State Healthcare Innovation Plan (SHIP), Patient Centered Medical Home (PCMH)
Transformation Webinar 5: Building Relationships

Notes

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Moderator: This is Lawrence Brown with the PCMH (Patient Centered Medical Home) team. You are currently in listen-only mode. After dialing into the webinar you should have entered your access code and audio PIN located on your control panel. It is important to enter your audio PIN as this enables me, as your moderator, to unmute your line so you are able to speak on the call. If you have a question during the presentation please write it in the questions pane on your control panel. This session is being recorded for the purpose of taking notes. I will now turn the presentation over to Margaret.

Presenter: Thank you, Lawrence, and welcome to everybody who is on the call today. I appreciate the fact that you are taking time out of your very busy schedules to talk with us about a very important topic, which is relationship-centered care. I know that this is a particularly busy season in many primary care clinics. I know for myself I was in clinic yesterday and I was there until nine o'clock last night because this is a busy season between the flu season and holiday schedules with all of our staff. We have a lot of college kids coming home from college and they need their checkups and to get their asthma medications topped off. Then we have a number of people who come in because it is the end of the year, they have finally met their deductible, and they want to get a bunch of stuff done. I recognize this is just a very busy time of year but I think that this will be a very rewarding topic.

It certainly has been a longstanding interest of mine talking about how relationships can build better care. While that seems like kind of an obvious thing in health care we are going to take it apart a little bit and talk about how can we really build relationships and how does that really impact the outcomes of health care.

For those of you who are more interested in this conversation, after we conclude our webinar today HMA (Health Management Associates) has developed a white paper on this subject, and the link to where you can access the white paper is on slide 18. He will give you greater depth around some of these concepts, more of the citations will be available there. The complete assessment tool, which we will preview later on in the webinar, is also located there. I am also happy to email it to anybody who contacts me after the presentation.

I should just back up for one minute. I think that I know everybody through our work with the SHIP (State Healthcare Innovation Plan), but just in case there are people on the phone whom I have not met who work with Idaho SHIP, I am Dr. Presenter. I am a family physician and have worked extensively in the PCMH (Patient Centered Medical Home) model, and still teach and deliver clinical care in a family medicine residency clinic that I was talking about just slightly earlier here.

Let us go to the learning objectives for today. You can see that there are six learning objectives. The first three learning objectives really are the what. What is relationship-center care? What do we really mean by that?

The fourth learning objective is why. Why should we care about this topic? Then five and six are really the how. Once we have decided we know what it is and why we care about it then how are we going to talk about it in a way moving forward? Because I think we all agree that relationships are important, that caring is important, but how do we actually integrate that into our clinical practices on a very practical, day-to-day basis?

If you are like me you have seen so many different adjectives applied to health care in the last ten years. It is definitely the word "patient-centered," and while we talk about the "patient-centered" medical home – and I am a very strong proponent of that model of primary care delivery, I think the word "patient-centered" get tossed around a lot, that many people use it to mean different things. It means that I have a choice, or it means that I am in charge of my care, or it means that the team is centered around need. There are just a lot of adjectives out there describing care.

We have all heard of the Accountable Care Act – lots of accountable care adjectives out there. Affordable care, of course, with the Affordable Care Act. Integrated care is another buzz term that we hear a lot. But I am not sure that we actually all have agreement on the word "care" itself. While we have a lot of adjectives, if you ask people to define what it means to care for a patient, that might actually be – there might actually be a variety of different opinions.

On the next slide, how do we know when we are actually cared for? How do we know, when we are patients ourselves, when we go to a clinic how do we know when we are cared for? I think we can all discuss when we have not felt cared for, when we have had an experience we did not think our care went right but how do we know when we do feel cared for?

I am going to ask for everybody to be unmuted now on the phone because I wanted to get some response to this idea of how do we know when we are participating in health care, how do we know when we are cared for? Because everybody is unmuted you can feel free to just respond to that.

Speaker: Listened to.

Presenter: When we feel listened to? When somebody has actually heard us? That is part of feeling cared for?

Presenter: Okay, thank you.

Speaker: I feel like we know what the game plan is.

Presenter: Okay, so you feel like you are engaged with the game plan, that we are not just a passenger, that we actually understand where the train is going? What else would define when we are cared for?

Speaker: I think when what matters to me is what also matters to the other person or my provider, that, what matters to me is what is part of the plan for it.

Presenter: Absolutely. My priorities are the same as the person who is giving me clinical advice. I think we have all had that experience where you are concerned about something and you go to the doctor and then they are focusing on something totally different. They are asking you about all of your medications and you just want to have somebody look at your rash. Absolutely true.

Other things: how do we know when we are cared for?

Speaker: When I am thought about when I am not just there. When I leave if they think about me, or if they have my long-term needs in mind when I am not in the office.

Presenter: Great. Knowing that it is not just a "one-night stand"; there is actually some contents and continuity.

Anybody else?

Now, if we were all in person together, I would be making intense eye contact with individuals, trying to get people to respond here. One more brave person who wants to talk about what defines feeling cared for?

Moderator: There was a comment in the questions pane, and somebody said, "When what is important to me is important to you."

Presenter: Okay. All right, well I appreciate all of those responses. We are going to go back on mute just in the interest of trying to keep down the background noise here. We will put everybody back on mute here. But I think that we have all had experiences on both sides of the health care delivery where we have felt cared for, or we feel like we are caring for individuals. We have also had those negative experiences where we have not felt cared for.

I am definitely a strong proponent of the PCMH model because I think that the patient-centered medical home creates a framework where the necessary ingredients for caring for the patients are in place. However, I do think that it is very possible to do everything write in the patient-centered medical home model to have depression screening for everybody and to have a care plan for everybody and check all of those boxes. Yet the heart of that medical home could be lacking, that the actual elements of caring for the patient could be lacking.

That is where relationship-centered care comes in to I think augment or supplement the medical home model, that it gives us a framework for actually defining how we care for patients and how we as patients ourselves, can feel cared for.

There are four principles of relationship-centered care. These are derived from the work of Catherine Beech and I think that footnote is somewhere else in my slide deck here. But the four principles are that relationships in health care ought to include the personhood of the participants, that this is not just the transaction of things, this is about people. That is person-centered or patient-centered. We are not diseases, we are whole people.

That affect and emotion are important components of these relationships, so that it is not just about bringing your technical skills to work. It is not just about the information that you know about differential diagnoses, or how do you do care management, that our emotions and the way we feel about these relationships are important.

The third concept is that all health-care relationships occur in context of reciprocal influence. Sometimes we forget that and we think, "Okay, we are providing care to other people, to patients, and they should feel cared for." But in fact we often have – we always have these affect and emotions where we are receiving something back from that relationship, whether it is the satisfaction or the enjoyment of being in relationships. But that reciprocity is an important component of delivering care, that we are not just – it is not just a one-way street.

Finally, the fourth idea in the fundamentals of relationship-centered care is that the formation and maintenance of genuine relationships in health care is more morally valuable. I totally agree with that. That is a philosophical and ethical underpinning of relationship-centered care. But in my pragmatic head it is hard for me to take moral value to the bank and to deliver a clinical enterprise based on moral values. We need to actually think about the value that relationship-centered care can bring in terms of saving money or delivering health outcomes.

That is also going to be a part of our conversation today is what is the actual value? What should we care about relationship-centered care? I mean we care – we truly care about our patients but what does it mean in terms of actual clinical outcomes and/or potentially utilization and financial outcomes?

If we are looking at relationship-center care HMA (Health Management Associates) has developed four domains of relationship-centered care. The first ones are the social relationships that patients have to each other, to their families, to people outside of the health care delivery systems. These are the supportive social networks that our patients may have.

The next aspect of relationship-centered care, or the next domain, are the relationships that patients have with their health care providers, their clinicians, the clinical enterprise. This is the one that we commonly think about when we talk about relationship-centered care, but I want to be clear that we actually have these four domains. This one really talks about that feeling cared for, that I am – that somebody cares about me, that it is not just a technical transaction, but in addition to that quality or that patient-centeredness there is also a continuity of care component. But the length of the relationship also makes a difference.

Of course there are these two ideas, the quality of the relationship and the length of the relationship are of course connected because when we do not feel cared for we do not tend to stay in that clinical practice very long.

The third aspect of relationship-centered care actually focuses on the relationship amongst the clinical team. Well we know that team-cased care is emerging as a more important enterprise and yet having a highly-functional team is important. Teams come with various relationships: people we get along with, people we do not get along with, people who are a little bit hard, people who are easy. Talking about that, those team relationships within our practices can be very important.

Finally, there is the relationship of our entire clinical enterprise to the community, that we do not exist in isolation, that we exist within the community. We are going to talk about each one of those aspects individually here.

Let us talk first about social connectedness. What are patients' experiences, not necessarily because of their relationships with us as health care providers but what they experience outside of the health care community, what their social networks are like. I am summarizing a bit of the literature here that shows that there are several studies that show that social isolation, loneliness, living alone, are actually risk factors for mortality and loss of function.

You can see that in the first study they showed that there was about a 30 percent increase in mortality based on loneliness. In the second study they are looking at decreased function but also increased risk of death. This study, after looking at multiple – looking at the research literature, concluded that loneliness was a more significant risk factor for decline and function and death than smoking. I think we all spend a lot of time talking about smoking and smoking cessation but I find that it is rare in clinical practices that we actually ask patients questions about are you lonely? Do you have social connections? Who do you live with? Where do you spend your time?

In addition to looking at loneliness as a predictor of morbidity and mortality across the board, loneliness has also been connected to disease-specific outcomes, especially in breast cancer. Definitely the larger social networks and being connected socially predicted better outcomes, and in post MI (myocardial infarction) care if you had higher perceived social support, which is basically a defined tool to measure loneliness or social connectedness that people who were more connected had a lower risk of death after myocardial infarction.

I know my own mother had aortic valve replacement over the summer, and I felt that it was a great practice in the practice where she had her valve replaced that they actually had volunteers. I think it was called the heart-to-heart program from the American Heart Association, who came by and pre-operatively and during her post-operative stay, and then also called her after she had gone home and there were patients who had already had heart valve replacement. I just thought that it was just a great program to increase social connectedness for patients. Especially we know that our older patients, their families are living farther away. Many of them have outlived their social networks, while we often focus on cobbling together their health care services like their home physical therapy and making sure they have seen the cardiologist. Now we are really focused on whether or not they have somebody to talk to and they are not lonely.

The next domain of relationship-centered care that I just want to touch on is that quality of caring, that feeling cared for or having that relationship with your provider or your nurse or your doctor, and really feeling that somebody cares about you. Now of course this is hard to measure in a quantifiable way but there are some various scales such as Hogan's Empathy Scale and other ways of asking about that.

When you ask patients about that, do you feel cared for? In fact the literature shows that they have better recovery, they have less concerns, they are less worried, but they have physical better recovery, they have improved emotional health. We think all those things would be true. But in addition to that people who feel cared for actually end up having less diagnostic tests and referrals, probably because they trust their clinicians more. They use less resources. In fact they have better outcomes, they have less – you can see one specific study looked at cardiovascular care for the hemoglobin A1C and the LDLs and showed that people – there was an association with this scoring of feeling cared for, and whether or not they got their testing done and their actual level of control.

Again, I think that intuitively makes sense to us because patients who feel cared for, who feel that we, as clinicians, are putting a personal investment – are more motivated to get their testing done and to be adherent to their medications and their diet and their exercise. We know that caring impacts outcomes.

The other aspect of that clinician-patient relationship is also the continuity of care, you know, whether or not we have a caring relationship but then how long has it been in effect. Looking at some various slides one recent study showed that Medicare beneficiaries who had chronic diseases – and we know that these are the tough diseases that are difficult to manage – showed that with a modest increase in continuity of care, meaning assuring that they saw the same clinician in this scoring system, just ten percent more of the time, that they were able to reduce costs around five percent.

That is actually a large reduction in cost, if you think about what we tried to do to save a little bit of money in health care. A relatively modest increase in the continuity of care definitely decreased costs. There are multiple other studies that show that continuity of care, seeing the same clinician over time improved receipt of preventive services, a higher patient satisfaction, patients are much less likely to go to the emergency room if they have a longitudinal relationship with one clinician.

There was a very good study published about 15 years ago now but I think it is still an excellent study, that looked at the various aspects of continuity of care. They parsed it out over informational continuity of care, which is, is your medical information available. If you go to the emergency room does that clinician there have access to your medical records? Information continuity. Longitudinal continuity, which is the idea that you have seen the same clinician over time so that your medical history unfolds and you do not have to repeat the story, and if you are in the middle of a complex treatment that people understand what is been done.

But the third element was really interpersonal continuity. That is the idea that you have had a caring relationship. Where you felt cared for and with a clinician over time. If you look at the studies that look at this interpersonal continuity of care 51 outcomes were significantly improved and only two outcomes had worse association, showing that interpersonal continuity actually improves outcome.

An additional 22 articles talked about the relationship between interpersonal continuity and cost, and showing that significant – there was significantly lower costs or utilization for 35 out of 41 of the cost variables. I think that this is an important take-home message that not only do we need continuity of care but this interpersonal continuity of care, meaning same clinician or that same caring relationship over time is not only valuable in terms of the patient feeling cared for on that moral or emotional sense but it actually can save money and improve outcomes.

We know that this is a component of the PCMH model where we are talking about empanelment and actually measuring continuity of care. I think that is a great opportunity for PCMH to connect with relationship-centered care.

Team-based care. This is the third domain within the relationship-centered care model where we really talk about what are the relationships that we have with each other. Not focusing on the relationships that we have with our patients but what are the relationships that we have with the entire team.

We know that team-based care is a bit of a double-edged sword. There are multiple studies showing that inclusion of additional team members such as pharmacists, peer managers, community health workers can improve care.

There are a little less data on whether or not adding all these team members saves money. It probably does down the road but it often takes an initial investment in, you know, hiring a care manager or hiring a pharmacist to do medication adherence counseling and the cost savings are accrued down the road.

But we also know that anytime you add another member to a team it can detract from building a more focused, therapeutic relationship, and there is also great response, you know, potential for team dysfunction. Any time you have more complex relationships – I think we are all coming up on the holidays here when we get together with a lot of relatives, and there is certainly people in the room we think, "Oh, it is going to be a little rough this year. They might make those comments again." I know that we all work in environments where we have complex relationships with the other people who work in the same environment.

I think that this is getting potentially more difficult for patients, too, because as we are building more and more care management and care coordination for our patients, which is absolutely important, patients can have more than one care coordinator. They can have their care coordinator and their primary care office. Then their insurance plan may offer them another care coordinator if they are a high-risk member. Then they may have a care coordinator if they have been in the hospital and the hospital is working to prevent readmission. It is a little bit almost an oxymoron as we are talking about the need for navigating our complex health care delivery system and the need for better care coordination that now we often have to coordinate our care coordination. Ensuring that the team is emotionally connected and highly functional is definitely an element within relationship-centered care.

The fourth domain is on the next slide. The fourth domain is really the relationship between the clinical enterprise, the clinical practice and the community. Here again we intersect with PCMH quite often where we know that there is a population health focus within PCMH that says that we need – we should do a community needs assessment and that we should define who our population is and make sure that our clinical enterprise addresses the needs of the community.

There is also a medical neighborhood focus which is talking about those transitions of care and ensuring that when my patient goes to the emergency room that I have sent the medical records. When one of my patients comes back from the hospital that I have the discharge summary. When patients see a specialist that there is bi-directional flow of information.

There is the component that addresses the social determinants of health, meaning that as a clinical enterprise I want to make sure my patients also have access to food and shelter and resources that they might need. It is part of my responsibility within the PCMH to do that.

All of that comes into play when we are talking about relationship-centered care and talking about the relationship of the clinical enterprise to the entire community. I would also say that relationship-centered care goes one step further and builds on that framework within the patient-centered medical home model, and it also identifies that a

practice itself is a vital element of building social connections and of building the community itself.

We know that practices and clinical enterprises are often an economic engine in many communities. They hire a large number of people and they contribute to the economic vitality of the community. But there is also a central role for practices to contribute to the social connectedness of communities.

I want to talk for a minute about a great book called *Heat Wave*. The reference there is on the bottom of your slide, and this is by Eric Klinenberg, and this was a phenomenon that happened in Chicago, and of course I am Chicago-based. That is probably why I am very familiar with this book. But it is a great book for anybody who enjoys public health and it is just a great work of research, and it is very readable. The author does a great job of presenting this, basically, social disaster in a great narrative.

This heat wave happened in July of 1995 in Chicago where the heat index got over 126 degrees. The heat index, of course, is where you have the temperature and the humidity. Chicago sustained over 700 deaths. This was really a public health disaster. I mean if you think about how many deaths we have encountered through Zika and Ebola, and some various things in the United States it does not get anywhere close to 700 deaths all in one – it was over like a three-day period.

What they discovered was that in adjacent neighborhoods with equivalent socioeconomic status – so clearly this impacted poorer neighborhoods where they did not have access to air conditioning more than other neighborhoods, but in adjacent neighborhoods with equivalent socioeconomic status there was a marked differing death rate. It was thought to be due to the social cohesion of those neighborhoods.

This relates a little bit back to domain number one where people are connected to each other and there is a neighbor who is willing to check in on an elderly neighbor. But this also talks about the social cohesion of the entire community. Relationship-centered care it suggests that there is a role for practices to deliver or participate in developing social cohesion in their neighborhoods and in their communities.

Those are the four domains of relationship-centered care. They are social connectedness among individuals, the relationship that we have as clinicians with our patients, and both the quality, the caringness of those relationships and the continuity of care. The relationships we have with each other in our health care teams, and finally the relationship between the practice and the community as a whole.

That is a large enterprise. If we think about all those various relationships and all the work and the effort that it takes to build that and pay attention to that, so really let us go to the next slide and I am going to ask everybody to unmute again. Please understand that we are unmuting now, and be cognizant of that.

What do you think are the barriers that impact really employing relationship-centered care or being able to act on relationship-centered care. Would anybody like to share what they think are potential barriers or impediments to working across these four domains of relationship-centered care?

Speaker: Hi, I am from Genesis Community Health. I think it is also going to kind of take a shift - from like mind shift from the patient's perspective. They are not used to maybe when you get into some of those like social factors and that kind of stuff they are maybe unsure

about sharing how much is going on in their lives and kind of developing that role or trust with the patient.

Presenter: Absolutely. The skepticism on the part of the patient that to enter into a relationship and share that information, or in some cases to get it into an electronic medical record and the idea that it could be shared broadly, definitely a factor.

Speaker: Time, I think, is going to be a big factor. A lot of times providers, you hear, "I just do not have time to do that," which probably definitely feel that way.

Presenter: Yeah. Time is a big factor. While you are checking your boxes to make sure you did your depression screening and you asked all those other questions, and then just having that time to focus emotionally on patients. Then also, these other domains like team-based care, I mean having time just to develop the team and it is like we are so busy taking care of patients we do not have time to think about taking care of ourselves or our teammates. Other things? Other impediments that people think might impact the ability to develop relationship-centered care?

Speaker: Hi, I am from Jazz. Can you hear me?

Presenter: Yes, absolutely. Thank you.

Speaker: One of the things we found was culture, having a very diverse population. A lot of cultures kind of were creating barriers for our relationships with the provider.

Presenter: A lot of cultures, you said, a lot of cross-cultural aspects of health care?

Moderator: Correct. Yes.

Presenter: Yes, definitely true. It is harder to connect in cross-cultural environments.

Other factors? Anybody else want to chime in?

Speaker: I am from St. Mary's, and I would echo what the folks from Genesis said as far as it is really going to be – it is a new way for patients to really think about this. You know, they want to come in, get their sore throat taken care of and be out the door. They do not necessarily want to have to go through everything and anything under the sun. It will take a change on their part, but it also will take a change on some of the providers and their way of thinking as well because for so long it is been bring them in, take care of their sore throat and get them out the door.

The other piece that is part of that too is until recently it is all been driven in a sense by the provider, and now we are bringing other players into the piece as well. Both from the provider having to make that shift, the other players making that shift and the patient making that shift. Patients are used to getting everything from their provider; now we are talking about bringing in the behavioral health piece or the nurse doing – you know? I think that those are, while not insurmountable, and certainly it seems like it is a better model that we are moving to there definitely will be barriers.

Presenter: Absolutely. Thank you. That was a very comprehensive response and you really touched on at least three different barriers there. One is the demand for access and convenience, that the patients are busy too and we know that there is a greater and greater demand for convenience and access to care. That is always a balance, balancing expanded

access with continuity in that caring relationship. Then talking about our own attitudes, maybe having to change, and whether or not we are experiencing burnout is a huge factor for a lot of clinicians, and whether or not they can really feel like they care for their patients. Definitely all those factors.

Another one that I think is an important factor to think about is medical complexity. I think things are getting more and more complex as we have more diseases to manage and they are living longer. We have higher rates of obesity. The average Medicare patient sees seven different doctors a year and 40 percent of Medicare patients have 11 doctors. We are talking about trying to be in relationship and have these medical complexity in and of itself is a factor.

Thank you very much for everybody's responses. I am sure we can all think of the barriers here, but I want to talk about potential solutions, so I am going to ask that we go on mute again, just to make sure that we can reduce the amount of background noise. I think Lawrence is going to do that for us.

In order to promote relationship-centered care in the primary care environment HMA built an assessment tool. It is really very similar to the PCMHA assessment tool and it is intended to be used in conjunction with patient-centered medical home assessments. It is intended to augment that.

It is divided along those four domains, looking at what patients, their social connectedness, the domain of the relationship of the provider to the patients or the clinicians to the patients, the relationship amongst the team and then finally the relationship of the practice to the community.

It is several pages long and it is available at this, the sources below there. It looks like it got cut off a little bit but I think you can probably get to the link after the slides are posted. If you are having difficult and you would like to use this tool I am certainly happy to email it to anybody who would like to use it. I would also welcome any feedback if you use it and you have things to say about it and offer feedback I would love to hear that because this is a long-term interest of mine to help promote and develop relationships within health care.

You can see that in this one example of looking at social connectedness, looking at element one, so it is designed very similarly to the PCMH model. Interpersonal relationships outside of the practice environment. This is looking at how socially connected our patients are.

On the left hand side of the assessment tool shows what I would say is a very rudimentary stage, and it allows – and then it moves across to the right hand side is a higher stage of implementing relationship-centered care practices. You can see on the left hand side is family history is limited to medical factors, and social history is limited to facts such as drug and alcohol use. The few facts have gathered regarding the patient's life or experience. On the far right, then, it says the practice actively engages in efforts to promote social connectedness through use of home visits or motivational interviewing. Actually proactively suggesting to patients that connection to each other and getting out and being socially connected is therapeutic. As much time as we spend around trying to get our patients to stop smoking and using motivational interviewing around some of those habits around exercise that we should also focus on really getting them to connect to a church or to a hobby or a group or something where they have social

connectedness because that impacts their morbidity and mortality and their long-term function.

I am obviously not going to walk through the entire tool but I do hope that some of you will pull it out and look at it and see if there are opportunities to implement some of the things in your practice environment as you are building your medical home.

There is a lot of synergy between the tool and the patient-centered medical home, the NCQA and other patient-centered medical home models. I want to talk just for a few minutes about three case studies that we have done here at HMA as we have worked in primary care environments.

In one large practice environment that was a large, primary care system with different clinics that were connected to an integrated delivery system as part of the safety net hospital. We recognized the continuity of care and empanelment were key features both for satisfaction of patients but also because it has a definite impact on utilization in a safety net environment that is very important for conservation of resources at decreased cost and it improves clinical outcomes.

HMA used our empanelment tool to proactively assign patients to one clinician's panel. We worked with the practices, developed workflows that encourage using care from one clinician, but also being able to balance access to care. We know that no clinician works seven days a week, 24 hours a day. There has to be some cross coverage. How do you balance that cross coverage or the patient who says, "Well I really want to be seen today," or, "I cannot come in on Tuesdays," with continuity of care. Developing those workflows are very important.

Then also having a way to assess the panels periodically to ensure that they are balanced in terms of, you know, you do not want one clinician to have all the really tough or challenging patients, and other clinicians to not be as busy, and to be able to measure that continuity of care. That was a great opportunity to work with that practice environment on that one aspect of relationship-centered care, but it had a significant impact on their patient satisfaction and the quality of care outcomes.

On a provider satisfaction too because we, as one of the cardinal features of relationship-centered care is that we as clinicians and other people in the practice environment, the receptionists and everybody are in relationship with our patients as well, and we value that continuity, that relationship.

Another thing that HMA has done with practices is help them develop the idea of reflective practice and taking a few minutes out to build our own emotional strengths. Working in primary care is hard. It is hard work and there is a lot of opportunity for burnout. You are never done. No matter how much work you do and how many things you take care of there are always more things that can be done for our patients. We just know the need is large.

HMA has come in to several practices and helped them develop tools for promoting that inner emotional strength and connecting to other team members.

For example, all of the practices are probably working on developing huddles. Huddles are a way of trying to improve our conversation around our patients. But that is actually a great opportunity to take a few minutes during the day and having a shared relaxation exercise, whether it is just a few minutes of deep breathing or a share affirmation or an

opportunity to reflect on something that gave me hope or was exciting yesterday in the clinical practice. Something that actually nurtures ourselves and helps us be more mindful and reflective about our own practice and that we are not just hamsters running on that wheel and doing flu shot after flu shot after flu shot. That was definitely my day last night.

There are opportunities to build those parts of relationship-centered care into our patient-centered medical homes. Finally, doing team training. This is another thing that HMA has done quite a bit of. Where we know that there are typically five dysfunctional areas that can happen in a team where there is; absence of trust or fear of conflict, lack of commitment, avoidance of accountability and inattention to results. Ss the teams are expanding and we know that a high-functioning team is necessary really to deliver on the PCMH model there should not just be an assumption that just because you have a group of people together and they all work together that is actually going to be able to be a functional team.

I saw a T-shirt once that said, "The definition of a team is a group of people doing everything I tell them to do." I thought to myself, "Hmm, there are a few people I worked with before who maybe could have benefitted from seeing that T-shirt as well."

Actual team training, having a retreat or paying attention to the teams, doing some exercises with different styles of learning or different styles of management and being able to address how does your team actually work together, kind of a building block for them – okay, now we are a high-functioning team, now we are going to go out and actually build the medical home. We really think that that is important for a lot of practices.

Okay, so we have come to sort of the end of our time together but I just want to recap to say that relationship-centered care is an important aspect that can complement the medical home. There is a large body of evidence that shows that relationship with our patients – caring relationships with our patients, social-connectedness, high functioning teams and the way our practices are connected to the community can have significant impact on patient satisfaction, provider satisfaction, health care outcomes, and actually reduce costs overall. When we are talking about trying to achieve the triple aim in health care relationship-centered care has a lot to offer.

I would like to open this now back up to – I guess we are taking a poll here. Is your practice paying attention to the development of relationship-centered care? Have you done anything in the context of building your medical homes that you think is paying attention to the development of relationship-centered care? If yes, can you share an example? Take the poll and then we are going to show the poll results, and then we will open up the phone lines again for people to talk about examples of what has worked with their – in developing elements of relationship-centered care.

Moderator: Okay, it looks like we are getting a good response rate for the poll, so I will just leave it open here a few more seconds. Then, as Margaret says, we will close the poll and share the results in just a moment.

Moderator: The lines are being unmuted now.

Moderator: Okay, it looks like the responses may have peaked, so I will close the poll and share the results.

Presenter: Okay, so 71 percent are paying attention to the development of relationship-centered care, and about a third of you are not. There is an opportunity for everybody to use the tool that we talked about and maybe give you some ideas of how you can apply the concepts of relationship-centered care in the context of your primary care environment. We are unmuted now, so would anybody like to share an example of where you have introduced relationship-centered care? If you are part of that 30 percent where you have not, and you have a question or you want to talk about maybe what you tried and it did not work we would love to hear that too.

Speaker: I am from Genesis Community Health. One way that we improve our relationship with the community around us we run what is called the Garden City Community Collaborative, which is like a partnership, like local non-profits, public health districts, some of the hospitals and stuff. It is kind of improved – like focused on improving the health and well-being of Garden City. We have seen a lot of relationships develop between us and a few of the qualified health centers, a couple of the local – like the local library, a few of the churches and also just other organizations that are working with adult education, that kind of stuff. We have been able to use those resources to turn back around and offer to our patients.

Presenter: That is great. Not only you are building those community resources, connecting to those on behalf of your patients but you are also really working on that community-building aspect. That is terrific.

Other examples of relationship-centered care? There must be at least 30 of you out there, 70 percent of the 50 people who are on the phone, so other examples of things you have done to implement relationship-centered care practices?

Speaker: Hi, I am from All Seasons Family Care Clinic. I will chime in. Good afternoon, everyone. I want to just give a couple of examples. Our clinic started out as behavioral health and we embedded primary care. When we really got into using coaching and all these resources around the patient-centered medical home we realized that the language that this multidisciplinary team was using was actually really, really holding us back. We have cross-trained the staff to understand some of the tools that were siloed, if you will, before, such as the PHQ9. Every therapist that interfaces with primary care understands the PHQ9 and has the language. We also help populate reasons for visit, referrals and participate in the huddles so we can get some of that medical language and some of what is appropriate dialed in and this is the identified patient.

We are starting to see collaboration and more of a global treatment plan. When the patients are traveling through the care system, service to service, it really we are getting a lot of feedback, that it is not as disjointed: "Oh, my doctor said that the PA – oh, I remember we talked about that." That has really helped us educate the patient about you have a team and here we are. They are seeing us.

We are trying also to coordinate concurrent treatments: behavioral health, your primary care if and when we can, if they happen to be in more extensive care and braid those together so they are also not traveling in and out of the clinic, in and out of the clinic, in and out of the clinic. That is – that is really starting to gel.

Presenter: That is great, Kelly. Thank you so much for sharing. I think the take-home message there was in order to serve your patients well you really had to navigate coming together as a team and being able to cross disciplinary cultures. I think somebody earlier on talked about the various cultural attributes of our patients, but we forget that we also are

very tribal in health care. Nurses have their own tribe and receptionists, the billers, and behavioral health and navigating those tribal differences and coming together as a true team is very important.

Thanks for that.

Anybody else want to share an example?

Moderator: Margaret? This is Lawrence real quick. We had a comment come in to the questions pane, who said that, "My organization creates opportunities for coworkers to simply have fun together. It gives us the opportunity to interact in a different way and builds relationships.

Presenter: Yes, that is a great thing to acknowledge that we work together and we work so hard. But having that opportunity to have fun there is a lot of literature that says that the single most important factor that makes us satisfied with our jobs is whether or not we have a best friend at work. Understanding those team-to-team relationships is definitely important. It is important to nurture that.

All right. Thank you

[End of Audio]