screen positive for opioid abuse disorder with medication-assisted treatment in the hospital and then arrange continued outpatient care with community partners. The B-team includes palliative care and internal medicine physicians, pharmacists, nurses and social workers.

During the stay, patients receive buprenorphine, which helps treat opioid addiction, and counseling. The patients are encouraged to share their stories, which they've generally not been asked to do before by the healthcare system, Moriates said.

The clinical teams were also trained on the best language to use when treating patients with substance disorder. Words like abusers or addicts "erode that trust. We don't call patients with diabetes sugar abusers. This is a chronic medical condition," said Richard Bottner, a physician assistant in the division of hospital medicine at Dell Seton.

The changes have been fulfilling for the clinicians as well, Bottner said. Before the program, patients would sometimes leave against medical advice because their addiction wasn't being addressed in the hospital and they were on detox.

"You feel like you have invested this time and effort and the patient just leaves," he said.

The medical center is currently working on expanding the services to the emergency department.

Building inclusiveness

UnityPoint Health focused on a segment that has been historically mistreated by the healthcare industry and society in general: the LGBTQ community.

The West Des Moines, Iowa-based healthcare system since early 2018 has designated two nights a month to providing primary-care services specifically for patients in the LGBTQ community at the UnityPoint clinic in Cedar Falls, Iowa.

UnityPoint saw a need to offer culturally competent care for this community after hearing stories from patients who were driving up to three hours away to the closest LGBTQ-designated clinic. "We felt that we had an opportunity to improve that experience and we could create it right here in our community," said Dr. Kyle Christiason, a family-practice physician at UnityPoint.

The health system formed focus groups to hear firsthand from LGBTQ patients of their prior experiences with the healthcare system and important characteristics needed in the clinic.

Christiason said many patients had stories of feeling disrespected by providers because of their sexual orientation and gender. As a result, staff training was essential to ensure patients were treated respectfully when making appointments and during their clinical visit, he said. As part of that, staff are taught how to appropriately ask if the patient has a preferred pronoun and name. Additionally, notes are made in the EHR to ensure the patient's correct name and pronoun are used throughout the visit.

The services offered include routine exams and vaccinations as well as hormone therapy and follow-up care after gender affirming surgeries.

Patients are surveyed right before they leave, and the results show high levels of satisfaction with the staff and care provided. Comments from patients are particularly powerful, Christiason said, including patients saying the clinic saved their life. "We see patients being affirmed and feeling positive about their health for the first time," he said.

Since its opening, nearly 180 patients have been treated at the clinic. Follow-up appointments are often done at normal business hours. UnityPoint has since opened a second LGBTQ clinic in Des Moines.

Sharing the decision

Since 2012, Massachusetts General Hospital in Boston has used shared decisionmaking tools to help patients understand if elective orthopedic surgeries are right for them.

The tools, and the conversation they ignite, fosters patient trust with providers, said Karen Sepucha, director of the Health Decision Sciences Center at Massachusetts General.

To establish trust, "patients want to feel heard and they want to make sure they are getting good information and those are things shared decision making can help with," she said.

The tool is a booklet that outlines the condition and then the different options—both surgical and non-surgical—the patient has. It details the benefits such as the outcomes associated with the surgery but also the risks including the likelihood for complications. Questions at the end of the booklet are used to gauge how well the patient understood the information as well as their personal preferences.

In some cases, physicians can review the patient's responses before the visit if they filled it out online using the patient portal. If not, they review the responses with the patient during the appointment.

The clinical team has been trained on how to have a conversation with the patient that communicates risks without confusing them, how to gather from the patient their goals and preferences and to understand when it's best to make a recommendation or leave the decision up to the patient.

One thing the tool doesn't address is the patient's expected out-of-pocket costs, which is a huge gap, said Chris Duke, director of the Center for Consumer Choice in Health Care at consultancy Altarum.

"A part of shared decisionmaking is knowing how much something will cost and agreeing to it. Maybe someone doesn't want that treatment if it's going to bankrupt them," he said.

Sepucha agreed that it's "certainly an area in need of more attention and tools."

Despite literature showing shared decisionmaking improves patient trust and satisfaction, the concept hasn't been widely adopted across the industry, she said. The current payment system is a big reason why. Often, shared decisionmaking encourages the patient to go the less-invasive route, which means fewer services are necessary.

"This will save money if you are the insurer but if you are the doctor, it's going to cost you," she said.

Since they're working at a leading academic medical center, Massachusetts General doctors don't have to worry about lack of demand for their services, "but that's not the case for everybody," Sepucha said.