Patient-Centered Care: Turning the Rhetoric Into Reality

Joel S. Weissman, PhD; Michael L. Millenson, BA; and R. Sterling Haring, DO, MPH

Patient-centered care (PCC) is perhaps one of the most-used and least-understood terms in healthcare today. Although it was proclaimed a core health system aim in a 2001 Institute of Medicine (IOM) report,[1] the term too often involves a series of aspirational statements about respect for patient values that give rise to widely different interpretations that are more "turn of phrase" than "term of art."[2]

Despite that ambiguity, Medicare accountable care organizations (ACOs) must find a way to turn ideal into real. The program includes a long list of regulatory patient-centeredness requirements that range from structural and clear (eg, place a beneficiary on the ACO governance board) to vaguely aspirational (eg, "patient-centeredness integrated into practice"). In the frontlines of care, however, a more practical viewpoint prevails.

Based on a literature review conducted by the authors and recommendations from an expert advisory panel, we interviewed clinicians and administrative leaders at 15 Medicare ACOs across the country that have been among the most successful in putting patient-centeredness into actual practice. Our primary purpose was to find 4 candidates for in-depth case studies; however, as we listened to these organizations closely, a disconnect between the patient-centered care theorists and the ACO implementers emerged.

The IOM, for instance, talks about responding to individual "preferences, needs, and values."[1] The ACOs we spoke to had a 3-pronged, practical approach: 1) engaging patients, as partners, with ACOs, thus ensuring that patients are activated, engaged in their care, and share decision-making power; 2) a proactive, customer-service orientation, making care convenient and accessible, and reaching out to patients—especially to those with chronic illness; and 3) individualized care coordination, with a whole-person orientation, tailored to the patient's unique needs across settings and over time, with family and caregivers included, as appropriate.

ACO leaders also added a caveat that cannot be found in any of the numerous definitions of patient-centered care, patient engagement, or the many other terms now in use: implementation requires an organization. That organizational context is important. Physicians acting alone will likely struggle to satisfy the PCC goals that are now routinely included in many value-based payment models. Organizational efforts to establish and enable such change are crucial.

For instance, the larger ACOs we interviewed made extensive use of sophisticated data analytics from the electronic health record system to identify chronic disease patients at risk, whereas smaller ACOs deployed nurse care coordinators and telephoned doctors and patients to accomplish the same task. Some ACOs trained physicians in motivational interviewing, and others directly measured patients' motivation through the Patient Activation Measure, using that information to tailor messaging.[3] Overall, turning a provider-centered organization into a patient-centered one means linking high-level leadership and goal-setting[4] to practical actions, cumulatively meant to ensure that patient-centeredness would take root.

With the federal government pushing for 30% of all traditional Medicare payments to come from ACOs or similar alternative payment models by the end of this year, it is time to get practical. The first step is for governmental and private payers to stop constantly

TAKEAWAY POINTS

Patient-centered care (PCC), endorsed by the Institute of Medicine and emphasized in the Affordable Care Act, has become a reimbursement-linked priority for government and private payers. Despite CMS' regulations on PCC, the concrete steps needed to implement it remain unclear and existing measures fall short. Clinicians and administrators at accountable care organizations (ACOs), which at the leading edge of healthcare innovation, are uniquely positioned to offer insight regarding lessons learned. In our interviews, leading ACOs shared valuable lessons on implementing PCC, which we have grouped into 3 categories: patients as partners, proactive customer service, and care coordination. This study helps to:

- Understand and plan PCC programs.
- Differentiate patient-centered from provider-centered activities.
- Clarify regulations on PCC.

TABLE. Characteristics of Provider-Centric Versus Patient-Centric Care

Provider-Centric Care	Patient-Centric Care
Care coordination/whole patient	
Disease/medical model	Multifaceted individual with unique values and preferences
Fragmented, cafeteria-style care	Seamlessly coordinated and integrated care
Proactive/customer service	
Bank hours	Extended appointment hours, weekend urgent care, chronic care clinics
Confusing billing processes	Transparent charges
Reactionary medicine	Proactive, preventive care
Built around needs and revenue streams of clinicians and facilities	Teams built around patient needs
Visiting hours in hospitals	Approved family members/ caregivers unlimited visiting
Patients as partners	
Closed patient notes	Open notes
Paternalistic relationship	Shared power

piling new requirements upon the old. Then, together, payers and providers need to examine far more closely what works in the frontlines of care. We believe learning from the approach of successful ACOs—having a framework of patients as partners, having a proactive customer-service orientation, and utilizing care coordination with a whole-person orientation—can guide the healthcare system as it moves "from volume to value" (**Table**). During this transition period, a true partnership becomes increasingly critical to patients, doctors and to the healthcare system as a whole. ■

Author Affiliations: Harvard Medical School (JSW, RSH), Boston, MA; Center for Surgery and Public Health, Brigham and Women's Hospital (JSW, RSH), Boston, MA; Health Quality Advisors, LLC (MLM), Highland Park, IL; Northwestern University Feinberg School of Medicine (MLM), Chicago, IL; Institute of Public Communication, Università della Svizzera Italiana (RSH), Lugano, Switzerland; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health (RSH), Baltimore, MD.

Source of Funding: Robert Wood Johnson Foundation.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (JSW, MLM, RSH); acquisition of data (JSW, MLM, RSH); analysis and interpretation of data (JSW, MLM, RSH); drafting of the manuscript (MLM); critical revision of the manuscript for important intellectual content (JSW, MLM, RSH); obtaining funding (JSW, MLM).

Address Correspondence to: Joel S. Weissman, PhD, Center for Surgery and Public Health, Harvard Medical School, Brigham and Women's Hospital, 1620 Tremont St, Suite 4-020, Boston, MA 02120. E-mail: Jweissman@partners.org.

REFERENCES

1. Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.
2. Grob R. The heart of patient-centered care. *J Health Polit Policy Law*. 2013;38(2):457-465. doi: 10.1215/03616878-1966406.
3. Hibbard JH, Stockard J, Mahoney ER, Tusler M. Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. *Health Serv Res*. 2004;39(4, pt 1):1005-1026. doi: 10.1111/j.1475-6773.2004.00269.x.
4. Shortell SM, Sehgal NJ, Bibi S, et al. An early assessment of accountable care organizations' efforts to engage patients and their families. *Med Care Res Rev*. 2015;72(5):580-604. doi: 10.1177/1077558715588874.

Full text and PDF at **www.ajmc.com**