Patients, Providers, And Systems Need To Acquire A Specific Set Of Competencies To Achieve Truly Patient-Centered Care

ABSTRACT Studies show that patients want to be more involved in their own health care. Yet insufficient attention has been paid to the specific competencies of both patients and providers that are needed to optimize such patient engagement and shared decision making. In this article we address the knowledge, skills, and attitudes that patients, physicians, and health care systems require to effectively engage patients in their health care. For example, many patient-physician interactions still follow the traditional office visit format, in which the patient is passive, trusting, and compliant. We recommend imaginative models for redesigned office care, restructured reimbursement schemes, and increased support services for patients and professionals. We present three clinical scenarios to illustrate how these competencies must work together. We conclude that effective shared decision making takes time to deliver proficiently and that among other measures, policy makers must change payment models to focus on value and support education and discussion of competencies for a modern health care system.

Often described as fragmented, uncoordinated, and unbalanced, the health care system in the United States provides costly and suboptimal care.\(^1\) To achieve better health, better health care, and lower per capita costs—the so-called Triple Aim\(^2\)—many health care organizations, health plans, and government programs are moving forward with initiatives that put the patient at the center of the care system.

A number of these initiatives—such as the Physician Quality Reporting System and accountable care organization pilots—have targeted the Triple Aim goals by, for example, improving transparency through public reporting or altering financial incentives through pay-for-performance reimbursement strategies.\(^3,4\)

The ABIM Foundation’s “Choosing Wisely” campaign seeks to inform providers and patients about the overuse of tests, procedures, and therapies that are potentially of little value.\(^5\) And the patient-centered medical home model of care seeks to transform primary care.\(^6\)

Essential to these quality improvements is the concept of patient-centeredness, or understanding care from the patients’ perspective.\(^7\) Studies show that patients want to be partners in their own health care, especially when confronted with a decision about which treatment option to choose.\(^8\) Yet insufficient attention has been paid to the specific competencies needed by patients, providers, and health care systems to optimize patient engagement. In this article we aim to identify these competencies to increase the potential of achieving the Triple Aim (a brief
discussion and definition of competencies can be found in online Appendix 1).9

Competencies in the context of patient-centered care enable providers, teams, institutions, and delivery systems to actively engage patients of diverse cultural backgrounds, literacy levels, and socioeconomic status in their care. Below we review principles of shared decision making and then present three clinical scenarios to illustrate how patients, providers, and systems acquire the competencies needed to engage patients effectively and achieve optimal outcomes.

Shared Decision Making
Existing models of patient involvement in health care decision making can be arranged on a continuum. At one extreme is an outmoded paternalistic model, in which the clinician makes decisions with little or no input from the patient. At the other extreme is an informed model,10 in which patients make their own decisions about their treatment. Informed models gained popularity in the late twentieth century, as patients began to have broader access to information, but there were also growing concerns about patients’ potential “abandonment” if clinicians offered information, but no guidance, on treatment choices.11

In the middle of the continuum are hybrid or intermediate models, including the model of shared decision making.12,13 In this model the physician and the patient make health-related decisions collaboratively, based on both the best available evidence and the patient’s values, beliefs, and preferences.

Shared decision making, therefore, is a competency domain that requires specific knowledge, skills, and attitudes on the provider’s part to engage a patient. Physicians and teams must apply these competencies through a series of behaviors and activities with patients, such as assessing patients’ preferences and uncovering important psychosocial factors that either facilitate or impede effective decision making. Shared decision making may be most appropriate in situations where there is equipoise14—that is, when two or more treatment options have different but equally acceptable outcomes.

We illustrate below some of the competencies that patients, physicians, and systems require to make shared decisions. Although the idea of using competencies as a framework for shared decision making is not new,14–16 we have expanded this perspective to consider the capacity of the system to support these competencies.

**Patient Competencies**
A number of key competencies in health care decision making are highlighted by Angela Towle and William Godolphin (Exhibit 1).16

In addition, Judith Hibbard has noted that patients can play one or more of the following three roles in improving their quality of care: the informed choice role, in which patients use quality of care as a key criterion for choosing providers, health plans, and hospitals; the coproducer role, in which patients help to “produce” health by acting as effective partners with providers; and the evaluator role, in which patients provide data on the performance of providers and systems and participate in defining the parameters of quality.7

Hibbard has suggested that these roles are synergistic. For example, if patients understand that they get better results when they are coproducers, they may want to select providers who support this coproducer role.

Patients vary in the roles and degree of control that they want to assume in decisions about their medical treatment.17 Although some patients are naturally inclined to participate, others may prefer that their physician direct their care. Patients may have low health literacy and numeracy, and they may not be able to understand the complex information inherent in medical care.18

Research also suggests that cultural differences, sex, age, education, and severity of illness influence patients’ degree of engagement in decision-making processes.19–22 Factors leading to patients’ low engagement include their perception that they lack knowledge,23 their perception that providers lack of respect for their preferences,24 and a lack of self-efficacy.25

Even if patients desire to engage in shared decision making about treatment options with their physicians, there are several obstacles to the process.26 One study found that even relatively affluent and well-educated patients felt compelled to conform to socially sanctioned roles and thus deferred to physicians during clinical consultations. The fear of being categorized as “difficult” prevented many patients from participating more fully in their own health care.25

Furthermore, we have little understanding of how accurately patients envision their future well-being and how this perspective influences their decisions. Within psychology, research on what is called “affective forecasting” consistently shows that people are not good at predicting their future ability to adapt to adversity. People often overestimate the impact and duration of their negative emotions in response to loss, and they fail to envision their own capacity to adapt to declines in health.27
provider competencies required for shared decision making (Exhibit 1).36 To begin with, physicians must agree that patients should be part of the decision-making process.28

One recent study found that physicians may advocate shared decision making as a philosophical tenet or value, but they do not necessarily adopt or use it in communicating with patients.29 Physicians sometimes present only partial information about a diagnosis to the patient; focus on increasing the chances that the patient will accept the physician’s preferred treatment option; and present choices as requiring immediate decisions, thereby limiting the patient’s opportunity for reflection.

Another study found that physicians rarely used validated shared decision-making behaviors and rarely invited patients to participate in the process.30 These data are consistent with research that shows that although respecting patients’ preferences is a fundamental goal of medicine, these preferences are vulnerable to manipulation and bias.31

Shared decision making requires attitudes and skills that many physicians may not possess or be familiar with. For example, partnering with a patient may require physicians to counsel patients about lifestyle issues or attend to patients’ emotional distress.32 Physicians may also need to negotiate their own professional biases and emotions.33 Studies have shown that when faced with a patient they view as difficult, physicians respond in problematic ways, ranging from avoidance to anger, and they use stereotypes as a form of distancing.32 Incorporating tools for reflective self-awareness into their practices—such as portfolios used for continuous professional development34—may help physicians improve their skills.35

A model for incorporating shared decision making into clinical practice has been proposed by Glyn Elwyn and colleagues.28 Research shows that decision aids, for example, reduce patients’ decisional conflict, increase patient satisfaction, facilitate treatment adherence, and improve patient-provider communication.36,37 Physicians

### Exhibit 1: Examples of Patient, Physician, and System Competencies for Shared Decision Making

<table>
<thead>
<tr>
<th>Patient competencies</th>
<th>Physician competencies</th>
<th>System competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the preferred doctor-patient relationship; find a physician and establish, develop, and adapt a partnership</td>
<td>Develop a partnership with the patient</td>
<td>Provide overarching support for physician’s and patient’s increased and timely access to patient-centered services</td>
</tr>
<tr>
<td>Articulate health problems, feelings, beliefs, and expectations in an objective and systematic manner</td>
<td>Establish or review the patient’s preferences for information about his or her health or treatment plan</td>
<td>Restructure reimbursement schemes to provide sufficient time and incentive for physicians to counsel and engage patients</td>
</tr>
<tr>
<td>Share relevant information with the physician clearly and at the appropriate time in the medical interview</td>
<td>Establish or review the patient’s preferred role in decision making and any uncertainty about the course of action to take; ascertain and respond to the patient’s ideas, concerns, and expectations</td>
<td>Create innovative models for redesigning care delivery in office settings to facilitate communication and optimize efficiency</td>
</tr>
<tr>
<td>Access information</td>
<td>Identify choices and evaluate the research evidence in relation to the individual patient</td>
<td>Implement new information systems to link patients with the best resources and decision aids available</td>
</tr>
<tr>
<td>Evaluate information</td>
<td>Present evidence, taking into account the patient’s competencies, framing effects, etc.</td>
<td>Increase access to understandable information about risks and benefits of therapy and diagnostic procedures</td>
</tr>
<tr>
<td>Negotiate decisions with the physician, give feedback, resolve conflict, and agree on a care plan</td>
<td>Help the patient reflect on and assess the impact of alternative decisions with regard to his or her values and lifestyle; negotiate decisions with the patient, resolve conflict; agree on a care plan, and arrange for follow-up</td>
<td>Add professional staff to help patients achieve self-management and health literacy; implement interprofessional collaboration and teamwork; reward and acknowledge high levels of professionalism</td>
</tr>
</tbody>
</table>

**Source:** Adapted from Towle A, Godolphin W. Framework for teaching and learning informed shared decision making (Note 16 in text).

**Notes:** System competencies are those required to support patient and physician competencies. The authors added this column to Towle and Godolphin’s framework.
must learn when decision aids are most appropriate, which patients are most likely to benefit from their use, and how to implement them in the realities of clinical practice.

Physicians cannot assume that “one size fits all” in shared decision making, with a common meaning and application of the process across different cultural groups. Physicians need to be aware of cultural assumptions underlying the process and be sensitive to the needs and preferences of patients in diverse cultural groups.

**System Competencies** Physicians’ and patients’ competencies in shared decision making require support from health care systems. Many systems do not engage patients in their health care in a timely or easily understood manner. Office visits generally consist of physicians asking questions and discussions of technical aspects of care, in contrast to personal or social concerns. This style of interaction reinforces the traditional patient’s role of passivity, trust, and compliance, making the system itself a barrier to shared decision making.

The changes to the system that are necessary to support patient engagement are just beginning to be understood. W. Edwards Deming’s view of a system as “a network of interdependent components that work together to try and accomplish the aim of the system” helps us conceptualize clinical Microsystems in medicine. Eugene Nelson and coauthors defined such a microsystem as a “small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. They have clinical and business aims, linked processes and a shared information environment, and produce performance outcomes. Microsystems evolve over time, and are often embedded in larger organizations (and systems).”

System performance in shared decision making is a function of the competencies of both individual patients and providers and of the system (Exhibit 1). Structural changes are required, such as new information systems needed to link patients with decision aids and other resources, redesigned models of office care, and restructured reimbursement schemes.

Systems must move toward stronger support of interprofessional collaboration and teamwork. France Légaré and colleagues recently developed and validated a conceptual model of shared decision making that accounts for teamwork. The model addresses the following three levels of health care systems: individual patients and their families, health care teams within organizations, and broader policies and social contexts. There is growing evidence that shared decision making can be implemented among teams to maximize the effectiveness of decision making.

The Chronic Care Model, developed by Ed Wagner and colleagues, relies on engaged patients and proactive clinical teams working in a functional microsystem. This model envisions a dynamic collaboration between a proactive, integrated health care team working within an effective microsystem and an “activated” patient, all in the context of a supportive macro-system. Nelson and colleagues have laid out key competencies of Microsystems to drive quality and patient engagement—competencies that include an intense focus on the patient and that align well with the Institute of Medicine’s framework emphasizing patient-centered care as the overarching competency for all health care providers.

**Maximizing Patient Engagement**

We now present three clinical scenarios to illustrate how the competencies of patients, providers, and systems work together, within the context of shared decision making.

**Chronic Disease Management: Diabetes**

Diabetes is a complex chronic illness requiring substantial engagement by patients and their health care teams to maintain control of blood sugar and blood pressure and to prevent complications. One of the authors, Eric Holmboe, participated in implementing the Chronic Care Model for a population of roughly 1,000 patients with diabetes in a general internal medicine clinic in the US Navy. Using information from an electronic database, Holmboe and his team found more than a hundred patients experiencing poor glycemic control who were at higher risk for complications.

We recruited and assigned a nurse case manager to these patients and learned very quickly that each of them had unique barriers preventing them from engaging in their own care. The nurse case manager, through personalized coaching, uncovered each patient’s issue or issues. The barriers were often psychosocial, such as depression that multiple physicians had failed to diagnose.

The interprofessional team, with shared decision making and effective engagement facilitated by a nurse with a high degree of competence in communication, was embedded in a system that facilitated patients’ care. Changes in the electronic health record to proactively track glycemic and blood pressure control made it possible to alert physicians to the status of their patients with diabetes, allowing them to coordinate care with other providers, manage referrals, and ensure patients’ timely access to the clinic when needed. These microsystem
Role of Clinicians

Operationalizing the Chronic Care Model into a viable longitudinal care program for diabetic patients.

Invasive Diagnostic Procedures: Elective Cardiac Catheterization

Patients with stable, uncomplicated angina do not increase their life expectancy or reduce their future risk of heart attack by undergoing invasive coronary artery catheterization, either with or without the placement of a stent. Yet catheterization continues to be widely used, and studies have found that many patients believed that the procedure would be effective in reducing these specific risks. These studies have also found that dysfunctional decision-making processes contributed to the use of the procedure.

Effective shared decision making is an essential competency in the case of a risky procedure with limited benefits, such as elective cardiac catheterization. Patients who have stable angina but do not have high-risk factors such as blockage of the left main artery need to fully understand that the procedure is effective only for reducing anginal symptoms. Providers need to offer, and make routine use of, validated decision-support instruments such as the Seattle Angina Questionnaire. Such tools can help both patients and providers determine the severity of the symptoms and then make an informed choice about whether to proceed with the catheterization. The Seattle angina tool assesses how functionally limiting the angina symptoms are, as well as asking patients how angina affects their quality of life.

This situation highlights the importance of the patient competencies of health literacy and numeracy and advocacy skills needed to understand the risks and benefits and make an informed decision. In turn, physicians need robust communication and informed decision-making skills, along with a strong foundation of professionalism. And systems need to provide the necessary clinical decision support, with sufficient time for patients and providers to reflect on and make wise choices about therapeutic procedures.

End-of-Life Decision Making

At the end of life, patients often receive unnecessary and expensive therapies that do not prolong life but that add unnecessary suffering. Consider, for example, a seventy-five-year-old woman diagnosed with recurrent lung cancer after the removal of a portion of the lung two years earlier. At this stage of disease, there are no curative therapies. For this particular patient’s cancer type, chemotherapy provides only a 20–40 percent chance of a “response”—that is, making the tumor shrink or stop growing for a short period of time—but often has substantial side effects that may markedly affect the patient’s quality of life. An open, honest conversation involving the physician, the patient, and her family is crucial if futile care is to be avoided at this point.

Research shows that physicians and other care providers struggle with these difficult conversations, and members of the health care team often give conflicting messages to patients and families. Disagreements about care management among providers, patients, and family members can lead to increased levels of stress and discomfort for providers, who often lack communication skills necessary for conducting end-of-life discussions.

Education and training can help increase this competency. For example, OncoTalk, an online program, offers education to oncologists on conducting “difficult conversations” and achieving better end-of-life communication skills.

Research suggests that cancer patients who are cared for by providers with expertise in hospice and palliative care experience better quality of life, fewer symptoms, fewer hospitalizations, and, paradoxically, longer survival time compared to patients who do not receive such specialized care. These favorable outcomes are achieved even though these patients often do not receive aggressive medical treatment such as chemotherapy. Thus, ensuring access to high-quality palliative care that is coordinated with the patient and his or her family and health care team is another system competency.

Implications

There is little debate about the fact that patient engagement in health care underpins the ability to achieve the Triple Aim. Using the concept and framework of competencies, we have expanded on some of the competencies needed by patients and health care providers to advance patient engagement by including competencies of systems. We believe that system-level change is required to facilitate and support engagement at both the patient and the provider levels. Our emphasis is on shared decision making as an approach based on both evidence and competency, and as a fundamental principle that must be embedded into our health care system.

Patient engagement through shared decision making is linked to increased patient satisfaction, health outcomes, and quality of decisions. However, the process is nonlinear and complex, as elements such as culture, experience, emotion, trust, fairness, and socioeconomics each interact with the required competencies in different ways to produce an outcome.

Moreover, not all patients will desire or have...
the capacity to engage in their own health care. Rigorous measures of patient engagement, and of the degree to which health care decisions truly reflect patient preferences, are needed to advance shared decision making in clinical practice.63

Although we recognize the realities of clinical practice, we also believe that the health care system cannot increase patient engagement in decision making without overcoming the underlying obstacles that impede patients’ access to and understanding of needed information.62 In addition, a multilevel partnership among all stakeholders committed to change in health care is required.63

The United States is not alone in grappling with health care quality and cost issues and recognizing shared decision making and patient engagement as important mechanisms to improve care and reduce costs. For example, the UK National Health Service is using Patient-Reported Outcome Measures for hip and knee replacement to help patients decide when to undergo joint replacement, and to ensure that they experience optimal and meaningful functional outcomes.64

Effective shared decision making takes time to deliver proficiently. As a result, policy makers need to develop payment models that reward efforts to practice shared decision making and focus on value of care, rather than on the volume of services delivered. Payment models are a large part of the health care macrosystem, and unless they are aligned with the system competencies needed to engage patients and providers, it is unlikely the United States can experience a more rapid transformation intended to achieve the Triple Aim. Although revised payment policies alone will not catalyze the necessary changes, continuing attention to the use and development of tools in shared decision making, professionalism, teamwork, and communication will further help redirect conversations about patient engagement to include competencies of patients, providers, and systems.

In addition, policy makers need to support modifying medical education and continuous professional development to train providers in the critical competencies needed to engage patients in meaningful discussions of care. For example, focusing on behaviors only and neglecting psychosocial and emotional aspects of the relationship may result in physicians and patients going through the motions of shared decision making without achieving satisfactory clinical outcomes.7

Furthermore, policy makers can help advance a more thoughtful and fact-based conversation about health care decisions. The same competencies and principles that underpin shared decision making among providers and patients should be used among policy makers and the health care community.65

Additional research is needed to clarify the goals of engagement and address the following remaining questions: What is the desired role for patients in health care based on their unique personal and social context and care issues? What does longitudinal engagement look like? How should the system engage patients who do not have access to care, and how will this situation change with the full implementation of the Affordable Care Act?

The full potential value of shared decision making among physicians and patients to reduce costs also remains unknown. Continued research in this area needs to be promoted to motivate policy makers’ interest. However, we believe that there is already sufficient evidence to help patients, health care professionals, and systems acquire and increase their proficiency in key competencies to achieve the goals of the Triple Aim.

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NOTES

ROLE OF CLINICIANS


9 To access the Appendix, click on the Appendix link in the box to the right of the article online.


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In this month’s *Health Affairs*, Elizabeth Bernabeo and Eric Holmboe argue that patients, physicians, and health care systems need to acquire a specific set of competencies, if the United States is to achieve an overall health system in which patients are effectively engaged in their health care. The authors outline the knowledge, skills, and attitudes that will be required among all these parties; present several clinical scenarios that illustrate why this is the case; and recommend initiatives that would support development and acquisition of these skill sets, such as restructured payment.

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