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It's All the Same – Seeing Through the Lens of the Patient

By: Abby Diehl*, Khalilah M. McCants*, Patrick H. DeLeon*

*PhD, Medical and Clinical Psychology, F. Edward Hebert School of Medicine Uniformed Services University

*Assistant Professor, Adult-Gerontology Clinical Nurse Specialist Program, Daniel K. Inouye Graduate School of Nursing Uniformed Services University of the Health Sciences

*Former President American Psychological Association

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Abstract

The healthcare delivery system is changing. A model of patient-centered interdisciplinary care is of paramount importance, which integrates primary care, behavioral, and mental health services with the social determinants of health. As the next generation of healthcare practitioners is trained, incorporating methods such as Motivational Interviewing and active listening skills are critical strategies for achieving patient-centered care. The increasing number of safety-net hospital closures not only reduces access to care for patients but also presents barriers to identifying sufficient clinical placement sites which are beneficial for training a diverse workforce in locations with a wide range of services.

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Introduction

The health care delivery system of the future will be drastically different than that experienced by our parents and grandparents. Unprecedented advances in technology such as telehealth, electronic health records, and artificial intelligence; expanding non-physician education, numbers, and scope of practices (NASEM, 2021b); and most importantly, societal expectations, will result in delivery systems that are truly patient/consumer oriented, with an emphasis upon wellness, prevention, and population-based care. The environmental and social determinants of health, which the Commonwealth Foundation reports accounts for as much as 55% of health outcomes, will, of necessity, be seriously addressed (August, 2021). Similarly, concerted efforts will be made to effectively integrate the critical behavioral/emotional mental health component of quality care into an interdisciplinary primary care model. No longer will our nation's health care systems willingly accept artificial barriers in reimbursement levels or practitioner clinical responsibilities that are not supported by data-based rationales. For ultimately, it is the patient

who decides what clinical care they will receive with well-educated practitioners essentially serving as consultants. This fundamental change in philosophy is particularly important for those individuals with disabilities, whether these be physical, emotional, or developmental.

As educators at the Uniformed Services University (USU) of the Department of Defense, we frequently ask our students: Have you ever stopped to think, what do *you* desire from your own health care? What do you want for *your* loved ones? If you had it your way, what would be the ideal health care for *you* to receive? We urge our students to actually sit down and listen to people. Ask what they want and need from their health care system. What do they say? Can you guess? First of all, they want to be listened to. They want to be understood. They want to be a person and not a diagnosis. They want to better live their lives in line with what is important to them. They do not want to suffer alone or in silence.

Recently, the National Academies of Sciences, Engineering, and Medicine presented a 2-day webinar on Implementing High-Quality Primary Care (NASEM, 2021a). "Primary care provides comprehensive, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities." At USU, during a speed mentoring workshop, one of us was asked a wonderful question: "If you had a magic wand and could change one thing about the health care system what would it be?" After a pause, she then answered "time for care providers to listen to and understand their patients." We need more time spent listening to and understanding rather than time spent being an expert, telling patients what to do. The scenario is far too common in health care. Providers frustrated their patients will not follow their expert advice. Patients left frustrated and misunderstood. Yet, we as health care providers persist and try to explain and advise 'harder'. We often think, if the information was just presented in the 'right' way or if they could 'just' understand better. However, all parties involved only become increasingly frustrated with the focus on symptoms, diagnosis, and trial treatment paradigm.

If you are not sure you believe us, try on a self-experiment for size. Ask a family member, co-worker, or friend, to talk about a change they are considering making in their life. Spend five minutes listening to them as if you are in an expert helper role, as if you have the best information to 'fix' their problem and it is critical that they understand this. Then spend another five minutes listening to them as if you are just trying to understand, as if you are a guide and they hold within themselves all the best information to solve the problem.

When providing Motivational Interviewing training and specifically discussing the Spirit of MI (Partnership, Acceptance, Compassion, and Evocation) (Miller & Rollnick, 2013), we lead medical students, graduate students, and clinical practitioners through the exercise. A shift in the mindset of how we view our conversations and relationships between care providers and care receivers is crucial to reimagining the foundation of high-quality health care. This cultural paradigm shift must begin in the foundation and become woven into and throughout health care training platforms. How might the world be different if we were listening to understand each other? This is one of the major challenges in health professions education today. Only by educating the practitioners of tomorrow in how to truly listen and to appreciate the clinical

competence of their colleagues, regardless of their discipline, in the *earliest stages* of their careers, will quality care ever be provided.

The Commonwealth Fund further reported that the United States ranked last in access to care and health care outcomes. Regarding access to care, one of the underlying elements of the social determinants of health and therefore, the key to effectively addressing the extraordinary adverse impact of Health Disparities, is ensuring that those who have been traditionally underserved have reasonable access to quality care. Their analysis found income-related disparities that served as barriers to obtaining health care, reduced debt from medical bills, and limited access to care after hours. In our Nation's Capital, Providence Hospital operated in the eastern side of the District of Columbia for more than 100 years. One of two hospitals operating on the east end of D.C., the hospital offered acute care, skilled nursing, and outpatient services to the community. It recently transitioned to an urgent care center essentially eliminating full service and emergency care from the eastern side of the District of Columbia resulting in gaps in care. Providence Hospital had a long history effectively serving a vulnerable population where 75% of those treated there were residents of the District of Columbia, and an estimated 50% carried Medicaid. This closure also exhausted the neighboring hospital's resources. Providence hospital had served as a full-service facility since its inception in 1896 when Congress approved a contract between Washington, D.C. and Providence to support destitute patients with medical treatment. At the time, the anticipated patient census was 1,319 with a $19,000 budget.

Another hospital in the D.C. area that terminated operating as a full-service hospital was D.C. General, which now functions as a homeless shelter. D.C. General was the first public hospital in the area treating patients with behavioral disorders and those convicted of minor crimes. It would later serve as a smallpox hospital. In 1953, it was named D.C. General Hospital and served the indigent population. However, it eliminated inpatient services in 2001.

It has been our observation that many public hospitals nationwide have been absorbed by nonprofit university hospitals or acquired by private entities. What are their real priorities? Traditionally, public hospitals provide free care to indigent populations through taxpayer dollars; for many, they are the true 'safety net' envisioned during President Lyndon Johnson's Great Society Era. D.C. General reported over 51,000 ER visits in 1999. Reflecting beyond patient care, closures of public hospitals directly impact the community's ability to produce a diverse workforce, including providers of care and a wide range of supportive services. They also serve as an outstanding locus for a wide range of health professional students and residents meeting academic requirements with the likelihood that upon graduation, these providers will return to help this impoverished community (Walker et al., 2008).

In exploring the social determinants of health, these closures must be considered a major loss to residents in those communities, especially those individuals and families without transportation to commute to another emergency room or inpatient unit in the middle of the night. The unfortunate closures compound the already strenuous issue of access to integrated care. These issues highlight the importance of the long-term role and responsibilities of State Health Planning and Development Agencies (SHPDA). They are responsible for developing a

comprehensive Health Systems Plan (HSP) which, informed by a comprehensive needs assessment, will result in providing equitable and accessible care to residents working with Departments of Health and others to guide providers and policy-makers on evidence-based strategies for treating the target population and closing gaps in care.

Concluding Observations

The challenge with accessing quality and integrated care for people with complex needs who find themselves infirmed is that this population contends with a health care system transitioning from provider-driven to patient-centered models. When policymakers determine that historically provided services offered to the community, at little to no cost, will be no longer available, the impact affects patients; and students working toward a clinical practicing degree, not to mention entire communities. As a result, the workforce does not get replenished with new culturally sensitive knowledgeable providers. Another consequence of service termination is the strain on neighboring facilities where resources often become exhausted. And, informing the work clinicians do to reduce health disparities starts with listening to other disciplines and, most importantly, the patient/consumer. In this way, clinicians can better support the community during the transition. Ultimately, the patient/consumer decides what clinical care they will receive with well-educated practitioners essentially serving as consultants. If these health care consultant providers are not empowered with the necessary communication skills, the envisioned new paradigm of patient-centered care is doomed before it can be fully realized. We must teach and practice active listening. And, we must come together inter-professionally to do so.

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