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“What Matters to You?” Supporting Evidence Review



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What Matters to You?

Executive Summary

Background

The concept of asking “What Matters to You?” (WMTY) to the people we care for, has gained momentum globally over the past several years. International “What Matters to You?” Day was first launched in Norway in 2012 and has since spread to 4 continents. In an essay published in the British Medical Journal in 2014 and during a keynote address at the Institute of Healthcare Improvement (IHI) National Forum, Maureen Bisognano, the former president of IHI, encouraged providers to shift healthcare from “What’s the Matter” to “What Matters to You?” She emphasized the impact on quality outcomes and healthcare costs that understanding patient priorities, including social determinants of health needs, can have when incorporated into care planning to provide truly patient-centered care. The impact of this strategy was demonstrated in Scotland, by Geraldine Marsh and her team, on four geriatrics wards at National Health Service Greater Glasgow and Clyde Hospital, where implementation of WMTY resulted in improved patient satisfaction as evidenced by a 50% reduction in formal complaints, improved safety measures including a 43% reduction in falls and significantly improved staff engagement and sense of purpose (Vackerberg, Levander, and Thor, 2016).

This document seeks to organize the evidence base for WMTY. We have structured our review around ten domains that we feel capture foundational elements of patient-centered care. The following executive summary provides an overview of the evidence supporting each domain organized into chapters.

Chapter 1: Importance of Empathetic Communication and Compassionate Care.

The landmark Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) included patient-centered care as one the six “Aims for Improvement”. The IOM report defined patient-centered care as “providing care that is respectful of, and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions.” Compassionate care is foundational to patient-centered care. In 2015, the Schwartz Center for Compassionate Healthcare interviewed 35 CEOs and senior leaders at 35 U.S. hospitals and health systems known for their commitment to compassionate care and patient experience improvement initiatives, including Montefiore’s own Dr. Steven Safyer. The resulting White Paper, called “*Building Compassion into the Bottom Line: The Role of Compassionate Care and Patient Experience in 35 U.S. Hospitals and Health Systems*” (2015) highlights the benefits of developing a compassionate workforce including lower staff

turnover, greater patient loyalty and reduced costs. Caregivers who are able to express compassion have greater job satisfaction, less stress and a greater sense of teamwork, and patients who are treated compassionately benefit from improved quality of care, fewer medical errors, better health and a deeper connection with their caregivers. Press Ganey in their 2017 Strategic Insights Report, *Achieving Excellence: The Convergence of Safety, Quality, Experience and Caregiver Engagement*, also found a positive correlation between hospitals with better safety and patient experience performance and better financial margins (Bailey, 2017; Lee, 2017).

In the first chapter of this document we share additional literature supporting the importance of empathetic communication and compassionate care. Compassionate care also involves having self-compassion (Raab, 2014). As medical students progress through their training to residency and early-state physicians, there is evidence that compassion fatigue may occur (Burks and Kobus; 2012; Raab, 2014). Therefore, strategies to promote compassion for patients while also engaging frontline staff in self-care activities are crucial (McQueen, 2004).

Additionally, Bronkhorst et al. (2015) found that both a positive work environment and good team dynamics were predictive of better psychosocial health (i.e., less depression and anxiety) and less burnout amongst staff.

Chapter 2: **Programs to Promote Compassion.**

In Chapter 2 of this report, we explore the evidence behind successful programs to promote compassion. Aligned organization culture is paramount to achieving compassionate care. Using tools such as the powerful "[Empathy: The Human Connection to Patient Experience](#)" video (Cleveland Clinic, 2013), organizations such as the Cleveland Clinic have successfully shifted workforce culture resulting in staff who routinely portray empathy and compassion in their daily work as caregivers (Merlino and Raman, 2017). Patients have reported that having "appreciative caring conversations" with staff improve their healthcare experiences (Dewar and Nolan, 2013). Additionally, programs that emphasize empathic and prosocial clinical care are recommended (Burks and Kobus, 2012). Programs to promote compassion, including mindfulness, self-reflection, and emotional intelligence are needed, and, when implemented, have demonstrated improvement in staff well-being (Burks and Kobus, 2012; Krasner et al., 2009; Suchman et al., 1997). The literature also reveals an opportunity to align one of the most important qualities associated with being a good physician (namely "empathy") with opportunities for career advancement and promotion (Carmel, 1996.)

Dr. Shalom Kalnicki, Chair and Professor, Department of Radiation Oncology, and a 2017 recipient of the Montefiore Presidents' award is an inspirational leader and role model who embodies and promotes compassionate care for both his patients and staff. Dr. Kalnicki's dedication to compassionate care was captured in a [recent article highlighting Montefiore-Einstein's own Comprehensive Cancer Center](#), where he said that "*our focus is the patient and their support system, not just the cancer.*" During a recent meeting of our Patient Experience Workgroup, Dr.

Kalnicki eloquently emphasized the importance of caring for ourselves and staff to be able to provide empathy to patients. He said “*we need to have internal peace and frame of mind to be able to accept someone else’s suffering in a way that can really help them*” and “*to form cohesive teams that can work well together.*”

Chapter 3:

Motivational Interviewing, Brief Action Planning and Shared Decision Making to Promote Change, Build Self-Efficacy and Improve Patient Engagement

Patient engagement and activation have been identified as the “blockbuster drug of the century” (Kish, as cited in Dentzer, 2013). Asking “What Matters to You?” is evocative in that it pulls out what is most important to the person at a specific point in time. It “elucidates patient priorities, social determinants of health, and potential barriers and facilitators for improving health (Kebede, 2016; Laurance, et al., 2014) and helps us to understand patients’ concerns, and why their priorities may not directly match the health priorities identified by their care team.” Actively listening to “what matters most” and incorporating it into care planning is a cornerstone of patient-centered compassionate care.

In the third edition of their groundbreaking book, *Motivational Interviewing: Helping People Change* 2012, Miller and Rollnick describe the four foundational elements that comprise the “Spirit of Motivational Interviewing” - Compassion, Acceptance (Supporting Autonomy), Partnership and Evocation. These constructs are the key to patient engagement and help build patient self-efficacy for change. In Chapter 3 of this report we review key evidence supporting these four foundational elements, and also share highlights of the relevant patient-centered goal setting and shared decision-making literature. Additionally, through other techniques such as motivational interviewing and brief-action planning, providers can work alongside patients on establishing and reaching their health goals (Gutnick et al., 2014; Knight et al., 2006; Kouwenhoven-Pasmooij, et al., 2018). Through listening to what matters to patients, as well as building patient self-efficacy, patients may then have a stronger relationship with their provider, and may, in turn, be more engaged in their care.

Chapter 4:

Focus on WMTY in Addressing Social Determinants of Health.

In Chapter 4 of this report we focus on the role WMTY can play in addressing social determinants of health.

Asking about what is most important to a patient often uncovers social determinants of health needs. Extensive evidence supports the potential impact of addressing social determinants on costs of care and patient wellbeing (depression, etc.). In order to improve patient outcomes while reducing costs, the healthcare system must be fully integrated, and stakeholders (including healthcare providers and staff) must be prepared to address and/or provide referrals for drivers of preventable hospital use (chiefly, social determinants of health). Social determinants of health,

(i.e., food insecurity, poverty, lack of access to adequate care and/or insurance, transportation, loneliness, etc.) have been thoroughly documented as negatively impacting patient outcomes (Axelson et al., 2018; Lax et al., 2017). Additionally, as healthcare transitions to a value-based payment system, and as social determinants of health (SDH) have been found to overwhelmingly impact patient outcomes, making sure the healthcare workforce is adequately prepared, informed, and able to deliver care as well as provide referrals as needed, is also imperative (Pettignano et al., 2017; Pinto & Bloch, 2017).

Chapter 5: **Burnout as an Impediment to Empathy and Compassion.**

In **Chapter 5** of this document we explore the literature around burnout as a potential impediment to empathetic and compassionate care.

Although adequately addressing patients' SDH will ultimately improve patient outcomes, it may pose a challenge to staff and providers who may be feeling overwhelmed and under-resourced. Healthcare staff and providers are susceptible to burnout, and burnout can adversely impact both provider's satisfaction at work and job tenure (i.e., staying in the healthcare field) (Raab, 2004; Sabo, 2011; Sanchez-Reilly et al., 2013). Burnout has also been linked to a higher rate of provider mistakes, reduced patient satisfaction, and even to longer post-discharge recovery times, (Halbesleben and Rathert, 2008; Shanafelt, 2009). Therefore, it is also important to identify organizational strategies, programs, and techniques that holistically train staff and providers to be empathic but resilient. In terms of assessment, it is also vital to measure healthcare staff and provider wellness (Hojat, ; 2004; Olayiwola, et al., 2018).

The impact of burnout on the healthcare workforce is a hot topic in the news today because physician burnout rates are climbing. A national survey study by Shanafelt et. al. (2015) reported that fifty-four percent of physicians were burnt out (up from 45.5% in 2011). Sinsky (Mayo Clin Proc. 2017) reported that nearly 1 in 5 US physicians intended to reduce clinical work hours and roughly 1 in 50 intended to leave medicine altogether because of drivers related to burnout. Early analysis of our own MHVC Provider and Staff Cultural Competence and Health Literacy staff engagement survey (1930 staff from 46 organizations) supports these findings. In our survey which included diverse staff roles ranging from front line clinicians to senior leadership, we found that 6% of staff were burnt out and an additional 57% are at high risk, using standard Maslach Burnout Inventory criteria. Our findings further suggest that frontline staff (i.e., social workers, nurses) are at the greatest risk for burnout and drivers of burnout include workload, burden of documentation, ineffective team work, absence of efficient workflows and lack of "joy" in work.

In order to achieve the Quadruple Aim, innovations in healthcare are vital. The fourth part of the Quadruple Aim is to build a resilient, empathic, and resourceful workforce across the healthcare system (Bisognano & Schummers, 2014; McQueen, 2004; Shanafelt, 2009). In his 2017 JAMA article, "The Business Case for Investing in Physician Wellbeing," Shanafelt et al. explores the

potential for return on investment related to bringing “Joy to Work” for physicians emphasizing the health system costs related to increased staff and physician turnover. The 2018 AMA Steps Forward module “Preventing Physician Burnout” outlines seven key steps health systems can take to prevent provider burnout. Additionally, this module includes a ten-item survey that assesses burnout and shares examples of successful burnout prevention programs in a variety of practice settings. Furthermore, this website introduces the [AMA’s Organizational Costs of Physician Burnout calculator](#). Assuming a physician workforce of 1000, a 54% rate of burnout and a 7% turnover rate, burnout contributes to excessive costs to the Montefiore Health System upwards of 13 million dollars annually.

The same issues that drive burnout also diminish “Joy in Work” for the healthcare workforce. Evidence supports a strong relationship between staff engagement and the ability to impact patient experience. The IHI recently released a framework for improving joy in work (Perlo et al., 2017) that involves asking staff what matters to them, engaging staff by addressing immediate concerns that can be easily resolved, involving all stakeholders in pursuing systems-level solutions, and drawing upon principles of improvement science to evaluate and establish strategies that are effective and sustainable.

Chapter 6:

Programs to Teach and Encourage Assessment of WMTY in Practice.

In Chapter 6 we explore the evidence around programs to teach and encourage assessment of WMTY in practice. There are several ways that providers can use to assess WMTY in practice, including promoting patient self-management and shared decision-making. Patient self-management involves promotion of patients’ sense that they are capable of achieving health goals (e.g., self-efficacy), along with providing the education, knowledge, and skills needed to manage their own condition (Bodenheimer, Lorig, Holman and Grumbach, 2002). A provider can also use brief action planning (Gutnick et al., 2014) to help a patient set an achievable goal towards improving their health.

Through asking patients “What Matters to You?” providers can uncover potential barriers and facilitators for self-management (Lang et al., 2017). For example, a provider may learn that social isolation due to inability to work, is what really matters to a patient with chronic debilitating pain. In this case, “doing” what matters” might include supporting patient self-management goals related to connecting to a personal support system rather than prescribing additional pain medication. Similarly, by asking WMTY, a provider may discover that a patient’s presumed resistance is actually a result of unidentified fears, social determinants or knowledge gaps. Learning for example that presumed reluctance to adhere to a diabetic diet or weight loss program may actually stem from a patient being self-conscious about going to the gym, food insecurity or not understanding how to prepare healthy meals.

The shared decision-making model takes patients out of the role of passive recipient, and treats them as vested partners in achieving healthcare goals. Alegria et al. (2018) examined shared decision-making and quality of care in culturally diverse populations, and found that shared-decision making improved patient-perceived quality of care.

The evidence supporting “[Minimally Disruptive Medicine \(MDM\)](#)” (Leppin, Montori and Gionfriddo, 2015) is also featured in Chapter 6. In his captivating [TED talk entitled “The Proposal for a Patient Revolution,”](#) Dr. Victor Montori, professor of medicine at the Mayo Clinic and a health services researcher recognized for his expertise in evidence-based medicine and shared decision making, uses a patient story (John) to emphasize how the burden of managing complex chronic conditions and comorbidities reduces a patients’ capacity to collaborate in their care (May, Montori and Mair 2009).

The MDM Care Model is a patient-centered approach to care that focuses on achieving patient goals for life and health while imposing the smallest possible treatment burden on patients’ lives. The model seeks to facilitate legitimate patient partnership by respecting patient values and preferences and considering ways to acceptably fit health care into the larger purpose of their lives. In a sense, the MDM model identifies “what matters most” to patients and incorporates WMTY into care planning to minimize the burden and maximize the benefit of chronic disease self-management. Foundational elements of the MDM model include: 1. Acknowledging the hard work required by the patient to manage a chronic disease and how this work impacts the individuals “whole” life, 2. Acknowledging the patient’s capacity and resilience to manage their own chronic disease (in physical, mental, social, financial, personal and environmental domains). 3. Acknowledging the complexity of managing a chronic disease and 4. Integrating the inputs (workload, capacity and complexity as they relate to affect patient outcomes) to address the complex ways in which relevant factors exist and interact: requiring wisdom and empathy is the key to the model.

Another component of assessing WMTY in practice is working with other stakeholders (e.g., social workers, attorneys, job readiness coaches, and other staff from community agencies) to address patient needs. Hansen and Metzl (2017) posit that interdisciplinary partnerships are crucial to addressing patient needs comprehensively and improving patient outcomes. As healthcare providers are being increasingly held accountable to quality metrics, addressing social determinants of health that drive lack of engagement are crucial considerations. Medical students must be trained to ask and respond to WMTY using the full range of available interventions, referrals and resources (Krishnaswami et al., 2018). Through WMTY training programs, providers can shift the conversation to uncovering and addressing broader needs that impinge on patients’ health goals. This will help to establish more effective care arrangements and will strengthen positive relationships between patients and providers.

Chapter 7: Assessment of “What Matters” to Patients.

In Chapter 7 of this report we review evidence related to available assessments to evoke from patients what matters to them. Additionally, we provide insights into how patients define their own health priorities and patient-reported outcomes. Patient-reported outcomes have been identified as centrally important in the world of healthcare (Katz et al., 2000). Without engaging patients fully into determining health priorities and self-reported outcomes, providers may not focus on what is most important to the patient, and may also be unaware of challenges that the patient faces. For example, disease-specific measures capture impact of illness and treatment that are missed by more global measures. Consider that salient aspects of quality of life scale are very different for a person with spinal cord injury than for a person living with lupus. In order to develop disease specific assessment, Tulsky et al. (2015) were able to identify health-related quality of life (HRQOL) priorities that are specific to spinal cord injury by engaging adults with spinal cord injury through focus groups, interviews, and surveys. Similar approaches have been employed with other patient populations (Morganstern et al., 2011; Panepinto et al., 2012). For many patients and especially for more dependent patients, both caregiver and patient perspectives should be considered to uncover HRQOL disease-specific priorities. For example, for pediatric patients with eosinophilic esophagitis (Franciosi et al., 2012), caregivers and pediatric patients identified both common and distinct health-related quality of life dimensions.

Beyond population and disease-specific factors, what matters to a patient can vary from person to person even within the same chronic condition/disease, and can change over time as the person experiences progression of illness, treatment side effects, remission or recovery (Li and Rapkin, 2009). Rapkin and colleagues have developed idiographic methods to take into account the fluid nature of concerns that affect individuals' health and well-being (Rapkin and Fisher, 1992). With idiographic methods, individuals are prompted to identify the life events, concerns and goals that are most important to them at any point in time. Through this idiographic (or self-written) process, each individual generates items that reflect the dimensions of quality of life that matter most to him or her at a particular time. Individuals ratings of these self-generated reflect quality of life on their own terms. Studies have shown that idiographic measures are complementary to traditional disease specific measures, and reflect more positive aspects of well-being as opposed to illness and loss (DuMont et al., 1999). Qualitative methods are used to code the themes that individuals mention at each point in time, so that analyses of outcomes can take into account differences in what patients consider to be important to their quality of life. For example, a pain medication that causes serious fatigue may be acceptable to a patient concerned with remaining comfortable but not to patient who wants to return to work or take care of grandchildren. It is not possible to accurately measure patient-reported outcomes of an intervention without addressing differences in what matters to different individuals (Rapkin and Fisher, 1992; Rapkin et al., 1993).

Lastly, Chapter 7 includes evidence supporting co-design to integrate patient preferences into the delivery system re-design process. Experience-based co-design (EBCD), integrates service

design methodology and principles of narrative-based research to improve patient and staff experience of care and has been adapted widely and demonstrated to improve patient experiences as well as healthcare workforce culture, values and behaviors. (Van Citters, 2017).

Chapter 8: **Assessment of Patient Satisfaction with Care.**

Chapter 8 of this report reviews evidence related to tools that can be used as assessments of patient satisfaction with care. Rapkin et al. (2008) created an idiographic Dynamics of Care (DoC) assessment that measures health-seeking behaviors, barriers, and perceptions of their healthcare treatments and services. The DoC assessment uncovered that satisfaction with care tends to be episode/situation-specific. For example, in a sample of persons living with HIV/AIDS, patients' ratings of the quality of communication with a provider around medication side-effects may differ greatly from their ratings of the same provider in regard to sexual health and risk. It is important to examine patient satisfaction as contextually-driven and sensitive to individual criteria and goals of care. Abrahamsen Grøndahl et al. (2013) also found that some of the biggest predictors of patient satisfaction were patient education, psychosocial health, and stress management skills.

Patient-centered care has been identified as the gold standard for improving patient outcomes and patient satisfaction (Barry and Edgman-Levitin, 2012; Cleary and McNeil, 1988). Planetree, Patient-centered care has been identified as an approach that can actually improve employee retention, reduce vacant positions, and create higher employee satisfaction (The Beryl Institute, 2018; Coulmont and Dumas, 2013). The Beryl Institute is a global community of practice dedicated to improving the patient experience through collaboration and shared knowledge. Beryl's recent inaugural report, *Consumer Perspectives on Patient Experience 2018*, shares the perspectives of 2,000 healthcare consumers across four continents on the patient experience.

Chapter 9: **Assessment of Provider Empathy and Skill at Addressing WMTY.**

Chapter 9 of this report reviews the literature around assessments of providers' empathy and skill at addressing WMTY. A significant part of empathy includes active listening, understanding, and compassionate communication. Additionally, in addressing what matters to patients, certain effective communication characteristics have included collaboration, credibility, compassion and coordination (Apker et al., 2006). Therefore, it is not only important that frontline providers demonstrate empathy to patients, but also working collaboratively with team members. It has been noted that while physician empathy has been identified as the most important quality of a "good" physician, it was ranked as the least important quality for career promotion and advancement (Carmel and Glick, 1996). While training frontline staff is imperative, the literature speaks also to the importance of creating a systemic change in healthcare for compassionate care and empathic staff (Crawford et al., 2014). It should also be noted that empathy is believed to be

a teachable skill, and relevant empathy trainings should be included in medical school and residency (Benbassat and Baumal, 2004). Several educational programs are proposed in Axelson, Stull, and Coates (2018) recent article about addressing social determinants of health in the emergency department. Axelson et al. (2018) recommend education about community agencies and resources that address social determinants of health, including social determinants of health topics in Morbidity and Mortality conferences and poverty simulation training. Given this evidence, the Montefiore Hudson Valley Collaborative has implemented Blueprint for Health Equity Poverty Simulation programming as part of our Cultural Competency Health Literacy Strategy.

Chapter 10: **Impact of “Asking,” “Listening,” and “Doing” What Matters.**

Finally, in **Chapter 10** we share early literature supporting the impact of “asking” “listening” and “doing” What Matters. This is a relatively new area of inquiry which our MHVC Research, Workforce and Quality teams aim to contribute to in the future through our pilot work with partners to systematically capture the impact of WMTY on quality and Patient Experience (HCAHPS, CAHPS) measures. In order to successfully transform the healthcare system, interventions must be systemic in nature and supported by leadership (Uchino et al., 2015). We have included some examples of what successful integration and implementation of a “What Matters to You?” movement may look like, including promoting joy in work, reducing staff burnout, addressing social determinants of health, including patients as partners in their healthcare, improving patient experience, addressing patients’ needs, and ultimately, improving the quality of care and patient outcomes (DiGloia et al., 2016; Lang et al., 2017).

Experience-based co-design (EBCD), referenced in Chapter 7, has also demonstrated the value of incorporating “What Matters” to patients into health care delivery system redesign efforts. For example, EBCD has been associated with reductions in formal complaints in a mental health ward; increases in the percent of patients with cancer who report always being treated with respect and dignity; and greater emergency department staff appreciation for how health care practices and environments affect patients.

The Esther model (Vackerberg, 2016 and Gray, 2016), uses continuous quality improvement, cross-organizational communication, problem-solving and staff training to provide the best care for elderly patients with complex care needs. The model provides an example of a successful ongoing redesign effort that incorporated consumer voice to improve patient flow through the care system. A composite patient persona - that is “Esther” - was created to represent elderly persons with complex care needs that involved a variety of providers. Creating a persona for the patient helps care givers focus on the needs, preferences, hopes and concerns of real people who need care. With Esther’s experience in mind, an extensive series of workshops and interviews identified redundancies and gaps in the medical and community care systems and guided the development of action plans for improvement. Early on, design team members focused on “What does Esther need? Over the years, the focus shifted to “What does Esther want? and

"what is important for Esther when she is not well? . . . in other words "What matters to Esther?" Implementation of the Esther model contributed to significant reductions in medical department admissions, decline in medical and geriatric hospital bed days and 30 day readmissions rates for patients age 65 and older. It is important to note that the Esther evaluation strategy was not a research project and that the Esther model was part of a multifaceted change program.

During DSrip's early years, our MHVC team and network partners co-developed composite "Esthers" for each of our DSrip projects (cardiovascular disease, asthma, behavioral health integration and crisis). Because each stakeholder workgroup member agreed to prioritize what was best for the patient above their own organizational needs (keep "what matters" to Esther front and foremost), we found that the use of patient "Esthers", facilitated engagement and creative problem solving between diverse stakeholders.

According to Eric Coleman, M.D., M.P.H., director of the Care Transitions Program at the University of Colorado Denver, the Esther approach not only represents an innovative approach to coordination across care settings but addresses another element of care that the U.S. struggles with: operationalizing person-centered or person-directed care. Coleman believes that in the U.S., the model could "perhaps shift from the question 'What is best for Esther?' to simply asking Esther what she believes would be best for her."

Chapter 1

Importance of Clinician Empathy and Compassion

[A Schwartz Center for Compassionate Healthcare White Paper. \(March 2015\).Building Compassion into the Bottom Line: The Role of Compassionate Care and Patient Experience in 35 U.S. Hospitals and Health Systems.](#)

ABSTRACT: According to interviews with CEOs and senior leaders at 35 U.S. hospitals and hospital based health systems known for their patient experience improvement initiatives and commitment to compassionate care: Organizations that place a high priority on delivering compassionate care benefit from lower staff turnover, higher retention, recruitment of more highly qualified staff, greater patient loyalty and reduced costs from shorter lengths of stay, lower rates of rehospitalization, better health outcomes, and fewer costly procedures. Caregivers who are able to express compassion for patients, families and each other experience higher job satisfaction, less stress, and a greater sense of teamwork. Patients who are treated compassionately benefit from improved quality of care, better health, fewer medical errors, and a deeper human connection with their caregivers. Factors Most Critical to Compassionate Care*

1. Capable and dedicated champions.
2. Departments or care groups that model compassionate care.
3. Visible support from the CEO and other senior leaders.
4. Making patient experience scores transparent.
5. Dedicated patient experience officer.
6. Substantial budget devoted to patient experience and compassionate care.

*Based on a survey of 67 Schwartz Center Rounds clinician leaders conducted as part of this project

[Bailey, D. \(2017\). Value-Based Care Alone Won't Reduce Health Spending and Improve Patient Outcomes. *Harvard Business Review*.](#)

Retrieved from: <https://hbr.org/2017/06/value-based-care-alone-wont-reduce-health-spending-and-improve-patient-outcomes>

Nemours Children's Health System has found that while a value-based care approach can decrease the costs of care for children with chronic conditions (when compared with a traditional fee-for-service model), transitioning to a value-based model involves added infrastructure and training costs. There's also the complexity of delivering care in an industry that mixes together fee-for-service and value-based reimbursement. To deliver on the promise of improved health and reduced spending, value-based care must be augmented with a structured approach to eliminating waste, such as Lean innovation methods. Moreover, value-based care is most effective when delivered in conjunction with efforts to mitigate broader issues that create problems for patients, such as lack of transportation, inadequate housing, and inability to read prescriptions.

[Berwick, D. M. \(2016\). "Era 3 for medicine and health care." *JAMA* 315\(13\): 1329-1330.](#)

Retrieved from: <https://jamanetwork.com/journals/jama/fullarticle/2499845>.

Constant conflict roils the health care landscape, including issues related to the Affordable Care Act, electronic health records, payment changes, and consolidation of hospitals and health plans. The morale of physicians and other clinicians is in jeopardy. One foundational cause of the discord is an epic collision of 2 eras with incompatible beliefs.

Bisognano, M. and D. Schummers (2014). "Flipping healthcare: an essay by Maureen Bisognano and Dan Schummers." *BMJ: British Medical Journal (Online)* 349: g5852.
Retrieved from: <https://www.bmjjournals.org/content/349/bmj.g5852/rapid-responses>

Maureen Bisognano and Dan Schummers argue that to meet today's health care challenges, we need to flip our thinking to develop innovative models of care that can improve health, improve care delivery, and lower costs — the goals of the Triple Aim. The article describes pioneering examples of "flipped health care" that put control in the hands of patients, leverage the power of teamwork, and engage communities in promoting health.

Bronkhorst, B., Tummers, L., Steijn, B., and Vijverberg, D. (2015). Organizational climate and employee mental health outcomes: A systematic review of studies in health care organizations. *Health Care Management Review*. Jul-Sep; 40(3):254-71.

Retrieved from: doi: 10.1097/HMR.0000000000000026.

BACKGROUND: In recent years, the high prevalence of mental health problems among health care workers has given rise to great concern. The academic literature suggests that employees' perceptions of their work environment can play a role in explaining mental health outcomes.

PURPOSES: We conducted a systematic review of the literature in order to answer the following two research questions: (1) how does organizational climate relate to mental health outcomes among employees working in health care organizations and (2) which organizational climate dimension is most strongly related to mental health outcomes among employees working in health care organizations?

METHODOLOGY/APPROACH: Four search strategies plus inclusion and quality assessment criteria were applied to identify and select eligible studies. As a result, 21 studies were included in the review. Data were extracted from the studies to create a findings database. The contents of the studies were analyzed and categorized according to common characteristics.

FINDINGS: Perceptions of a good organizational climate were significantly associated with positive employee mental health outcomes such as lower levels of burnout, depression, and anxiety. More specifically, our findings indicate that group relationships between coworkers are very important in explaining the mental health of health care workers. There is also evidence that aspects of leadership and supervision affect mental health outcomes. Relationships between communication, or participation, and mental health outcomes were less clear.

PRACTICAL IMPLICATIONS: If health care organizations want to address mental health issues among their staff, our findings suggest that organizations will benefit from incorporating organizational climate factors in their health and safety policies. Stimulating a supportive atmosphere among coworkers and developing relationship-oriented leadership styles would seem to be steps in the right direction.

Committee on Quality Health Care in America, Institute of Medicine. (2001) *Crossing the Quality Chasm: a New Health System for the 21st Century*. Washington, D.C.: National Academy Press

This report from the Institute of Medicine focuses on closing the quality gap between what we know to be good health care and the health care that people actually receive. The report recommends a redesign of the American health care system by providing six "Aims for Improvement": Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, Equity. These principles set forth a specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others to improve the US health care system.

Drenkard, K., Swartwout, E., Deyo, P., and O'Neil, M. (2015) Interactive care model: a framework for more fully engaging people in their health care. *Journal of Nursing Administration*. 45(10): 503–510.

Transformation of care delivery requires rethinking the relationship between the person and the clinician. The model described provides a process to more fully engage patients in their care. Five encounters include assessing capacity for engagement, exchanging information and choices, planning, determining interventions, and evaluating the effectiveness of engagement interventions. Created by researchers and validated by experts, implications for practice, education and policy are explored.

Larson, E.B, and Yao, Y. (2005). Clinical empathy as emotional labor in the patient–physician relationship. *JAMA*, 293:1100–1106.

Empathy should characterize all health care professions. Despite advancement in medical technology, the healing relationship between physicians and patients remains essential to quality care. We propose that physicians consider empathy as emotional labor (i.e., management of experienced and displayed emotions to present a certain image). Since the publication of Hochschild's *The Managed Heart* in 1983, researchers in management and organization behavior have been studying emotional labor by service workers, such as flight attendants and bill collectors. In this article, we focus on physicians as professionals who are expected to be empathic caregivers. They engage in such emotional labor through deep acting (i.e., generating empathy consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the method-acting tradition used by some stage and screen actors), surface acting (i.e., forging empathic behaviors toward the patient, absent of consistent emotional and cognitive reactions), or both. Although deep acting is preferred, physicians may rely on surface acting when immediate emotional and cognitive understanding of patients is impossible. Overall, we contend that physicians are more effective healers—and enjoy more professional satisfaction—when they engage in the process of empathy. We urge physicians first to recognize that their work has an element of emotional labor and, second, to consciously practice deep and surface acting to empathize with their patients. Medical students and residents can benefit from long-term regular training that includes conscious efforts to develop their empathic abilities. This will be valuable for both physicians and patients facing the increasingly fragmented and technological world of modern medicine.

McQueen, A. C. (2004). "Emotional intelligence in nursing work." *Journal of Advanced Nursing* 47(1): 101-108.

Retrieved from: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2648.2004.03069.x>

BACKGROUND: Emotional labor has been widely accepted in the literature as part of nursing work, however the contribution of emotional intelligence in the nursing context requires further study. **AIM:** This paper aims to present an analysis of the literature on emotional intelligence and emotional labor, and consider the value of emotional intelligence to nursing.

METHOD: A literature search was undertaken using the CINAHL and MEDLINE databases. Search terms used were 'emotions', 'intelligence', 'emotions and intelligence' and 'emotional labor'. A hand-search of relevant journals and significant references added to the data.

RESULTS: Emotional intelligence plays an important part in forming successful human relationships. Emotional labor is important in establishing therapeutic nurse-patient relationships but carries the risk of 'burnout' if prolonged or intense. To prevent this, nurses need to adopt strategies to protect their health. The potential value of emotional intelligence in this emotional work is an issue that still needs to be explored.

CONCLUSIONS: Analysis of the literature suggests that the modern demands of nursing draw on the skills of emotional intelligence to meet the needs of direct patient care and co-operative negotiations with the multidisciplinary team. The significance of this needs to be recognized in nurse education. The link between emotional intelligence and emotional labor is a fruitful area for further research. The potential benefits of gaining a better understanding of how these concepts interact is largely conjecture until we have more evidence. The prospect that there may be advantages to both nurses and patients is a motivating factor for future researchers.

Perlo, J., Balik, B., Swensen, S., Kabcenell, A., Landsman, J., and Feeley, D. (2017) IHI Framework for Improving Joy in Work. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement;

Retrieved from: www.ihi.org

With increasing demands on time, resources, and energy, in addition to poorly designed systems of daily work, it's not surprising health care professionals are experiencing burnout at increasingly higher rates, with staff turnover rates also on the rise. Yet, joy in work is more than just the absence of burnout or an issue of individual wellness; it is a system property. Burnout leads to lower levels of staff engagement, patient experience, and productivity, and an increased risk of workplace accidents. Lower levels of staff engagement are linked with lower-quality patient care, including safety, and burnout limits providers' empathy — a crucial component of effective and person-centered care. So, what can health care leaders do to counteract this epidemic? IHI believes an important part of the solution is to focus on restoring joy to the health care workforce. This white paper is intended to serve as a guide for health care organizations to engage in a participative process where leaders ask colleagues at all levels of the organization, "What matters to you?" — enabling them to better understand the barriers to joy in work, and co-create meaningful, high-leverage strategies to address these issues. The white paper describes the following: The importance of joy in work (the "why"); Four steps leaders can take

to improve joy in work (the “how”); The IHI Framework for Improving Joy in Work: nine critical components of a system for ensuring a joyful, engaged workforce (the “what”); Key change ideas for improving joy in work, along with examples from organizations that helped test them; and Measurement and assessment tools for gauging efforts to improve joy in work.

Press Ganey (2017). Strategic Insights Report. Achieving Excellence: The Convergence of Safety, Quality, Experience and Caregiver Engagement.

Retrieved from: http://healthcare.pressganey.com/2017-Strategic-Insights?s=White_Paper-PGHero

Value-based, patient-centered care is the ideal to which today’s hospitals and health systems aspire. Such care is not only essential to meeting patients’ needs and expectations, it is also the key to competitive success in the new, consumer-driven health care marketplace. To make meaningful progress on this journey, health care leaders must recognize patient-centered care as a dynamic, multifaceted concept that reflects the safety, quality and experience of care and the engagement of the physicians, nurses and employees who are responsible for its delivery. Research has consistently demonstrated that each of these elements—safety, quality, experience of care and caregiver engagement—contributes to the patient centeredness of care. The findings from new cross-domain analyses suggest that these elements also are highly interrelated with one another and with financial outcomes, and that the most successful organizations are those that are able to achieve optimal performance across all of them. Specifically, the research indicates the following:

- The safety and quality of care influence patients’ perceptions of their care experience.
- Patient experience of care and the safety and quality of care are associated with the engagement level of the health care workforce.
- Both workforce engagement and patient experience of care influence organizations’ financial performance.

Excellence across these domains requires a robust, high-performing organizational culture defined by aligned leadership, a capable and competent workforce, a supportive and positive work environment, an unrelenting focus on eliminating patient harm, a shared commitment to reducing suffering, and accountability and transparency at all levels. Achieving this objective requires investing the time, energy and resources needed to nurture a healthy organizational culture. To that end, leaders must embrace, define and clearly communicate goals for performance on indicators of care safety, quality and experience; provide caregivers with the tools, guidance and support they need to reach those goals; and continually measure and monitor progress toward the goals in order to drive and sustain improvement.

Raab, K. (2014). "Mindfulness, self-compassion, and empathy among health care professionals: a review of the literature." *Journal of Health Care Chaplaincy* 20(3): 95-108.

Retrieved from: <https://www.tandfonline.com/doi/abs/10.1080/08854726.2014.913876>

The relationship between mindfulness and self-compassion is explored in the health care literature, with a corollary emphasis on reducing stress in health care workers and providing compassionate patient care. Health care professionals are particularly vulnerable to stress

overload and compassion fatigue due to an emotionally exhausting environment. Compassion fatigue among caregivers in turn has been associated with less effective delivery of care. Having compassion for others entails self-compassion. In Kristin Neff's research, self-compassion includes self-kindness, a sense of common humanity, and mindfulness. Both mindfulness and self-compassion involve promoting an attitude of curiosity and nonjudgment towards one's experiences. Research suggests that mindfulness interventions, particularly those with an added loving-kindness component, have the potential to increase self-compassion among health care workers. Enhancing focus on developing self-compassion using MBSR and other mindfulness interventions for health care workers holds promise for reducing perceived stress and increasing effectiveness of clinical care.

Salyers, M., Hudson, C., Morse, G., Rollins, A., Monroe-DeVita, M., Wilson, C., and Freeland, L. (2011). BREATHE: a pilot study of a one-day retreat to reduce burnout among mental health professionals. *Psychiatric Services; 62(2):214-7.*

Retrieved from: doi: 10.1176/ps.62.2.pss6202_0214 (see also Chapter 5).

OBJECTIVE: Staff burnout is a frequent problem for mental health providers and may be associated with negative outcomes for providers, consumers, and organizations. This study tested an intervention to reduce staff burnout.

METHODS: *Community mental health providers were invited to participate in a day-long training session to learn methods to reduce burnout. A Web-based survey was given at time of registration, before the intervention, and again six weeks later.*

RESULTS: *Eighty-four providers participated in the training, and follow-up data were available for 74. Six weeks after the day-long training, staff reported significant decreases in emotional exhaustion and depersonalization and significant increases in positive views toward consumers. There were no significant changes in providers' sense of personal accomplishment, job satisfaction, or intention to leave their position. Ninety-one percent of the staff reported the training to be helpful.*

CONCLUSIONS: This brief intervention is feasible, is acceptable to staff, and may improve burnout and staff attitudes.

Sarason, S. B. (1985). Caring and compassion in clinical practice: Issues in the selection, training, and behavior of helping professionals. Rowman & Littlefield.

Retrieved from:

[https://books.google.com/books?hl=en&lr=&id=EMiLgdnvKSEC&oi=fnd&pg=PP1&dq=Sarason,+S.+B.+%\(1985\).+Caring+and+compassion+in+clinical+practice:+Issues+in+the+selection,+training,+and+behavior+of+helping+professionals,+Rowman+%26+Littlefield.++&ots=zdrNG6z3hP&sig=sFCIytNn7PGQSaCTMLiNc08m5Lk#v=onepage&q=Sarason%2C%20S.%20B.%20\(1985\).%20Caring%20and%20compassion%20in%20clinical%20practice%3A%20Issues%20in%20the%20selection%2C%20training%2C%20and%20behavior%20of%20helping%20professionals%2C%20Rowman%20%26%20Littlefield.&f=false](https://books.google.com/books?hl=en&lr=&id=EMiLgdnvKSEC&oi=fnd&pg=PP1&dq=Sarason,+S.+B.+%(1985).+Caring+and+compassion+in+clinical+practice:+Issues+in+the+selection,+training,+and+behavior+of+helping+professionals,+Rowman+%26+Littlefield.++&ots=zdrNG6z3hP&sig=sFCIytNn7PGQSaCTMLiNc08m5Lk#v=onepage&q=Sarason%2C%20S.%20B.%20(1985).%20Caring%20and%20compassion%20in%20clinical%20practice%3A%20Issues%20in%20the%20selection%2C%20training%2C%20and%20behavior%20of%20helping%20professionals%2C%20Rowman%20%26%20Littlefield.&f=false)

SUMMARY: Although no conscientious practitioner in a helping profession wishes to be regarded as insensitive, too frequently such professionals treat their patients more like illnesses or problems than persons in distress. Seymour Sarason, a founder of community psychology, shows that such treatment derives not from a lack of caring, but rather from institutional and

systemic problems inherent in behavioral health. Problem definition, scope, and potential solutions are discussed.

Sinclair, S., Beamer, K., Hack, T., McClement, S., Bouchal, S., Chochinov, H., and Hagen, N. (2017). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Journal of Palliative Medicine*. 31(5): 437–447.

Retrieved from: <http://journals.sagepub.com/doi/10.1177/0269216316663499>

BACKGROUND: Compassion is considered an essential element in quality patient care. One of the conceptual challenges in healthcare literature is that compassion is often confused with sympathy and empathy. Studies comparing and contrasting patients' perspectives of sympathy, empathy, and compassion are largely absent. Aim: The aim of this study was to investigate advanced cancer patients' understandings, experiences, and preferences of "sympathy," "empathy," and "compassion" in order to develop conceptual clarity for future research and to inform clinical practice.

DESIGN: Data were collected via semi-structured interviews and then independently analyzed by the research team using the three stages and principles of Straussian grounded theory.

SETTING/PARTICIPANTS: Data were collected from 53 advanced cancer inpatients in a large urban hospital.

RESULTS: Constructs of sympathy, empathy, and compassion contain distinct themes and sub-themes. Sympathy was described as an unwanted, pity-based response to a distressing situation, characterized by a lack of understanding and self-preservation of the observer. Empathy was experienced as an affective response that acknowledges and attempts to understand individual's suffering through emotional resonance. Compassion enhanced the key facets of empathy while adding distinct features of being motivated by love, the altruistic role of the responder, action, and small, supererogatory acts of kindness. Patients reported that unlike sympathy, empathy and compassion were beneficial, with compassion being the most preferred and impactful.

CONCLUSION: Although sympathy, empathy, and compassion are used interchangeably and frequently conflated in healthcare literature, patients distinguish and experience them uniquely. Understanding patients' perspectives is important and can guide practice, policy reform, and future research.

Chapter 2

Programs to Promote Compassion

Burks, D. J. and Kobus, A. M. (2012). "The legacy of altruism in health care: the promotion of empathy, prosociality and humanism." *Medical Education* 46(3): 317-325.

OBJECTIVES: This study aimed to examine concepts of altruism and empathy among medical students and professionals in conjunction with health care initiatives designed to support the maintenance of these qualities.

METHODS: We searched for the terms 'altruism', 'altruistic', 'helping', 'prosocial behavior' and 'empathy' in the English-language literature published from 1980 to the present within the Ovid MEDLINE, PsycInfo and PubMed databases. We used conceptual analysis to examine the relationships among altruism, empathy and related prosocial concepts in health care in order to understand how such factors may relate to emotional and career burnout, cynicism, decreased helping and decreased patient-centeredness in care.

RESULTS: Altruistic ideals and qualities of empathy appear to decrease among some medical students as they progress through their education. During this process, students face increasingly heavy workloads, deal with strenuous demands and become more acquainted with non-humanistic informal practices inherent in the culture of medicine. In combination, these factors increase the likelihood that emotional suppression, detachment from patients, burnout and other negative consequences may result, perhaps as a means of self-preservation. Alternatively, by making a mindful and intentional choice to endeavor for self-care and a healthy work-life balance, medical students can uphold humanistic and prosocial attitudes and behaviors.

CONCLUSIONS: Promoting altruism in the context of a compensated health care career is contradictory and misguided. Instead, an approach to clinical care that is prosocial and empathic is recommended. Training in mindfulness, self-reflection and emotion skills may help medical students and professionals to recognize, regulate and behaviorally demonstrate empathy within clinical and professional encounters. However, health care initiatives to increase empathy and other humanistic qualities will be limited unless more practical and feasible emotion skills training is offered to and accepted by medical students. Success will be further moderated by the culture of medicine's full acceptance of empathy and humanism into its customs, beliefs, values, interactions and daily practices.

Carmel, S. and Glick, S. M. (1996). "Compassionate-empathic physicians: personality traits and social-organizational factors that enhance or inhibit this behavior pattern." *Social Science & Medicine* 43(8): 1253-1261.

Retrieved from: https://ac.els-cdn.com/0277953695004459/1-s2.0-0277953695004459-main.pdf?_tid=de805813-35c4-4fed-9886-181c9ecda988&acdnat=1530896284_1014906412aa4264d29aec483d4afdcf

Compassionate-empathic physicians (CEPs) are desired by patients, but rarely found in medical settings. The purpose of this study was to promote our understanding of this gap by determining

personal characteristics that distinguish CEPs from other physicians, and organizational factors that might enhance or inhibit physicians' compassionate-empathic behavior (CEB). In the first stage of the study, three groups of physicians who differed in their compassionate-empathic pattern of behavior toward patients were identified by a sociometric questionnaire distributed to 324 physicians in a general hospital. In the second stage, almost all of these physicians ($N = 308$) were asked to fill out a self-administered structured questionnaire, and 214 (69.5%) responded. Comparisons among the three groups show that the physicians identified as CEPs, more than other physicians, are younger, have fewer years in medical practice, and score higher on pro-social, non-stereotypic attitudes toward patients and on empathy measures. Their self-esteem is, however, similar to that of the non-CEPs. The CEPs express similar levels of satisfaction with work on most dimensions, but they report more emotional exhaustion (burnout) than other physicians. A consensus among all physicians was found with regard to two rank orders: (a) the important qualities for being "a good physician"; and (b) the important qualities for being promoted in the hospital. However, while empathic behavior was considered the most important quality for being "a good physician", it was ranked as the least important for being promoted in the hospital. The conclusions can serve as a scientific base for improving methods of selection of medical students, and for re-evaluating the existent criteria for promoting medical staff in general hospitals.

Cook, A. (2013). "Engaging Patients with Effective Communication." The Beryl Institute: Patient Experience Grant Program Series Research Report.

Retrieved from: <https://www.theberylinstitute.org/store/download.asp?id=7F28DE7A-1975-425D-AF45-76473DAB3495>.

Lehigh Valley Physician Group (LVPG) is an 800-provider, multi-specialty group that includes over 40 specialties practicing in over 60 clinical care sites across six regional counties. LVPG is a part of Lehigh Valley Health Network (LVHN), which includes a premier not-for-profit academic community hospital across three sites that is dedicated to helping the people of our service area achieve and maintain optimum health status. As one of Pennsylvania's oldest teaching hospitals with 17 residency programs, a vast array of services are offered to maintain wellness and enhance life's quality. LVHN has long been committed to improving quality, patient safety and service excellence through research and quality initiatives. In LVPG, we touch the lives of many patients. In our last fiscal year, we had in excess of 1.6 million visits, which is our highest number to date. Our physician group size continues to grow every year, and with that growth comes the opportunity to heal, comfort and care for patients and their families. Given that patients will often connect how they were treated (service) with the clinical care (quality) they receive, we recognize that communication is a central component to the patient experience. An area which has been challenging for us is that with the Press Ganey patient satisfaction survey (which is the vendor our network uses), we don't always have a high number of returns. This results in data which may or may not accurately represent how that practice is doing. We wanted to know how well we are engaging with patients with our communication skills, for this goes to the heart of many issues which are important to them, such as keeping them informed about delays, wait times, and communication with their provider.

Crawford, P., Brian, B., Kvangarsnes, M., and Gilbert, P. (2014). "The design of compassionate care." *Journal of Clinical Nursing*, 23(23-24): 3589-3599.

Retrieved from:

<http://eprints.nottingham.ac.uk/40195/1/compassionate%20designjcrevised3.pdf>

AIMS AND OBJECTIVES: To investigate the tension between individual and organizational responses to contemporary demands for compassionate interactions in health care.

BACKGROUND: Health care is often said to need more compassion among its practitioners. However, this represents a rather simplistic view of the issue, situating the problem with individual practitioners rather than focusing on the overall design of care and healthcare organizations, which have often adopted a production-line approach.

DESIGN: This is a position paper informed by a narrative literature review.

METHODS: A search of the PubMed, Science Direct and CINAHL databases for the terms compassion, care and design was conducted in the research literature published from 2000 through to mid-2013.

RESULTS: There is a relatively large literature on compassion in health care, where authors discuss the value of imbuing a variety of aspects of health services with compassion including nurses, other practitioners and, ultimately, among patients. This contrasts with the rather limited attention that compassionate practice has received in healthcare curricula and the lack of attention to how compassion is informed by organizational structures and processes. We discuss how making the clinic more welcoming for patients and promoting bidirectional compassion and compassion formation in nursing education can be part of an overall approach to the design of compassionate care.

CONCLUSIONS: We discuss a number of ways in which compassion can be enhanced through training, educational and organizational design, through exploiting the potential of brief opportunities for communication and through initiatives involving patients and service users, as well as practitioners and service leaders.

RELEVANCE TO CLINICAL PRACTICE: The development of contemporary healthcare systems could usefully address the overall design of compassionate care rather than blame individual practitioners for a lack of compassion.

Dewar, B. and Nolan, M. (2013). "Caring about caring: developing a model to implement compassionate relationship centered care in an older people care setting." *International Journal of Nursing Studies* 50(9): 1247-1258.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S0020748913000333>

AIM: This study actively involved older people, staff and relatives in agreeing a definition of compassionate relationship-centered care and identifying strategies to promote such care in acute hospital settings for older people. It was a major component of a three year program (the Leadership in Compassionate Care Program, LCCP) seeking to integrate compassionate care across practice and educational environments. **Background:** Compassionate caring and promoting dignity are key priorities for policy, practice and research worldwide, being central to the quality of care for patients and families, and job satisfaction for staff. Therapeutic

relationships are essential to achieving excellence in care but little is known about how to develop and sustain such relationships in a culture that increasingly focuses on throughput and rapid turnover.

APPROACH AND METHODS: The study used appreciative inquiry and a range of methods including participant observation, interviews, storytelling and group discussions to actively engage older people, relatives and staff. A process of immersion crystallization was used to analyze data with staff as co-analysts.

FINDINGS: The study adds considerably to the conceptualization of compassionate, relationship-centered care and provides a model to aid staff deliver such care in practice, based on 'appreciative caring conversations' that enable all parties to gain two forms of 'person and relational knowledge' about 'who people are and what matters to them' and 'how people feel about their experience'. Such knowledge enables staff, patients and carers to 'work together to shape the way things are done'. The study generated a model called the 7 'C's that captures in detail the factors necessary to promote 'appreciative caring conversations'.

CONCLUSIONS AND IMPLICATIONS: The study demonstrates that engaging in 'appreciative caring conversations' promotes compassionate, relationship-centered care but that these conversations involve practitioners taking risks. Such 'relational practices' must therefore be valued and accorded status. Staff require appropriate support, facilitation and strong leadership if these practices are to flourish. (C) 2013 Elsevier Ltd. All rights reserved.

Halbesleben, J.R. and Rathert, C. (2008) Linking physician burnout and patient outcomes: exploring the dyadic relationship between physicians and patients. *Health Care Management Review*, 33(1):29-39 (see also Chapter 5)

BACKGROUND: Although patient outcomes of hospital stays have been widely explored, particularly patient satisfaction, there is a dearth of research linking health care provider burnout and patient outcomes at a dyadic level. In this article, we develop and test a model to explain the relationship between dimensions of burnout and patient outcomes, including patient satisfaction and recovery time.

PURPOSE: The purpose of this article is to explore the relationship between physician burnout and patient satisfaction and the time required to regain normal functioning after hospital discharge.

METHODS: This study was based upon a survey of 178 matched pairs of patients and physicians. The patients were people who had been hospitalized within the previous year.

RESULTS: We found support for the notion that the depersonalization dimension of physician burnout was associated with patient outcomes of lower satisfaction and longer post-discharge recovery time (after controlling for severity of illness and other demographic factors).

IMPLICATIONS FOR PRACTICE: The findings suggest that physician burnout has an impact on patient outcomes. Although this is a preliminary study, it suggests that organizations that take proactive steps to reduce burnout through system wide intervention programs will see greater benefits in terms of patient satisfaction and recovery.

Krasner, M. S., Epstein, R.M., Beckman, H., Suchman, A.L., Chapman, B., Mooney, C.J., and

Quill, T.E. (2009) Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA*, 302(12):1284-1293.

Retrieved from: <https://jamanetwork.com/journals/jama/fullarticle/184621> (see also Chapter 5)

CONTEXT: Primary care physicians report high levels of distress, which is linked to burnout, attrition, and poorer quality of care. Programs to reduce burnout before it results in impairment are rare; data on these programs are scarce.

OBJECTIVE: To determine whether an intensive educational program in mindfulness, communication, and self-awareness is associated with improvement in primary care physicians' well-being, psychological distress, burnout, and capacity for relating to patients.

DESIGN, SETTING, AND PARTICIPANTS: Before-and-after study of 70 primary care physicians in Rochester, New York, in a continuing medical education (CME) course in 2007-2008. The course included mindfulness meditation, self-awareness exercises, narratives about meaningful clinical experiences, appreciative interviews, didactic material, and discussion. An 8-week intensive phase (2.5 h/wk, 7-hour retreat) was followed by a 10-month maintenance phase (2.5 h/mo).

MAIN OUTCOME MEASURES: Mindfulness (2 subscales), burnout (3 subscales), empathy (3 subscales), psychosocial orientation, personality (5 factors), and mood (6 subscales) measured at baseline and at 2, 12, and 15 months.

RESULTS: Over the course of the program and follow-up, participants demonstrated improvements in mindfulness (raw score, 45.2 to 54.1; raw score change [Delta], 8.9; 95% confidence interval [CI], 7.0 to 10.8); burnout (emotional exhaustion, 26.8 to 20.0; Delta = -6.8; 95% CI, -4.8 to -8.8; depersonalization, 8.4 to 5.9; Delta = -2.5; 95% CI, -1.4 to -3.6; and personal accomplishment, 40.2 to 42.6; Delta = 2.4; 95 CI, 1.2 to 3.6); empathy (116.6 to 121.2; Delta = 4.6; 95% CI, 2.2 to 7.0); physician belief scale (76.7 to 72.6; Delta = -4.1; 95% CI, -1.8 to -6.4); total mood disturbance (33.2 to 16.1; Delta = -17.1; 95 CI, -11 to -23.2), and personality (conscientiousness, 6.5 to 6.8; Delta = 0.3; 95% CI, 0.1 to 5 and emotional stability, 6.1 to 6.6; Delta = 0.5; 95% CI, 0.3 to 0.7). Improvements in mindfulness were correlated with improvements in total mood disturbance ($r = -0.39$, $p < .001$), perspective taking subscale of physician empathy ($r = 0.31$, $p < .001$), burnout (emotional exhaustion and personal accomplishment subscales, $r = -0.32$ and 0.33 , respectively; $p < .001$), and personality factors (conscientiousness and emotional stability, $r = 0.29$ and 0.25 , respectively; $p < .001$).

CONCLUSIONS: Participation in a mindful communication program was associated with short-term and sustained improvements in well-being and attitudes associated with patient-center care. Because before-and-after designs limit inferences about intervention effects, these findings warrant randomized trials involving a variety of practicing physicians.

Merlino, J., and Ananth, R. (2013) Health Care's Service Fanatics: How the Cleveland Clinic Leaped to the Top of the Patient-satisfaction Surveys. *Harvard Business Review*, 91(5), 108–116.

The Cleveland Clinic has long had a reputation for medical excellence. But in 2009 the CEO acknowledged that patients did not think much of their experience there, and he decided to act. Since then the Clinic has leaped to the top tier of patient-satisfaction surveys, and it now draws hospital executives from around the world who want to study its practices. The Clinic's journey

also holds lessons for organizations outside health care that must suddenly compete by creating a superior customer experience. The authors, one of whom was critical to steering the hospital's transformation, detail the processes that allowed the Clinic to excel at patient satisfaction without jeopardizing its traditional strengths.

Singh, P., King-Shier, K., and Sinclair, S. (2018). The colours and contours of compassion: A systematic review of the perspectives of compassion among ethnically diverse patients and healthcare providers. PLOS.

Retrieved from: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0197261>

OBJECTIVE: To identify and describe the perspectives, experiences, importance, and impact of compassionate care among ethnically diverse population groups.

METHODS: A systematic search of peer-reviewed research focused on compassionate care in ethnically diverse populations published between 1946 and 2017 was conducted.

RESULTS: A total of 2296 abstracts were retrieved, out of which 23 articles met the inclusion criteria. Synthesis of the literature identified the perspectives, facilitators and barriers of compassion in healthcare within ethnic groups. Compassion was described as being comprised of healthcare provider (HCP) virtues (honesty, kindness, helpful, non-judgment) and actions (smile, touch, care, support, flexibility) aimed at relieving the suffering of patients. The importance and impact of providing compassion to ethnically diverse patients was also identified which included overcoming cultural differences, alleviating distress at end-of-life, promoting patient dignity and improving patient care. This review also identified the need for more contextual studies directly exploring the topic of compassion from the perspectives of individuals within diverse ethnic groups, rather than superimposing a pre-defined, enculturated and researcher-based definition of compassion.

CONCLUSIONS: This review synthesizes the current evidence related to perceptions of compassion in healthcare among diverse ethnic groups and the role that compassion can play in bridging ethno-cultural differences and associated challenges, along with identifying gaps in literature related to compassionate care within diverse ethnic groups. Establishing an evidence base grounded in the direct accounts of members of diverse ethnic communities can enhance culturally sensitive compassionate care and improve compassion related health outcomes among diverse ethnic groups

Suchman, A. L., Markakis, K., Beckman, H.B., and Frankel, R. (1997). A model of empathic communication in the medical interview. JAMA, 277(8): 678-682.

Retrieved from:

http://www.medecine.unige.ch/enseignement/apprentissage/module2/circ/apprentissage/internet/cc/rel_med_ccdc_suchman.pdf

OBJECTIVE: To formulate an empirically derived model of empathic communication in medical interviews by describing the specific behaviors and patterns of interaction associated with verbal expressions of emotion.

DESIGN: A descriptive, qualitative study of verbal exchanges using 11 transcripts and 12 videotapes of primary care office visits to a total of 21 physicians. **SETTING:** An urban health

maintenance organization (HMO), an urban university-based general medicine clinic, and an urban community hospital general medicine clinic.

ANALYTIC METHOD: Individual review of transcripts by each research team member to identify instances of expressed or implied emotional themes and to observe the physicians' responses. Individual ratings were compared in group discussions to achieve consensus about the classifications. Similar consensus-based classification was used for review of videotapes.

RESULTS: We observed that patients seldom verbalize their emotions directly and spontaneously, tending to offer clues instead. If invited to elaborate, patients may then express the emotional concern directly, and the physician may respond with an accurate and explicit acknowledgment. In most of the interviews, the physicians allowed both clues and direct expressions of affect to pass without acknowledgment, returning instead to the preceding topic, usually the diagnostic exploration of symptoms. With emotional expression so terminated, some patients attempted to raise the topic again, sometimes repeatedly and with escalating intensity. We noted a parallel dynamic for encounters in which patients sought praise. We summarized the full interactional sequence in a simple descriptive model.

CONCLUSIONS: This empirically derived model of empathic communication has practical implications for clinicians and students who want to improve their communication and relationship skills. Based on our observations, the basic empathic skills seem to be recognizing when emotions may be present but not directly expressed, inviting exploration of these unexpressed feelings, and effectively acknowledging these feelings so the patient feels understood. The frequent lack of acknowledgment by physicians of both direct and indirect expressions of affect poses a threat to the patient-physician relationship and warrants further study.

Chapter 3

Motivational Interviewing, Brief Action Planning and Shared Decision Making to Promote Change, Build Self-Efficacy and Improve Patient Engagement

Anderson, L., Spanjol, J., Jefferies, J., Ostrom, A., Nations Baker, C., Bone, S., Downey, H., Mende, M., and Rapp, J. (2016) Responsibility and Well-Being: Resource Integration Under Responsibilization in Expert Services. *Journal of Public Policy & Marketing*, 35(2), 262–279.

Retrieved from: <https://diginole.lib.fsu.edu/islandora/object/fsu:405693/datastream/PDF/view>

Responsibilization, or the shift of functions and risks from providers and producers to consumers, has become an increasingly common policy in service systems and marketplaces (e.g., financial, health, governmental). Because responsibilization is often considered synonymous with consumer agency and well-being, the authors take a transformative service research perspective and draw on resource integration literature to investigate whether responsibilization is truly associated with well-being. The authors focus on expert services, for which responsibilization concerns are particularly salient, and question whether this expanding policy is in the public interest. In the process, they develop a conceptualization of resource integration under responsibilization that includes three levels of actors (consumer, provider, and service system), the identification of structural tensions surrounding resource integration, and three categories of resource-integration practices (access, appropriation, and management) necessary to negotiate responsibilization. The findings have important implications for providers, public and institutional policy makers, and service systems, all of which must pay more active attention to the challenges consumers face in negotiating responsibilization and the resulting well-being outcomes.

Cole, S. and Berg, J. (2013). The Medical Interview E-book: The Three Function Approach. Third Edition, Elsevier.

This text equips providers with a framework and tools to enhance effective communication with patients including language and cultural barriers, sexual issues, elderly patients, breaking bad news and non-adherence, to support optimal care delivery. It presents a practical, systematic approach to honing basic interviewing skills and managing common challenging communicating situations. Its Three-Function Approach – "Build the Relationship," "Assess and Understand," and "Collaborative Management" offers straightforward tasks, behaviors, and skills that can be easily mastered, making it an ideal learning tool for beginners and a valuable reference for experienced healthcare professionals.

Davis, C., Reims, K., Gutnick, D. and Domes, A. (2014) Shared Decision Making Guide.
https://centrecmi.ca/wp-content/uploads/2017/08/Shared_Decision_Making_Guide_2014-02-05.pdf

Retrieved from: <https://centrecmi.ca/>

Additional information available: https://centrecmi.ca/wp-content/uploads/2017/08/Shared_Decision_Making_Flow_Chart_2014-2-04b.pdf

Shared Decision Making (SDM) is a conversation structured around 4 questions, below. Depending on the response, other follow-up questions may be asked. The SDM conversation may develop over time as the patient and clinician gain a greater understanding of each other's knowledge, values and preferences. SDM is evolving and questions remain about the time requirements and how teams can best work together to support SDM in practice.

Emmons, K. M. and Rollnick, S. (2001). Motivational interviewing in health care settings: opportunities and limitations. *American Journal of Preventive Medicine*, 20(1): 68-74.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S0749379700002543>

Motivational interviewing (MI) has been well studied in specialist settings. There has been considerable interest in applying MI to community health care settings. Such settings represent a significant departure from the more traditional, specialist settings in which MI has been developed and tested. The purpose of this paper is to provide a brief overview of MI and to identify and discuss the key issues that are likely to arise when adapting this approach to health care and public health settings. This paper provides an overview of important issues to consider in adapting an effective counseling strategy to new settings, and is intended to begin a dialogue about the use of MI in community health care settings.

Gutnick, D., Reims, K., Davis, C., Gainforth, H., Jay, M., and Cole, S. (2014). Brief action planning to facilitate behavior change and support patient self-management. *Journal of Clinical Outcomes Management*, 21(1): 17-29.

Retrieved from: http://www.turnerwhite.com/pdf/jcom_jan14_facilitate.pdf

OBJECTIVE: To describe Brief Action Planning (BAP), a structured, stepped-care self-management support technique for chronic illness care and disease prevention.

METHODS: A review of the theory and research supporting BAP and the questions and skills that comprise the technique with provision of a clinical example.

RESULTS: BAP facilitates goal setting and action planning to build self-efficacy for behavior change. It is grounded in the principles and practice of Motivational Interviewing and evidence-based constructs from the behavior change literature. Comprised of a series of 3 questions and 5 skills, BAP can be implemented by medical teams to help meet the self-management support objectives of the Patient-Centered Medical Home.

CONCLUSION: BAP is a useful self-management support technique for busy medical practices to promote health behavior change and build patient self-efficacy for improved long-term clinical outcomes in chronic illness care and disease prevention.

Jennings, A. (2017). Utilizing Standardized Patients to Teach Motivational Interviewing to

Gerontology Health Care Providers Journal of Gerontology and Geriatric Research, 6(385): 2.

Retrieved from:

<https://pdfs.semanticscholar.org/3fb3/ded835f7987749ed13ab03aac3b76986b802.pdf>

Case Report Health care institutions across the United States are facing challenges to train their gerontology health care providers to offer the best care possible to older patients in order to achieve optimal patient health outcomes. Innovative training strategies for gerontology health care providers to improve patient care may include the utilization of standardized patients. This paper discusses the use of simulation training using standardized patients to teach motivational interviewing (MI) techniques to VA health care professionals who care for older Veterans. MI is a client centered approach for eliciting behavior change by assisting clients in exploring and resolving ambivalence about their treatment regimen [1]. MI is a topic of interest nationally throughout the Veterans Health Administration (VHA) system. MI is a component featured in the National Center for health promotion and disease prevention (NCP) program at the VHA [2]. To implement MI, NCP has trained health behavior coordinators (HBC's) in MI skills and provided them with resources to provide MI training within their VA facilities. The HBC's have targeted predominantly nurses and physicians within the patient aligned care team (PACT). The PACT is a national initiative on delivering primary care and is similar to the medical home model used in the private sector. A PACT is part of the VA healthcare system's program with the mission of delivering health care that is patient oriented, data-driven, continuously improving, and team based [3].

Kathol, R.G., Andrew, R.L., Squire, M., and Dehnel, P.J. (2018). Motivational Interviewing and Health Behavior Change in Individuals with Health Complexity. *The Integrated Case Management Manual*, Springer: 85-102.

To review research on the effectiveness of motivational interviewing. To clarify the importance of strong initial and ongoing training in motivational interviewing. To define motivational interviewing processes and key skills in managing complex individuals.

Institute of Medicine. Living well with chronic illness: a call for public health action.

Washington (DC); The National Academies Press; 2012.

Retrieved from:

http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2012/Living-Well-with-Chronic-Illness/livingwell_chronicillness_reportbrief.pdf

Chronic illnesses have emerged as major health concerns of Americans in recent decades. People are increasingly focused not simply on living longer, but on maintaining or even improving their capacity to live well over their entire lives. In general, chronic illnesses are slow in progression and long in duration, and they require medical treatment. All chronic illnesses have the potential to limit the functional status, productivity, and quality of life of people who live with them. In addition, chronic illnesses are a major contributor to health care costs; the medical care costs of people with chronic illnesses represent 75 percent of the \$2 trillion in U.S. annual health care spending. The Centers for Disease Control and Prevention (CDC) and the nonprofit Arthritis Foundation sought assistance from the Institute of Medicine (IOM) to help identify public health

actions to reduce disability and improve the function and quality of life for people living with chronic illness

Knight, K., McGowan, L., Dickens, C., and Bundy, C. (2006). A systematic review of motivational interviewing in physical health care settings. *British Journal of Health Psychology*, 11(2): 319-332.

Retrieved from: <https://doi.org/10.1348/135910705X52516>

PURPOSE: Motivational interviewing (MI), a method of augmenting an individual's motivation to change problematic behaviors, is a patient-centered counselling style that seeks to help patients resolve ambivalence about behavior change. MI has successfully been used in the field of addictions and has recently received increased interest as a means of promoting treatment adherence in physical health care settings. This systematic review is aimed to evaluate the effectiveness of MI interventions in physical health care settings.

METHODS: Electronic databases were searched for articles specifying the use of 'motivational interviewing' in physical health care settings between 1966 and April 2004. Fifty-one relevant abstracts were yielded and data was extracted from eight relevant selected studies.

RESULTS: Eight studies were identified in the fields of diabetes, asthma, hypertension, hyperlipidemia, and heart disease. The majority of studies found positive results for effects of MI on psychological, physiological, and life-style change outcomes. Problems with research in this area include: small sample sizes, lack of power, use of disparate multiple outcomes, inadequate validation of questionnaires, poorly-defined therapy and training.

CONCLUSIONS: While MI has high face validity across a number of Chapters in physical health care settings, the general quality of trials in this area is inadequate and therefore recommendations for its dissemination in this area cannot yet be made. More research into MI applied to health behavior change is urgently required.

Krist, A., Tong, S., Aycock, R., and Longo, D. (2017). Engaging patients in decision-making and behavior change to promote prevention. *Information Services and Use*. 240:284-302

ABSTRACT: Effectively engaging patients in their care is essential to improve health outcomes, improve satisfaction with the care experience, reduce costs, and even benefit the clinician experience. This article will address the topic of patient engagement directly and review the relationships between health literacy and patient engagement. While there are many ways to define patient and family engagement, this article will consider engagement as "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making – to improve health and health care [Health Aff (Millwood) 32 (2013), 223–231]." We will specifically focus on the patient engagement and health literacy needs for three scenarios (1) decision-making, (2) health behavior change, and (3) chronic disease management; we will include the theoretical underpinnings of engagement, the systems required to better support patient engagement, how social determinants of health influence patient engagement, and practical examples to demonstrate approaches to better engage patients in their health and wellbeing. We will close by describing the future of patient engagement, which extends beyond

the traditional Chapters of decision-making and self-care to describe how patient engagement can influence the design of the healthcare delivery system; local, state, and national health policies; and future research relevant to the needs and experiences of patients.

Kouwenhoven-Pasmooij, T. A., Robroek, S.J., Nieboer, D., Helmout, P.H., Wery, M.F., Hunink, M., and Burdorf, A. (2018). Quality of motivational interviewing matters: the effect on participation in health-promotion activities in a cluster randomized controlled trial. Scandinavian Journal of Work, Environment & Health, 44(4): 414-422.

OBJECTIVES: This study aims to evaluate the effectiveness of a "blended" workplace health-promotion intervention, alongside identification of key components beneficial for future implementation strategies.

METHODS: Within a cluster randomized controlled trial, 491 employees at increased risk of cardiovascular disease were allocated to the limited (N=217; 9 clusters) or extensive (N=274; 8 clusters) intervention. The extensive intervention consisted of motivational interviewing (MI) within the framework of a web-based health risk assessment (HRA), a blended care approach. The limited intervention received solely the web-based HRA. Occupational health physicians (N=21) within three organizations delivered the intervention. Implementation components investigated included: HRA (reach and participation), newsletters (percentage read), and MI sessions (number and quality). MI quality was determined by scoring audiotaped MI sessions, using the MI treatment integrity code. After 6 and 12 months, effects on participation in health-promotion activities and its associations with components of implementation were determined by mixed-effects models.

RESULTS: Over 80 of employees participated in health-promotion activities, with an additional 8 in the extensive compared to the limited group. In the extensive intervention, those with more or better quality MI sessions were more likely to participate in health-promotion activities. Increased MI quality was associated with sustained participation.

CONCLUSIONS: This study suggests that participation in health-promotion activities can be increased by adding MI to a web-based approach and improving the quality of the MI delivered. Interventions with MI should include optimized delivery and quality of MI sessions.

McDonough, J.E.(2014) Health system reform in the United States. International Journal of Health Policy Management, 2(1):5–8.

Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3937950/>

In 2010, the United States adopted its first-ever comprehensive set of health system reforms in the Affordable Care Act (ACA). Implementation of the law, though politically contentious and controversial, has now reached a stage where reversal of most elements of the law is no longer feasible. The controversial portions of the law that expand affordable health insurance coverage to most U.S. citizens and legal residents do not offer any important lessons for the global community. The portions of the law seeking to improve the quality, effectiveness, and efficiency of medical care as delivered in the U.S., hold lessons for the global community as all nations struggle to gain greater value from the societal resources they invest in medical care for their peoples. Health reform is an ongoing process of planning, legislating, implementing, and

evaluating system changes. The U.S. set of delivery system reforms has much for reformers around the globe to assess and consider.

Montori V. (2014) Minimally Disruptive Medicine.

Retrieved from: <https://www.youtube.com/watch?v=cHSWDMH2rfc>

Additional information available: <https://www.youtube.com/watch?v=kYW6bC3unLM>

<https://minimallydisruptivemedicine.org/>

In this popular Mayo Clinic video, Dr. Victor Montori, a professor of endocrinology and a health researcher at the Mayo Clinic with expertise in evidence based care and shared decision making, describes why understanding “What Matters” to a patient is foundational to providing patient centered care. Dr. Montori introduces a fictional patient named John to demonstrate why and how “Minimally Disruptive Medicine” (MDM) and Shared Decision Making are important keys to effective patient engagement.

Reims, K., Gutnick D., Davis C., Cole S. (2014) Brief Action Planning: A White Paper. Centre for Collaboration Motivation and Innovation.

Retrieved from: <http://www.centrecmi.ca/>

This White Paper defines Brief Action Planning (BAP), describes the eight clinical competencies to use it effectively, explains the rationale for its development, and discusses ways to use it in health care, medical education, health care systems, and Patient Centered Medical Homes. An appendix provides a demonstration clinical vignette. Videos demonstrating BAP interactions are available on the Centre for Collaboration, Motivation and Innovation website: <http://www.centrecmi.ca/>

Rollnick, S. and Miller, W. (2012). Motivational interviewing: Helping People Change. Third Edition, Taylor & Francis.

In the third edition of their groundbreaking book, *Motivational Interviewing: Helping People Change* 2012, Miller and Rollnick describe the four foundational elements that comprise the “Spirit of Motivational Interviewing” - Compassion, Acceptance (Supporting Autonomy), Partnership and Evocation, the Four Process (Engaging, Focusing, Evoking and Planning) and the core skills of Motivational Interviewing (Open Ended Questions, Affirmations, Reflections, Summaries) These constructs are the key to patient engagement and help build patient self-efficacy for change.

Rollnick, S., Miller, W. Butler C.C. (2008) Motivational interviewing in Health Care: Helping People Change Behavior. (Applications of Motivational Interviewing) First Edition, The Guilford Press, NY

Much of health care today involves helping patients manage conditions whose outcomes can be greatly influenced by lifestyle or behavior change. Written specifically for health care professionals, this concise book presents powerful tools to enhance communication with patients and guide them in making choices to improve their health, from weight loss, exercise, and smoking cessation, to medication adherence and safer sex practices. Engaging dialogues and vignettes bring to life the core skills of motivational interviewing (MI) and show how to

incorporate this brief evidence-based approach into any health care setting. Appendices include MI training resources and publications on specific medical conditions.

Vallabhan, M. K., Kong, A.S., Yakes-Jimenez, E.Y., Summers, L.C., DeBieck, C.J., and Feldstein-Ewing, S.W. (2017). Training primary care providers in the use of motivational interviewing for youth behavior change. *Research and Theory for Nursing Practice*, 31(3): 219.

Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5695044/>

BACKGROUND AND PURPOSE: Adolescent obesity is a global epidemic. Motivational interviewing (MI) is a promising strategy to address adolescent obesity risk behaviors. However, primary care providers (PCPs) tend to express discomfort with learning and adopting MI practices and with addressing patient weight issues. PCP proficiency in using MI to discuss body mass index, health screening results, and nutrition and physical activity behaviors after receiving training and coaching from an MI expert and practicing the technique was evaluated. We hypothesized that comfort with MI would increase consistently over time. Methods: Self-assessment surveys in MI proficiency were administered to PCPs after every youth participant MI session. MI comfort as determined by proficiency was categorized into low, medium, and high comfort according to survey Likert scale responses. Data were analyzed using analysis of variance (ANOVA) and Fisher's exact tests. Results: Two hundred twenty-seven youth were seen for MI-based discussions by 4 PCPs. Two hundred twenty-six surveys had complete data for analysis. As anticipated, overall PCPs reported significantly more comfort with MI from the first to the final MI session over a 2- to 3-month period ($p<.001$). Comfort scores did not increase linearly over time for all PCPs. Despite standard training practices, overall MI proficiency as measured by comfort scores varied by PCP ($p<.01$). Implications for

PRACTICE: This type of MI training program should be considered for clinical nurses and nurse practitioners during their nursing education training to facilitate their ability to consistently and effectively support youth behavior change for conditions such as obesity (ClinicalTrials.gov Number NCT02502383).

Chapter 4

Focus on WMTY in Addressing Social Determinants of Health

Baffour, T. D. (2017). Addressing the Social Determinants of Behavioral Health for Racial and Ethnic Minorities: Recommendations for Improving Rural Health Care Delivery and Workforce Development. *Journal of Best Practices in Health Professions Diversity: Education, Research & Policy*, 10(2).

Retrieved from: <http://eds.a.ebscohost.com/eds/pdfviewer/pdfviewer?vid=1&sid=25a27a7b-934e-43c3-9869-dc4e4fcfb25a%40sessionmgr4010>

ABSTRACT: The social determinants of behavioral health impact quality-of-life outcomes, including socioeconomic status, educational attainment, access to healthy and affordable food choices, employment and job stability, housing status, exposure to toxic environments, and access to quality health and behavioral health services. These challenges for rural ethnic and minority groups are particularly obdurate and long-standing. Improving rural behavioral health care delivery systems and workforce development must effectively address ways to recruit and train a diverse and culturally inclusive cadre of rural physicians, nurses, social workers, psychologists, and licensed counselors conversant with best-practices approaches. Recommendations for systems-level change include increasing the social capital of rural ethnic and racial minorities, as well as funding improvements for enhanced behavioral health access and workforce development through micro-, mezzo-, and macro level interventions.

Dentzer, S. (2013). "Rx for the 'blockbuster drug' of patient engagement." *Health Affairs (Millwood)*. 32 (2): 202.

Retrieved from: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0037>

Even in an age of hype, calling something “the blockbuster drug of the century” (as mentioned by Leonard Kish) <http://healthstandards.com/blog/2012/08/28/drug-of-the-century/> grabs our attention. In this case, the “drug” is actually a concept—patient activation and engagement—that should have formed the heart of health care all along. The topic of this thematic issue of Health Affairs, patient engagement is variously defined; the Institute for Healthcare Improvement describes it as “actions that people take for their health and to benefit from care.” Engagement’s close cousin is patient activation—“understanding one’s own role in the care process and having the knowledge, skills, and confidence to take on that role,” as Judith Hibbard and coauthors explain. More holistic definitions broaden these concepts further, describing patients and families working with providers all across health care, in such areas as patient-centered outcomes research. Two articles in this issue, including Entry Point, examine engagement in the “ultimate conversation” about the end of life.

Engelgau, M. M., Venkat Narayan, K.M., Ezzati, M., Salicrup, L.A., et al. (2018). Implementation Research to Address the United States Health Disadvantage: Report of a

National Heart, Lung, and Blood Institute Workshop. *Global Heart*, S2211-8160(18)30059-0.
doi: 10.1016/j.gheart.2018.03.003.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S2211816018300590>

Four decades ago, U.S. life expectancy was within the same range as other high-income peer countries. However, during the past decades, the United States has fared worse in many key health Chapters resulting in shorter life expectancy and poorer health-a health disadvantage. The National Heart, Lung, and Blood Institute convened a panel of national and international health experts and stakeholders for a Think Tank meeting to explore the U.S. health disadvantage and to seek specific recommendations for implementation research opportunities for heart, lung, blood, and sleep disorders. Recommendations for National Heart, Lung, and Blood Institute consideration were made in several areas including understanding the drivers of the disadvantage, identifying potential solutions, creating strategic partnerships with common goals, and finally enhancing and fostering a research workforce for implementation research. Key recommendations included exploring why the United States is doing better for health indicators in a few areas compared with peer countries; targeting populations across the entire socioeconomic spectrum with interventions at all levels in order to prevent missing a substantial proportion of the disadvantage; assuring partnership have high-level goals that can create systemic change through collective impact; and finally, increasing opportunities for implementation research training to meet the current needs. Connecting with the research community at large and building on ongoing research efforts will be an important strategy. Broad partnerships and collaboration across the social, political, economic, and private sectors and all civil society will be critical-not only for implementation research but also for implementing the findings to have the desired population impact. Developing the relevant knowledge to tackle the U.S. health disadvantage is the necessary first step to improve U.S. health outcomes.

Farber, E. W., Ali, M.K., Van Sickle, K.S., and Kaslow, N.J. (2017). Psychology in patient-centered medical homes: Reducing health disparities and promoting health equity. *American Psychologist* 72(1): 28.

Retrieved from: <https://www.apa.org/pubs/journals/releases/amp-a0040358.pdf>

With persisting health disparities contributing to a disproportionate impact on the health and well-being of socially disenfranchised and medically underserved populations, the emerging patient-centered medical home (PCMH) model offers promise in bridging the health disparities divide. Because behavioral health care is an important component of the PCMH, psychologists have significant opportunity to contribute to the development and implementation of PCMH services in settings that primarily serve medically underserved communities. In this article, after briefly defining the PCMH model and its role in clinical settings for medically underserved populations for whom health disparities are present, roles of psychologists as interprofessional collaborators on PCMH medical care teams are explored. Next, the constellation of competencies that position psychologists as behavioral health specialists to contribute to PCMH care teams for medically underserved groups are characterized. The article concludes with reflections on the prospects for psychologists to make tangible contributions as health care team members toward reducing health disparities and promoting health equity in patients served in the PCMH. (PsycINFO Database Record)

Feo, R. and Kitson, A. (2016). "Promoting patient-centered fundamental care in acute healthcare systems." *International Journal of Nursing Studies*, 57: 1-11.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S0020748916000079>

Meeting patients' fundamental care needs is essential for optimal safety and recovery and positive experiences within any healthcare setting. There is growing international evidence, however, that these fundamentals are often poorly executed in acute care settings, resulting in patient safety threats, poorer and costly care outcomes, and dehumanizing experiences for patients and families. Whilst care standards and policy initiatives are attempting to address these issues, their impact has been limited. This discussion paper explores, through a series of propositions, why fundamental care can be overlooked in sophisticated, high technology acute care settings. We argue that the central problem lies in the invisibility and subsequent devaluing of fundamental care. Such care is perceived to involve simple tasks that require little skill to execute and have minimal impact on patient outcomes. The propositions explore the potential origins of this prevailing perception, focusing upon the impact of the biomedical model, the consequences of managerial approaches that drive healthcare cultures, and the devaluing of fundamental care by nurses themselves. These multiple sources of invisibility and devaluing surrounding fundamental care have rendered the concept underdeveloped and misunderstood both conceptually and theoretically. Likewise, there remains minimal role clarification around who should be responsible for and deliver such care, and a dearth of empirical evidence and evidence-based metrics. In explicating these propositions, we argue that key to transforming the delivery of acute healthcare is a substantial shift in the conceptualization of fundamental care. The propositions present a cogent argument that counters the prevailing perception that fundamental care is basic and does not require systematic investigation. We conclude by calling for the explicit valuing and embedding of fundamental care in healthcare education, research, practice and policy. Without this re-conceptualization and subsequent action, poor quality, depersonalized fundamental care will prevail.

Laurance, J., Henderson, S., Howitt, P.J., Matar, M., Al Kuwari, H., Edgman-Levitan, S., and Darzi, A. (2014). Patient engagement: four case studies that highlight the potential for improved health outcomes and reduced costs. *Health Affairs*, 33(9): 1627-1634.

Retrieved from: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0375>

The energy of patients and members of the public worldwide who care about improving health is a huge, but still largely unrecognized and untapped, resource. The aim of patient engagement is to shift the clinical paradigm from determining "what is the matter?" to discovering "what matters to you?" This article presents four case studies from around the world that highlight the proven and potential abilities of increased patient engagement to improve health outcomes and reduce costs, while extending the reach of treatment and diagnostic programs into the community. The cases are an online mental health community in the United Kingdom, a genetic screening program in the United Arab Emirates, a World Health Organization checklist for new mothers, and a hospital-based patient engagement initiative in the United States. Evidence from these and similar endeavors suggests that closer collaboration on the part of patients, families,

health care providers, health care systems, and policy makers at multiple levels could help diverse nations provide more effective and population-appropriate health care with fewer resources.

Lax, Y., Martinez, M., and Brown, N.M. (2017). "Social determinants of health and hospital readmission." *Pediatrics*, 140(5): e20171427.

Retrieved from:

<http://pediatrics.aappublications.org/content/pediatrics/140/5/e20171427.full.pdf>

Hospital readmissions are influenced not only by patients' health status but also by access to resources such as income, insurance, and social support systems. Optimizing hospital discharge education, planning, and care coordination with outpatient providers are essential strategies to prevent avoidable hospital readmissions.¹ Researchers also suggest hospitals should consider social determinants of health (SDH) when assessing readmission risk.² SDH can be defined as the conditions in which people are born, live, work, and age, and are shaped by the distribution of money, power, and resources.³ Research reveals that SDH contribute to an elevated burden of disease in affected children.⁴ Children in poverty who experience housing insecurity, food insecurity, and low rates of parental education have higher rates of hospital readmission.⁵ Recent studies reveal that race and/or ethnicity and household income are predictors of pediatric readmissions.^{1,5,6} We present a case in which lack of comprehensive screening for SDH contributed to a hospital readmission. We share the perspectives of the patient's mother, the primary care physician, and a pediatric resident involved in the hospitalization and offer suggestions for collaborative interventions to prevent potentially avoidable hospital readmissions that may be driven by SDH.

Matthews, A. K., Breen, E., and Kittiteerasack, P. (2018). Social determinants of LGBT cancer health inequities. *Seminars in Oncology Nursing*, 34(1), 12-20.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S0749208117301158>

OBJECTIVES: To describe the extant literature on social determinants of health as they relate to the cancer disparities and to highlight the research findings relating to lesbian, gay, bisexual, and transgender (LGBT) populations.

DATA SOURCES: Published scientific literature and clinical literature, and published reports from the World Health Organization and US Department of Health and Human Services.

CONCLUSION: The larger literature on health inequities is moving beyond individual-level predictors of risk to evaluate the influence of social determinants of health on the persistent health inequalities in a population. As it has for other groups, additional research into social determinants of health for LGBT persons of color may play an important role in identifying and reducing cancer inequities for this group. Implications for Nursing Practice: Increased awareness of the factors that contribute to health inequities for the LGBT population may provide insight into improving patient-provider relationships with LGBT patients. A large body of experiential and clinical knowledge positions nurses to conduct meaningful research to expand the current understanding of the social determinants of LGBT cancer health inequities.

McClintock, H. F. and Bogner, H. R. (2017). Incorporating Patients' Social Determinants of

Health into Hypertension and Depression Care: A Pilot Randomized Controlled Trial.

Community Mental Health Journal, 53(6): 703-710.

Retrieved from: <https://link.springer.com/article/10.1007/s10597-017-0131-x>

The objective of this study was to carry out a randomized controlled pilot trial to test the effectiveness of an integrated intervention for hypertension and depression incorporating patients' social determinants of health (enhanced intervention) versus an integrated intervention alone (basic intervention). In all, 54 patients were randomized. An electronic monitor was used to measure blood pressure, and the nine-item Patient Health Questionnaire (PHQ-9) assessed depressive symptoms. Patients in the enhanced intervention had a significantly improved PHQ-9 mean change from baseline in comparison with patients in the basic intervention group at 12 weeks ($p = 0.024$). Patients in the enhanced intervention had a significantly improved systolic and diastolic blood pressure mean change from baseline in comparison with patients in the basic intervention group at 12 weeks ($p = 0.003$ and $p = 0.019$, respectively). Our pilot trial results indicate integrated care management that addresses the social determinants of health for patients with hypertension and depression may be effective.

Northwood, M., Ploeg, J., Markle-Reid, M., and Sherifali, D. (2018). Integrative review of the social determinants of health in older adults with multimorbidity. *Journal of Advanced Nursing, 74(1): 45-60.*

Retrieved from: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/jan.13408>

AIM: To examine how the social determinants of health have been considered in conceptualizations of multimorbidity in older adults in the literature and to identify implications for nursing practice, research and healthcare planning and policy.

BACKGROUND: The common conceptualization of multimorbidity is the presence of multiple chronic conditions where one is not more central than others.

DESIGN: The integrative review methodology of Whittemore and Knafl was employed. The World Health Organization Social Determinants of Health framework was used to determine how the social determinants of health have been considered in conceptualizations of multimorbidity.

DATA SOURCES: A search of electronic databases (2000-2015) generated 22 relevant articles, including quantitative and qualitative studies and grey literature reports.

REVIEW METHODS: A systematic process was used to appraise the quality of the documents, conduct qualitative data analysis procedures of data extraction, coding and theme development, and synthesize conclusions.

RESULTS: Current conceptualizations of multimorbidity provide limited consideration of the complex interplay of multimorbidity with the broader social determinants of health. Gender, education, behaviors and the health system were the most commonly cited determinants. Ethnicity, socioeconomic status/social class and material circumstances received little attention. Most of the dimensions of socioeconomic political context were not discussed.

CONCLUSION: The predominant conceptualization of multimorbidity focuses on the biomedical dimensions of multimorbidity. Consequently, nursing practice, research and policy informed by this literature could inadvertently sustain the mismatch between the needs of older adults with multimorbidity and the services they receive. Future research to inform a new conceptualization is necessary.

Pacquiao, D. F. (2008). Nursing care of vulnerable populations using a framework of cultural competence, social justice and human rights. *Contemporary Nurse*, 28(1-2): 189-197.

The article attempts to present a model linking cultural competence with advocacy for social justice and protection of human rights in caring for vulnerable groups such as refugees and asylum seekers. Using the human rights principle focuses the moral obligation to address social inequities and suffering of vulnerable populations. Cultural competent care and culturally-congruent actions place the universal principles of social justice and protection of human rights within the cultural contexts of people's lives and the environment in which they are situated. Compassion is identified as the key component for culturally-competent advocacy for social justice and human rights protection. Compassion compels actions advocating social justice and protection of human rights for marginalized and powerless groups. Educational strategies for developing compassion are centered on collaboration, partnership and advocacy. Integration Of experiential and didactic learning relevant to cultural competent care for refugees and asylum seekers are recommended.

Pettignano, R., Bliss, L., McLaren, S., and Caley, S. (2017). Interprofessional Medical–Legal Education of Medical Students: Assessing the Benefits for Addressing Social Determinants of Health. *Academic Medicine*, 92(9): 1254-1258.

Retrieved from:

https://journals.lww.com/academicmedicine/Fulltext/2017/09000/Interprofessional_Medical_Legal_Education_of.22.aspx

PROBLEM: Screening tools exist to help identify patient issues related to social determinants of health (SDH), but solutions to many of these problems remain elusive to health care providers as they require legal solutions. Interprofessional medical–legal education is essential to optimizing health care delivery.

APPROACH: In 2011, the authors implemented a four-session didactic interprofessional curriculum on medical–legal practice for third-year medical students at Morehouse School of Medicine. This program, also attended by law students, focused on interprofessional collaboration to address client/patient SDH issues and health-harming legal needs. In 2011–2014, the medical students participated in pre- and postintervention surveys designed to determine their awareness of SDH’s impact on health as well as their attitudes toward screening for SDH issues and incorporating resources, including a legal resource, to address them. Mean ratings were compared between pre- and postintervention respondent cohorts using independent-sample t tests. Outcomes: Of the 222 medical students who participated in the program, 102 (46%) completed the preintervention survey and 100 (45%) completed the postintervention survey. Postintervention survey results indicated that students self-reported an increased likelihood to screen patients for SDH issues and an increased likelihood to refer patients to a legal resource ($P < .001$).

NEXT STEPS: Incorporating interprofessional medical–legal education into undergraduate medical education may result in an increased likelihood to screen patients for SDH and to refer patients with legal needs to a legal resource. In the future, an additional evaluation to assess the

curriculum's long-term impact will be administered prior to graduation.

Pinto, A. D. and Bloch, G. (2017). Framework for building primary care capacity to address the social determinants of health. *Canadian Family Physician*, 63(11): e476-e482.

Retrieved from: <http://www.cfp.ca/content/cfp/63/11/e476.full.pdf>

PROBLEM ADDRESSED: Family physicians have long understood that social factors influence the health of individuals and communities; however, most primary care organizations have yet to develop the capacity to specifically address these social determinants of health (SDOH).

OBJECTIVE OF PROGRAM: To support SDOH interventions and foster an organizational culture in which addressing SDOH is considered part of high-quality primary care.

PROGRAM DESCRIPTION: An academic family health team in Toronto, Ont, established a committee comprising a diverse group of health professionals focused on the SDOH. The committee analyzes how social factors affect patients and supports the development and implementation of interventions. The committee's current interventions include the following: collecting and analyzing detailed sociodemographic data to identify health inequities; launching an income security health promotion service; establishing a medical-legal partnership; implementing a child literacy program in its clinics; and developing an advocacy and service program to improve access to decent work. Each intervention includes a rigorous evaluation plan to assess implementation and effect. Next steps include developing tools to enable organizations to "move upstream" and adopt a health equity approach to all work, including joining in advocacy.

CONCLUSION: Primary care providers are well situated to address SDOH. This article provides a framework that can assist every large primary care organization in establishing a similar committee dedicated to SDOH, which could help build a network across Canada to share lessons learned and support joint advocacy.

Schoenthaler, A. M. (2017). Reexamining medication adherence in black patients with hypertension through the lens of the social determinants of health. *The Journal of Clinical Hypertension*, 19(10): 1025-1027.

Retrieved from: <https://onlinelibrary.wiley.com/doi/full/10.1111/jch.13071>

Despite the prominent place of health disparities on the national research agenda over the past 2 decades,¹ marked racial and ethnic disparities in hypertension between blacks and whites still persist.² Approximately 41% of black persons have hypertension, as compared with 28% of whites, making the prevalence in blacks among the highest in the world.² Poor adherence to prescribed antihypertensive medications has been indicated as a major contributor to poor hypertension control in black patients and may explain the racial disparities in health outcomes.³ An extensive body of research has been dedicated to understanding the reasons for nonadherence to prescribed antihypertensive medications among patients with hypertension.^{4, 5} The evidence from all previous research to date indicates that the barriers to adherence are multifactorial and interventions must move beyond a "single bullet approach" to address the growing burden of medication nonadherence on the healthcare system.⁶ However, despite the millions of dollars spent on interventions targeted at medication adherence each

year, the rates are still abysmally low, especially among black persons.⁷

Schroeder, K., Kohl Malone, S., McCabe, E., and Lipman, T. (2018). Addressing the Social Determinants of Health: A Call to Action for School Nurses. *The Journal of School Nursing*, 34(3): 182-191.

Social determinants of health (SDOH), the conditions in which children are born, grow, live, work or attend school, and age, impact child health and contribute to health disparities. School nurses must consider these factors as part of their clinical practice because they significantly and directly influence child well-being. We provide clinical guidance for addressing the SDOH when caring for children with three common health problems (obesity, insufficient sleep, and asthma). Given their unique role as school-based clinical experts, care coordinators, and student advocates, school nurses are well suited to serve as leaders in addressing SDOH.

Simmons, R. A., Cosgrove, S.C., Romney, M.C., Plumb, J.D., Brawer, R.O., et al. (2017). Health literacy: cancer prevention strategies for early adults. *American Journal of Preventive Medicine*, 53(3): S73-S77.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S0749379717302064>

Health literacy, the degree to which individuals have the capacity to obtain, process, and understand health information and services needed to make health decisions, is an essential element for early adults (aged 18-44 years) to make informed decisions about cancer. Low health literacy is one of the social determinants of health associated with cancer-related disparities. Over the past several years, a nonprofit organization, a university, and a cancer center in a major urban environment have developed and implemented health literacy programs within healthcare systems and in the community. Health system personnel received extensive health literacy training to reduce medical jargon and improve their patient education using plain language easy-to-understand written materials and teach-back, and also designed plain language written materials including visuals to provide more culturally and linguistically appropriate health education and enhance web-based information. Several sustainable health system policy changes occurred over time. At the community level, organizational assessments and peer leader training on health literacy have occurred to reduce communication barriers between consumers and providers. Some of these programs have been cancer specific, including consumer education in such areas as cervical cancer, skin cancer, and breast cancer that are targeted to early adults across the cancer spectrum from prevention to treatment to survivorship. An example of consumer-driven health education that was tested for health literacy using a comic book-style photonovel on breast cancer with an intergenerational family approach for Chinese Americans is provided. Key lessons learned from the health literacy initiatives and overall conclusions of the health literacy initiatives are also summarized.

Spatz, M. A. (2000). Providing consumer health information in the rural setting: Planetree Health Resource Center's approach. *Bulletin of the Medical Library Association*, 88(4), 382–388.

Both lifestyle and geography make the delivery of consumer health information in the rural

setting unique. The Planetree Health Resource Center in The Dalles, Oregon, has served the public in a rural setting for the past eight years. It is a community-based consumer health library, affiliated with a small rural hospital, Mid-Columbia Medical Center. One task of providing consumer health information in rural environments is to be in relationship with individuals in the community. Integration into community life is very important for credibility and sustainability. The resource center takes a proactive approach and employs several different outreach efforts to deepen its relationship with community members. It also works hard to foster partnerships for improved health information delivery with other community organizations, including area schools. This paper describes Planetree Health Resource Center's approach to rural outreach.

Chapter 5

Burnout as an Impediment to Empathy and Compassion

Dewa, C.S., Loong, D., Bonato, S., Nguyen, X.T., and Jacobs, P. (2014) How does burnout affect physician productivity? A systematic literature review. *BMC Health Services Research*, 14(325).

Retrieved from: <https://doi.org/10.1186/1472-6963-14-325>

BACKGROUND: Interest in the well-being of physicians has increased because of their contributions to the healthcare system quality. There is growing recognition that physicians are exposed to workplace factors that increase the risk of work stress. Long-term exposure to high work stress can result in burnout. Reports from around the world suggest that about one-third to one-half of physicians experience burnout. Understanding the outcomes associated with burnout is critical to understanding its affects on the healthcare system. Productivity outcomes are among those that could have the most immediate effects on the healthcare system. This systematic literature review is one of the first to explore the evidence for the types of physician productivity outcomes associated with physician burnout. It answers the question, "How does burnout affect physician productivity?"

METHODS: A systematic search was performed of: *Medline Current*, *Medline in process*, *PsycInfo*, *Embase*, and *Web of Science*. The search period covered 2002 to 2012. The searches identified articles about practicing physicians working in civilian settings. Articles that primarily looked only at residents or medical students were excluded. Productivity was captured by hours worked, patients seen, sick leave, leaving the profession, retirement, workload and presenteeism. Studies also were excluded if: (1) the study sample was not comprised of at least 50% physicians, (2) the study did not examine the relationship between burnout and productivity or (3) a validated measure of burnout was not used.

RESULTS: The search identified 870 unique citations; 5 met the inclusion/exclusion criteria. This review indicates that globally there is recognition of the potential impact of physician burnout on productivity. Productivity was examined using: number of sick leave days, work ability, intent to either continue practicing or change jobs. The majority of the studies indicate there is a negative relationship between burnout and productivity. However, there is variation depending on the type of productivity outcome examined.

CONCLUSIONS: There is evidence that burnout is associated with decreased productivity. However, this line of inquiry is still developing. A number of gaps are yet to be filled including understanding how to quantify the changes in productivity related to burnout.

Dyrbye, L.N., Varkey, P., Boone, S.L., Satele D.V., Sloan, J.A., and Shanafelt, T.D. (2013). Physician Satisfaction and Burnout at Different Career Stages. *Mayo Clinic Proceedings*. 88(1), 1358-1367.

OBJECTIVE: To explore the work lives, professional satisfaction, and burnout of US physicians by career stage and differences across sexes, specialties, and practice setting.

PARTICIPANTS AND METHODS: We conducted a cross-sectional study that involved a large sample of US physicians from all specialty disciplines in June 2011. The survey included the Maslach Burnout Inventory and items that explored professional life and career satisfaction. Physicians who had been in practice 10 years or less, 11 to 20 years, and 21 years or more were considered to be in early, middle, and late career, respectively.

RESULTS: Early career physicians had the lowest satisfaction with overall career choice (being a physician), the highest frequency of work-home conflicts, and the highest rates of depersonalization (all $p<.001$). Physicians in middle career worked more hours, took more overnight calls, had the lowest satisfaction with their specialty choice and their work-life balance, and had the highest rates of emotional exhaustion and burnout (all $P<.001$). Middle career physicians were most likely to plan to leave the practice of medicine for reasons other than retirement in the next 24 months (4.8%, 12.5%, and 5.2% for early, middle, and late career, respectively). The challenges of middle career were observed in both men and women and across specialties and practice types.

CONCLUSION: Burnout, satisfaction, and other professional challenges for physicians vary by career stage. Middle career appears to be a particularly challenging time for physicians. Efforts to promote career satisfaction, reduce burnout, and facilitate retention need to be expanded beyond early career interventions and may need to be tailored by career stage.

Freudenberger, H. J. (1989). "Burnout: Past, present, and future concerns." *Loss, Grief & Care*, 3(1-2): 1-10.

Retrieved from:

<https://books.google.com/books?hl=en&lr=&id=EVrfAQAAQBAJ&oi=fnd&pg=PA1&ots=K2mJWUpxsr&sig=VhaxYHqWD7bdacllcEV7XsUmX0Q#v=onepage&q&f=false>

Traces the origin of the term and development of the concept of burnout. Ascertaining, coping with, and changing the root causes of burnout require examination of (1) the values, ethics, and morality of society; (2) the organization; and (3) the individual worker within the institution. Contributions of the field to society include introducing and emphasizing the concepts of stress and burnout into the consciousness of society as well as enhancing the philosophies of wellness programs and holistic health. Future accomplishments might include new models and instruments of measurement as well as prevention programs.

Keeton, K., Fenner D.E., Johnson, T.R.B., and Hayward, R.A. (2007). Predictors of Physician Career Satisfaction, Work–Life Balance, and Burnout. *Obstetrics & Gynecology* 109(4).

Retrieved from: <https://pdfs.semanticscholar.org/f711/4e37caf64fb7024bcb91cb75da8aec732c8.pdf>

Objective: To explore factors associated with physician career satisfaction, work–life balance, and burnout focusing on differences across age, gender, and specialty.

METHODS: A cross-sectional, mailed, self-administered survey was sent to a national sample of 2,000 randomly-selected physicians, stratified by specialty, age, and gender (response rate 48%). Main outcome measures included career satisfaction, burnout, and work–life balance. Scales ranged from 1 to 100.

RESULTS: Both women and men report being highly satisfied with their careers (79% compared with 76%, $P<.01$), having moderate levels of satisfaction with work–life balance (48% compared

with 49%, $P=.24$), and having moderate levels of emotional resilience (51% compared with 53%, $P=.09$). Measures of burnout strongly predicted career satisfaction (standardized β 0.36–0.60, $P<.001$). The strongest predictor of work–life balance and burnout was having some control over schedule and hours worked (standardized β 0.28, $P<.001$, and 0.20–0.32, $P<.001$, respectively). Physician gender, age, and specialty were not strong independent predictors of career satisfaction, work–life balance, or burnout.

CONCLUSION: This national physician survey suggests that physicians can struggle with work–life balance yet remain highly satisfied with their career. Burnout is an important predictor of career satisfaction, and control over schedule and work hours are the most important predictors of work–life balance and burnout. Level of Evidence: II.

Klimecki, O. and Singer, O. (2012). Empathic distress fatigue rather than compassion fatigue? Integrating findings from empathy research in psychology and social neuroscience.

Pathological Altruism: 368-383.

Altruism, which is usually defined as an unselfish concern for the welfare of others, was identified early on by scientists and philosophers as a crucial component of our social interactions. However, despite the strong positive connotation of altruism in our society, there are also downsides to altruism, which can be subsumed under the umbrella term of pathological altruism. In this chapter, we begin by describing compassion fatigue—a form of burnout—as an example of how an excess of altruism in caregivers may result in suffering and actually lead to decreased levels of helping. After reviewing definitions of the concepts related to empathy and compassion, we discuss how these concepts have been studied scientifically in the fields of social and developmental psychology and social neuroscience. Finally, we propose an integrative model and argue that compassion fatigue should instead be renamed empathic distress fatigue. We close the chapter by outlining suggestions for promoting prosocial behavior while circumventing pathological altruism in the form of compassion (or empathic distress) fatigue.

Leiter, M. P. and Spence-Laschinger, H.K. (2006). Relationships of Work and Practice Environment to Professional Burnout: Testing a Causal Model. Nursing Research: 55(2) p. 137-146.

Retrieved from:

https://journals.lww.com/nursingresearchonline/Abstract/2006/03000/Relationships_of_Work_and_Practice_Environment_to.9.aspx

BACKGROUND: Research has established clear links between nurses' experience of professional burnout and many qualities of work environments but more work is needed to clarify interrelationships among aspects of complex organizational settings.

OBJECTIVE: To test a nursing worklife model that defined structured relationships among professional practice environment qualities and burnout.

METHODS: Hospital-based nurses in Canada ($N = 8,597$) completed an assessment of worklife (Nursing Work Index, NWI) and burnout (Maslach Burnout Inventory-Human Service Scale, MBI-HSS).

RESULTS: A causal model was used to confirm the factor structure of the Professional Environment Scale (NWI-PES) on a subset of NWI items and the factor structure of the MBI-HSS. The analysis provided support for a structural model (nursing worklife model) linking the five worklife factors used to define a fundamental role for nursing leadership in determining the quality of worklife regarding policy involvement, staffing levels, support for a nursing model of care, and physician-nurse relationships. The analysis supported a direct path (negatively weighted) from staffing to emotional exhaustion and a direct path (positively weighted) from nursing model of care to personal accomplishment.

DISCUSSION: Implications for refining a model of worklife are discussed. Implications for enhancing the quality of worklife and supporting engagement with work are considered.

Olayiwola, J. N., Willard-Grace, R., Dube, K., Hessler, D., Shunk, R., et al. (2018). Higher Perceived Clinic Capacity to Address Patients' Social Needs Associated with Lower Burnout in Primary Care Providers. *Journal of Health Care for the Poor and Underserved, 29*(1): 415-429.

PURPOSE: Primary care physicians (PCP) experience high rates of professional burnout. These symptoms may be magnified in underserved populations. This study explores relationships between clinic capacity to address patients' social needs (SN) and PCP burnout.

METHODS: We conducted a cross-sectional survey of PCPs from three delivery systems in San Francisco. Surveys included three components of burnout, measured by the Maslach Burnout Inventory (MBI) and a four-item instrument exploring attitudes, confidence, individual skills and organizational capacity to address patients' SN.

RESULTS: Provider perception of higher clinic capacity to address patients' SN was the strongest independent predictor of lower burnout. Providers who perceived high clinic capacity and resources to address SN reported significantly greater professional efficacy ($p<.01$), lower emotional exhaustion ($p<.05$), and lower cynicism ($p<.05$).

CONCLUSIONS: Provider perceptions of greater clinic capacity to address SN are significantly associated with lower burnout. Devoting organizational resources to address SN may reduce PCP burnout.

Sabo, B. (2011). Reflecting on the concept of compassion fatigue. *Online journal of issues in nursing 16*(1): 1.

Retrieved from:

<http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No1-Jan-2011/Concept-of-Compassion-Fatigue.html>

A review of the literature on the health of nurses leaves little doubt that their work may take a toll on their psychosocial and physical health and well-being. Nurses working in several specialty practice areas, such as intensive care, mental health, pediatrics, and oncology have been found to be particularly vulnerable to work-related stress. Several types of occupational stress have been identified, including burnout, compassion fatigue, and vicarious traumatization. While the emphasis of this article is on compassion fatigue and its theoretical conceptualization, the concepts of burnout and vicarious traumatization are also discussed. Two questions are posed for discussion: 1) Does compassion fatigue exist on a continuum of occupational stress? If so, is

burnout a pre-condition for compassion fatigue; 2) What are the relationships between the types of occupational stress? To what extent does non-resolution of compassion fatigue increase the risk for developing vicarious traumatization? Case examples are provided to support this discussion.

Sanchez-Reilly, S., Morrison, L.J., Carey, E., Bernacki, R., O'Neill, L., et al. (2013). Caring for oneself to care for others: physicians and their self-care." *The Journal of Supportive Oncology*, 11(2): 75.

Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3974630/>

It is well known that clinicians experience distress and grief in response to their patients' suffering. Oncologists and palliative care specialists are no exception since they commonly experience patient loss and are often affected by unprocessed grief. These emotions can compromise clinicians' personal well-being, since unexamined emotions may lead to burnout, moral distress, compassion fatigue, and poor clinical decisions which adversely affect patient care. One approach to mitigate this harm is self-care, defined as a cadre of activities performed independently by an individual to promote and maintain personal well-being throughout life. This article emphasizes the importance of having a self-care and self-awareness plan when caring for patients with life-limiting cancer and discusses validated methods to increase self-care, enhance self-awareness and improve patient care.

Shanafelt, T.D., Dyrbye, L.N., Sinsky, C., Hasan, O., Satele, D., Sloan, J., and West, C.P. (2016). Relationship Between Clerical Burden and Characteristics of the Electronic Environment With Physician Burnout and Professional Satisfaction. Mayo Clinic Proceedings, 91: p. 836–848.

Retrieved from:

<https://static1.squarespace.com/static/527a6f47e4b06d382162aed0/t/5831e9442994ca3ef536c769/1479665990345/MCP+2016+EHR+burn.pdf>

To evaluate associations between the electronic environment, clerical burden, and burnout in US physicians. Physicians across all specialties in the United States were surveyed between August and October 2014. Physicians provided information regarding use of electronic health records (EHRs), computerized physician order entry (CPOE), and electronic patient portals. Burnout was measured using validated metrics. Of 6375 responding physicians in active practice, 5389 (84.5%) reported that they used EHRs. Of 5892 physicians who indicated that CPOE was relevant to their specialty, 4858 (82.5%) reported using CPOE. Physicians who used EHRs and CPOE had lower satisfaction with the amount of time spent on clerical tasks and higher rates of burnout on univariate analysis. On multivariable analysis, physicians who used EHRs (odds ratio [OR]=0.67; 95% CI, 0.57-0.79; P<.001) or CPOE (OR=0.72; 95% CI, 0.62-0.84; P<.001) were less likely to be satisfied with the amount of time spent on clerical tasks after adjusting for age, sex, specialty, practice setting, and hours worked per week. Use of CPOE was also associated with a higher risk of burnout after adjusting for these same factors (OR=1.29; 95% CI, 1.12-1.48; P<.001). Use of EHRs was not associated with burnout in adjusted models controlling for CPOE and other factors. In this large national study, physicians' satisfaction with their EHRs and CPOE was generally low. Physicians who used EHRs and CPOE were less satisfied with the amount of time spent on clerical tasks and were at higher risk for professional burnout.

Shanafelt, T. D. (2009). Enhancing meaning in work: a prescription for preventing physician burnout and promoting patient-centered care. *JAMA*, 302(12): 1338-1340.

Retrieved from: <https://jamanetwork.com/journals/jama/fullarticle/184612>

Burnout is a pervasive problem among physicians.¹ The burnout syndrome is characterized by losing enthusiasm for work (emotional exhaustion), treating people as if they were objects (depersonalization), and having a sense that work is no longer meaningful (low personal accomplishment).² Numerous global studies involving nearly every medical and surgical specialty indicate that approximately 1 of every 3 physicians is experiencing burnout at any given time. The prevalence of burnout among physicians is cause for concern. Burnout appears to alter both the physician-patient relationship and the quality of care physicians provide. Physicians' degree of burnout and professional satisfaction are related to physician empathy and compassion, prescribing habits, referral practices, professionalism, and the likelihood of making medical errors.^{1,3-5} Physician burnout also appears to influence patient adherence to recommended therapy, the degree of trust and confidence patients have in their physician, and patients' satisfaction with their medical care.^{6,7} In addition to these professional repercussions, burnout can have profound personal consequences for physicians, including substance abuse, intent to leave medical practice, and suicide.^{1,8}

Shanafelt, T., Hasan, O., Dyrbye, L., Sinsky, C., Satele, D., Sloan, J., and West, C. (2015). Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014. *Mayo Clinic Proceedings*, 90(12):1600-13.

Retrieved from: doi: 10.1016/j.mayocp.2015.08.023.

OBJECTIVE: To evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US workers in 2014 relative to 2011.

PATIENTS AND METHODS: From August 28, 2014, to October 6, 2014, we surveyed both US physicians and a probability-based sample of the general US population using the methods and measures used in our 2011 study. Burnout was measured using validated metrics, and satisfaction with work-life balance was assessed using standard tools.

RESULTS: Of the 35,922 physicians who received an invitation to participate, 6880 (19.2%) completed surveys. When assessed using the Maslach Burnout Inventory, 54.4% (n=3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5% (n=3310) in 2011 ($p<.001$). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (48.5% vs 40.9%; $p<.001$). Substantial differences in rates of burnout and satisfaction with work-life balance were observed by specialty. In contrast to the trends in physicians, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working US adults, resulting in an increasing disparity in burnout and satisfaction with work-life balance in physicians relative to the general US working population. After pooled multivariate analysis adjusting for age, sex, relationship status, and hours worked per week, physicians remained at an increased risk of burnout (odds ratio, 1.97; 95% CI, 1.80-2.16; $p<.001$) and were less likely to be satisfied with work-life balance (odds ratio, 0.68; 95% CI, 0.62-0.75; $p<.001$).

CONCLUSION: Burnout and satisfaction with work-life balance in US physicians worsened from 2011 to 2014. More than half of US physicians are now experiencing professional burnout.

Zwack, J. and Schweitzer, J. (2013). If Every Fifth Physician Is Affected by Burnout, What About the Other Four? Resilience Strategies of Experienced Physicians. Academic Medicine: 88(3), p. 382-389.

Retrieved from:

https://journals.lww.com/academicmedicine/fulltext/2013/03000>If_Every_Fifth_Physician_Is_Affected_by_Burnout,.29.aspx?casa_token=X-LzkWfQQMAAAAA:aP7qG5iNFUCwx5g1CHqJ3hMKwcJoAOkoLjqJpNWuqiYAreV7Qx9d4k_NC-DLvDLzNTOZeMpwvZGKPUXT6-bmA

PURPOSE: To identify health-promoting strategies employed by experienced physicians in order to define prototypical resilience processes and key aspects of resilience-fostering preventive actions.

METHOD: From January 2010 to March 2011, the authors conducted 200 semistructured interviews with physicians of different ages, disciplines, and hierarchical status from Germany. The interview transcripts were analyzed according to the Content Analysis method.

RESULTS: Analysis revealed 30 subcodes in three dimensions: (1) job-related gratifications derived from treatment interactions, (2) practices, such as leisure-time activities, self-demarcation, limitation of working hours, and continuous professional development, and (3) attitudes, such as acceptance of professional and personal boundaries, a focus on positive aspects of work, and personal reflexivity.

CONCLUSIONS: The reported strategies and attitudes helped to develop mental, physical and social resource pools that fostered effective decision making. Successful coping, in turn, encouraged the maintenance of resilience-promoting abilities. In relation to Conservation of Resources Theory, physician resilience emerged as the ability to invest personal resources in a way to that initiates positive resource spirals in spite of stressful working conditions. Enriching traditional stress management approaches with the dynamic of positive as well as negative resource spirals would thus appear to be a promising approach.

Chapter 6:

Programs to Teach and Encourage Assessment of WMTY in Practice

Alegria, M., Nakash, O., Johnson, K., Ault-Brutus, A., Carson, N., Fillibrunn, M., et al. (2018). Effectiveness of the DECIDE interventions on shared decision making and perceived quality of care in behavioral health with multicultural patients: A randomized clinical trial. *JAMA Psychiatry*, 75(4),325-335.

Retrieved from: <https://doi.org/10.1001/jamapsychiatry.2017.4585>

IMPORTANCE: Few randomized clinical trials have been conducted with ethnic/racial minorities to improve shared decision making (SDM) and quality of care.

OBJECTIVE: To test the effectiveness of patient and clinician interventions to improve SDM and quality of care among an ethnically/racially diverse sample.

DESIGN, SETTING, AND PARTICIPANTS: This cross-level 2 × 2 randomized clinical trial included clinicians at level 2 and patients (nested within clinicians) at level 1 from 13 Massachusetts behavioral health clinics. Clinicians and patients were randomly selected at each site in a 1:1 ratio for each 2-person block. Clinicians were recruited starting September 1, 2013; patients, starting November 3, 2013. Final data were collected on September 30, 2016. Data were analyzed based on intention to treat.

INTERVENTIONS: The clinician intervention consisted of a workshop and as many as 6 coaching telephone calls to promote communication and therapeutic alliance to improve SDM. The 3-session patient intervention sought to improve SDM and quality of care.

MAIN OUTCOMES AND MEASURES: The SDM was assessed by a blinded coder based on clinical recordings, patient perception of SDM and quality of care, and clinician perception of SDM.

RESULTS: Of 312 randomized patients, 212 (67.9%) were female and 100 (32.1%) were male; mean (SD) age was 44.0 (15.0) years. Of 74 randomized clinicians, 56 (75.7%) were female and 18 (4.3%) were male; mean (SD) age was 39.8 (12.5) years. Patient-clinician pairs were assigned to 1 of the following 4 design arms: patient and clinician in the control condition ($n = 72$), patient in intervention and clinician in the control condition ($n = 68$), patient in the control condition and clinician in intervention ($n = 83$), or patient and clinician in intervention ($n = 89$). All pairs underwent analysis. The clinician intervention significantly increased SDM as rated by blinded coders using the 12-item Observing Patient Involvement in Shared Decision Making instrument ($b = 4.52$; $SE = 2.17$; $P = .04$; Cohen $d = 0.29$) but not as assessed by clinician or patient. More clinician coaching sessions (dosage) were significantly associated with increased SDM as rated by blinded coders ($b = 12.01$; $SE = 3.72$; $P = .001$; Cohen $d = 0.78$). The patient intervention significantly increased patient-perceived quality of care ($b = 2.27$; $SE = 1.16$; $P = .05$; Cohen $d = 0.19$). There was a significant interaction between patient and clinician dosage ($b = 7.40$; $SE = 3.56$; $P = .04$; Cohen $d = 0.62$), with the greatest benefit when both obtained the recommended dosage.

CONCLUSIONS AND RELEVANCE: The clinician intervention could improve SDM with minority populations, and the patient intervention could augment patient-reported quality of care.

Berg, K., Majdan, J., Berg, D., Veloski, J., and Hojat, M. (2011). Medical Students' Self-Reported Empathy and Simulated Patients' Assessments of Student Empathy: An Analysis by Gender and Ethnicity. *Academic Medicine*, 86(8) p. 984-988.

Retrieved from:

https://journals.lww.com/academicmedicine/fulltext/2011/08000/Medical_Students__Self_Reported_Empathy_and.22.aspx

PURPOSE: To examine the contribution of students' gender and ethnicity to assessments by simulated patients (SPs) of medical students' empathy, and to compare the results with students' self-assessments of their own empathy.

METHOD: In 2008, the authors used three different tools to assess the empathy of 248 third-year medical students. Students completed the Jefferson Scale of Physician Empathy (JSPE), and SPs completed the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE) and a global rating of empathy (GRE) in 10 objective structured clinical examination (OSCE) encounters.

RESULTS: Of the 248 students who completed an end-of-third-year OSCE, 176 (71%) also completed the JSPE. Results showed that women scored higher than men on all three measures of empathy. The authors detected no significant difference between white and Asian American students on their self-report JSPE scores. However, the SPs' assessments on the JSPPPE and on the GRE were significantly lower, indicating less empathy, for Asian American students.

CONCLUSIONS: A tool for SPs to assess students' empathy during an OSCE could be helpful for unmasking some deficits in empathy in students during the third year of medical school. Because the authors found no significant differences on self-reported empathy, the differences they observed in the SPs' assessments of white and Asian American students were unexpected and need further exploration. These findings call for investigation into the reasons for such differences so that OSCEs and other examinations comply with the guidelines for fairness in educational and psychological testing as recommended by professional testing organizations.

Bowie, P., McNab, D., Ferguson, J., de Wet, C., Smith, G., et al. (2015). Quality improvement and person-centeredness: a participatory mixed methods study to develop the 'always event' concept for primary care. *BMJ Open*, 5(4): e006667.

Retrieved from:

https://bmjopen.bmj.com/content/5/4/e006667?utm_source=trendmd&utm_medium=cpc&utm_campaign=bmjopen&trendmd-shared=1&utm_content=Journalcontent&utm_term=TrendMDPhase4

OBJECTIVES: (1) To ascertain from patients what really matters to them on a personal level of such high importance that it should 'always happen' when they interact with healthcare professionals and staff groups. (2) To critically review existing criteria for selecting 'always events' (AEs) and generate a candidate list of AE examples based on the patient feedback data.

DESIGN: Mixed methods study informed by participatory design principles.

SUBJECTS AND SETTING: Convenience samples of patients with a long-term clinical condition in Scottish general practices.

RESULTS: 195 patients from 13 general practices were interviewed (n=65) or completed questionnaires (n=130). 4 themes of high importance to patients were identified from which examples of potential 'AEs' (n=8) were generated: (1) emotional support, respect and kindness (e.g., "I want all practice team members to show genuine concern for me at all times"); (2) clinical care management (e.g., "I want the correct treatment for my problem"); (3) communication and information (e.g., "I want the clinician who sees me to know my medical history") and (4) access to, and continuity of, healthcare (e.g., "I want to arrange appointments around my family and work commitments"). Each 'AE' was linked to a system process or professional behavior that could be measured to facilitate improvements in the quality of patient care.

CONCLUSIONS: This study is the first known attempt to develop the AE concept as a person-centered approach to quality improvement in primary care. Practice managers were able to collect data from patients on what they 'always want' in terms of expectations related to care quality from which a list of AE examples was generated that could potentially be used as patient-driven quality improvement (QI) measures. There is strong implementation potential in the Scottish health service. However, further evaluation of the utility of the method is also necessary.

Campbell-Scherer, D., Rogers, J., Manca, D., Lang-Robertson, K., Bell, S., et al. (2014).
Guideline harmonization and implementation plan for the BETTER trial: Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Family Practice. CMAJ Open, 2(1): E1.

Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006665/>

BACKGROUND: The aim of the Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Family Practice (BETTER) randomized controlled trial is to improve the primary prevention of and screening for multiple conditions (diabetes, cardiovascular disease, cancer) and some of the associated lifestyle factors (tobacco use, alcohol overuse, poor nutrition, physical inactivity). In this article, we describe how we harmonized the evidence-based clinical practice guideline recommendations and patient tools to determine the content for the BETTER trial.

METHODS: We identified clinical practice guidelines and tools through a structured literature search; we included both indexed and grey literature. From these guidelines, recommendations were extracted and integrated into knowledge products and outcome measures for use in the BETTER trial. End-users (family physicians, nurse practitioners, nurses and dieticians) were engaged in reviewing the recommendations and tools, as well as tailoring the content to the needs of the BETTER trial and family practice.

RESULTS: In total, 3-5 high-quality guidelines were identified for each condition; from these, we identified high-grade recommendations for the prevention of and screening for chronic disease. The guideline recommendations were limited by conflicting recommendations, vague wording and different taxonomies for strength of recommendation. There was a lack of quality evidence for maneuvers to improve the uptake of guidelines among patients with depression. We developed the BETTER clinical algorithms for the implementation plan. Although it was difficult to identify high-quality tools, 180 tools of interest were identified.

INTERPRETATION: The intervention for the BETTER trial was built by integrating existing guidelines and tools, and working with end-users throughout the process to increase the

intervention's utility for practice. TRIAL REGISTRATION: ISRCTN07170460.

Chen, D.C.R., Pahilan, M.E. & Orlander, J.D. (2010). Comparing a Self-Administered Measure of Empathy with Observed Behavior Among Medical Students. *Journal of General Internal Medicine*, 25(200).

Retrieved from: <https://link.springer.com/article/10.1007/s11606-009-1193-4>

PURPOSE: Studies show that measures of physician and medical students' empathy decline with clinical training. Presently, there are limited data relating self-reported measures to observed behavior. This study explores a self-reported measure and observed empathy in medical students.

METHOD: Students in the Class of 2009, at a university-based medical school, were surveyed at the end of their 2nd and 3rd year. Students completed the Jefferson Scale of Physician Empathy-Student Version (JSPE-S), a self-administered scale, and were evaluated for demonstrated empathic behavior during Objective Structured Clinical Examinations (OSCEs).

RESULTS: 97.6% and 98.1% of eligible students participated in their 2nd and 3rd year, respectively. The overall correlation between the JSPE-S and OSCE empathy scores was 0.22, $p < 0.0001$. Students had higher self-reported JSPE-S scores in their 2nd year compared to their 3rd year (118.63 vs. 116.08, $p < 0.0001$), but had lower observed empathy scores (3.96 vs. 4.15, $p < 0.0001$).

CONCLUSIONS: Empathy measured by a self-administered scale decreased, whereas observed empathy increased among medical students with more medical training.

Hansen, H. and Metzl, J.M. (2017). New Medicine for the US Health Care System: Training Physicians for Structural Interventions. *Academic Medicine: Journal of the Association of American Medical Colleges*, 92(3): 279-281.

Retrieved from:

[https://journals.lww.com/academicmedicine/fulltext/2017/03000/New Medicine for the U S Health Care System .13.aspx](https://journals.lww.com/academicmedicine/fulltext/2017/03000/New_Medicine_for_the_U_S_Health_Care_System_.13.aspx)

Structural competency provides a language and theoretical framework to promote institutional-level interventions by clinical practitioners working with community organizations, non-health-sector institutions, and policy makers. The special collection of articles on structural competency in this issue of Academic Medicine addresses the need to move from theory to an appraisal of core educational interventions that operationalize the goals of and foster structural competency. In this Commentary, the authors review the role of clinical practitioners in enhancing population-level health outcomes through collaborations with professionals in fields outside medicine, including the social sciences and law. They describe the core elements of structural competency in preclinical and clinical education, as illustrated by the articles of this special collection: perceiving the structural causes of patients' disease, envisioning structural interventions, and cultivating alliances with non-health-sector agencies that can implement structural interventions. Finally, the authors argue that preparing trainees to form partnerships will empower them to influence the social determinants of their patients' health and reduce health inequalities.

**Kebede, S. (2016). Ask patients "What matters to you?" rather than "What's the matter?"
BMJ: (Online) 354, [i4045]. DOI: 10.1136/bmj.i4045**

Maureen Bisognano, one of the keynote speakers at this year's International Forum on Quality and Safety in Healthcare in Gothenburg, Sweden, told delegates that we should ask our patients, "What matters to you?" rather than, "What is the matter?" The question "What matters to you?" tries to get to the essence of patient centered care, which the Institute of Medicine has listed as one of the priorities for quality improvement. As physicians, our success in treating illness depends mostly on our ability to diagnose what the matter is with the patient. Pattern recognition, attention to verbal and visual cues from the patient, deductive reasoning, and good clinical judgment are time revered skills that good physicians spend years perfecting.

**Krishnaswami, J., Jaini, P.A., Howard, R., and Ghaddar, S. (2018). Community-Engaged Lifestyle Medicine: Building Health Equity Through Preventive Medicine Residency Training.
American Journal of Preventive Medicine. In press,**

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S0749379718316957>

Vulnerable populations in the U.S. experience persistent disparities in chronic disease and associated lifestyle-based risk factors. Because of environmental, cultural, and health systems barriers affecting vulnerable populations, lifestyle medicine interventions may miss those at highest risk for chronic disease. Numerous reports suggest that graduate medical education (GME) inadequately prepares physicians to promote healthy lifestyles and health equity in vulnerable groups. General Preventive Medicine/Public Health (GPM/PH), the medical specialty dedicated to health promotion and disease prevention in populations, can fill this gap. However, virtually no published reports describe health equity-oriented GPM/PH residency programs. The authors describe implementation of the novel Community-Engaged Lifestyle Medicine at the University of Texas Rio Grande Valley GPM/PH residency program between 2017 and 2018. Community-Engaged Lifestyle Medicine applies community engagement principles to lifestyle medicine practice, training residents in multilevel, intersectoral approaches promoting behavior change and health equity. Community-Engaged Lifestyle Medicine is described in the context of health equity and the local border community, along with associated curricular objectives and experiences. In 2017, the authors assessed first-year Community-Engaged Lifestyle Medicine process outcomes, fidelity to health equity mechanisms, and feasibility in a GPM/PH residency, by mapping Community-Engaged Lifestyle Medicine activities to American Council of Graduate Medical Education and the American College of Lifestyle Medicine competencies. The Community-Engaged Lifestyle Medicine framework was successfully implemented in 2017, meets all American Council of Graduate Medical Education competency Chapters, and demonstrates fidelity to mechanisms of community engagement, health equity, and the practice of lifestyle medicine. Community-Engaged Lifestyle Medicine represents a feasible and valid framework to promote health equity via GPM/PH and GME training and practice.

Lang, D., Hoey, C., Whelan, M., and Price, G. (2017) The introduction of “What Matters to You”: a quality improvement initiative to enhance compassionate person-centered care in hospitals in Ireland. *International Journal of Integrated Care*, 17(5): A445, pp. 1-8, Retrieved from: DOI: dx.doi.org/10.5334/ijic.3765

Rationale for this initiative: On admission and throughout the acute hospital stay, the main focus of the healthcare professional is the medical model of care, which revolves around the physical status of the patient (Dewar & Nolan 2013). Hospital staff work in a system where patient flow and lengths of stay are indicators of effective organisations (Shahin & Mahood 2007). The emphasis appears to centre on “What’s the matter with you” (Doyle et al. 2010). While the presenting health issue is a concern to the patient, their experience of hospital care is measured by the level of dignity, compassion and respect with which they are treated (HSE & Age Friendly Ireland 2015).

Leppin, A., Montori, V.M., and Gionfriddo, M.R. (2015) Minimally Disruptive Medicine: A Pragmatically Comprehensive Model for Delivering Care to Patients with Multiple Chronic Conditions. *Healthcare*, 3(1) 50-63.

Retrieved from: doi: 10.3390/healthcare3010050

An increasing proportion of healthcare resources in the United States are directed toward an expanding group of complex and multimorbid patients. Federal stakeholders have called for new models of care to meet the needs of these patients. Minimally Disruptive Medicine (MDM) is a theory-based, patient-centered, and context-sensitive approach to care that focuses on achieving patient goals for life and health while imposing the smallest possible treatment burden on patients' lives. The MDM Care Model is designed to be pragmatically comprehensive, meaning that it aims to address any and all factors that impact the implementation and effectiveness of care for patients with multiple chronic conditions. It comprises core activities that map to an underlying and testable theoretical framework. This encourages refinement and future study. Here, we present the conceptual rationale for and a practical approach to minimally disruptive care for patients with multiple chronic conditions. We introduce some of the specific tools and strategies that can be used to identify the right care for these patients and to put it into practice. [View Full-Text](#)

Lorig, K., Ritter, P.L., Moreland, C., and Laurent, D.D. (2015). Can a box of mailed materials achieve the triple aim of health care? The mailed chronic disease self-management toolkit study. *Health Promotion Practice*, 16(5): 765-774.

Retrieved from: <http://journals.sagepub.com/doi/abs/10.1177/1524839915571633>

Not all patients with chronic conditions are able or willing to participate in small-group or Internet self-management programs. Based on the Arthritis Mailed Tool Kit Program and the Chronic Disease Self-Management Program, a mailed Chronic Disease Self-Management Tool Kit, delivered in a onetime mailing, was developed as an alternative mode of delivery. Kits were mailed to a national sample of 255 participants with varying chronic conditions and evaluated in a longitudinal (6-month) trial. Outcomes reflected the triple aims of health care. At 6 months, participants demonstrated better health care indicators, better health indicators, and less health

care utilization. There were significant improvements in two health care indicators and six health indicators and reductions in physician visits. Follow-up response rate was high (85%). There were no significant baseline differences between responders and nonresponders. Subgroup analyses were performed for a number of subgroups, including those with arthritis (58%) and/or depression (43%), and for African Americans (14%). Subgroups demonstrated improvements equal to or better than the overall group. The Mailed Chronic Disease Self-Management Tool Kit represents a third mode, along with small groups and Internet, of delivering self-management patient education, and appears to contribute to meeting the triple aims of health care for those who actively chose this mode of delivery.

Manca, D.P., Greiver, M., Carroll, J.C., et al. (2014). "Finding a BETTER way: a qualitative study exploring the prevention practitioner intervention to improve chronic disease prevention and screening in family practice." BMC family practice 15(1): 66.

Retrieved from: <https://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-15-66>

BACKGROUND: Our randomized controlled trial (The BETTER Trial) found that training a clinician to become a Prevention Practitioner (PP) in family practices improved chronic disease prevention and screening (CDPS). PPs were trained on CDPS and provided prevention prescriptions tailored to participating patients. For this embedded qualitative study, we explored perceptions of this new role to understand the PP intervention.

METHODS: We used grounded theory methodology and purposefully sampled participants involved in any capacity with the BETTER Trial. Two physicians and one coordinator in each of two cities (Toronto, Ontario and Edmonton, Alberta) conducted eight individual semi-structured interviews and seven focus groups. We used an interview guide and documented research activities through an audit trail, journals, field notes and memos. We analyzed the data using the constant comparative method throughout open coding followed by theoretical coding.

RESULTS: A framework and process involving external and internal practice facilitation using the new role of PP was thought to impact CDPS. The PP facilitated CDPS through on-going relationships with patients and practice team members. Key components included: 1) approaching CDPS in a comprehensive manner, 2) an individualized and personalized approach at multiple levels, 3) integrated continuity that included linking the patients and practices to CPDS resources, and 4) adaptability to different practices and settings.

CONCLUSIONS: The BETTER framework and key components are described as impacting CDPS through a process that involved a new role, the PP. The introduction of a novel role of a clinician within the primary care practice with skills in CDPS could appropriately address gaps in prevention and screening.

May, C., Montori, V.M., and Mair, F.S. (2009) We need minimally disruptive medicine. BMJ: British Medical Journal (Online), 339.

Retrieved from: DOI:10.1136/bmj.b2803

The burden of treatment for many people with complex, chronic, comorbidities reduces their capacity to collaborate in their care. Carl May, Victor Montori , and Frances Mair argue that to be effective, care must be less disruptive

Montori, V. (2010) Minimally Disruptive Medicine. Mayo Clinic Video

Retrieved from: <https://vimeo.com/13406874>

In this popular Mayo Clinic video, Dr. Victor Montori, a professor of endocrinology and a health researcher at the Mayo Clinic with expertise in evidence based care and shared decision making, describes why understanding “What Matters” to a patient is foundational to providing patient centered care. Dr. Montori introduces a fictional patient named John to demonstrate why and how “Minimally Disruptive Medicine” (MDM) and Shared Decision Making are important keys to effective patient engagement.

Mullins, C. D., Shaya, F.T., Blatt, L., and Saunders, E. (2012). "A qualitative evaluation of a citywide Community Health Partnership program." *Journal of the National Medical Association*, 104(1): 53-60.

Retrieved from: <https://search-proquest-com.eblibrary.einstein.yu.edu/docview/1009646492?accountid=58896>

While there have been numerous community-based programs in Baltimore, Maryland, aimed at helping patients access medical treatments and services, they historically were underutilized and did not operate synergistically. For that reason, Sanofi-Aventis, along with key stakeholders in Baltimore, developed the Community Health Partnership (CHP) to educate, empower, and connect patients to community health resources to enable patients to be more proactive about their health. The CHP utilizes a community health liaison (CHL) and a community health action team (CHAT) consisting of community health leaders who are hands-on activists and health care workers who coordinate activities and provide guidance for the CHP. The goal of the program is to foster community collaboration to raise awareness of the need to improve health in the community and to identify and connect patients to existing resources and services that can help. A qualitative evaluation of the Baltimore CHP was conducted through focus group and key informant interviews with members of the CHAT and CHP. Results suggest that the CHP program has enhanced patient-provider relationships, brought together a wealth of resources, and made people more aware of health information. The CHP facilitated providers' ability to help patients find resources and empowered patients in the community to better manage their health conditions. In parallel, physicians requested additional culturally sensitive resources on medical conditions that addressed the health literacy of their diverse patients. Through stakeholder engagement, many more communities beyond Baltimore can become better networked to help patients navigate the health care system and improve their health.

Ogle, J., Bushness, J., and Caputi, P. (2013) Empathy is related to clinical competence in medical care. *Medical Education*, 47(8).

Retrieved from: <https://onlinelibrary.wiley.com/doi/abs/10.1111/medu.12232>

OBJECTIVES: Most medical schools focus upon aspects of interpersonal functioning such as empathy in the doctor–patient relationship with the aim of training clinically competent doctors. This study investigated the relationship between empathy and clinical competence among medical students. **METHODS:** Fifty-seven medical students participated in the study. Clinical

competence was assessed in an objective structured clinical examination (OSCE). Empathy was rated by an independent observer of the clinical interaction in OSCE stations. In addition, empathy was self-rated using the Jefferson Scale of Physician Empathy–Student Version.

RESULTS: Observed behaviour indicative of empathy, as rated objectively by an independent observer, was strongly associated with clinical competence. The strong association between the behavioural manifestation of empathy and clinical competence was evident across a range of medical conditions and types of consultation. In addition, observable empathy was strongly associated with patients' ratings of the students' performances. Self-rated empathy, however, was not associated with clinical competence. Significant differences in mean total competence scores were noted between students low in observed empathy (mean ± standard deviation [SD]: 165.86 ± 12.92) and students high in observed empathy (mean ± SD: 190.35 ± 14.00) ($t[55] = 6.28$, $p = 0.000$, $\alpha \leq 0.01$).

CONCLUSIONS: In medical education, strategies that enhance the behavioural expression of empathy (or at least retard its decay) could help to make medical students appear to be more clinically competent to both examiners and patients. However, if medical students' internal emotions are found to be discrepant with their behaviour, these findings will raise difficult questions regarding the fundamental nature of genuine empathy and alert us to the possibility that medical students may learn that it pays to subscribe to the view that if a person does not feel empathy, he or she can fake it.

Oxman, A. and Flottorp, S. (2001). An overview of strategies to promote implementation of evidence-based health care. *Evidence-based Practice in Primary Care*, 101: 120.

Retrieved from:

https://www.researchgate.net/profile/Andy_Haines/publication/244178344_Evidence_Based_Practice_in_Primary_Care/links/54bcffde0cf27c8f2812f4fe/Evidence-Based-Practice-in-Primary-Care.pdf#page=112

Evidence is essential but not sufficient for evidence-based practice. At least three types of information and three types of judgments are needed for well-informed decisions (Figure 8.1). First, clinical judgment is needed to identify and diagnose health problems, to learn which health outcomes are important to the patient and to identify which preventive, diagnostic, treatment, or rehabilitation options should be considered. Information for this must be collected from the patient (through history taking, physical examination and diagnostic tests). Second, to estimate the effects of different options on health outcomes, judgments must be made about effectiveness and adverse effects. This information comes from comparative studies, particularly systematic reviews of reliable evidence.¹ It is also important to consider the applicability of comparative studies, diagnostic accuracy and prognostic factors.

Turner, K. (2018). Sharing decisions: what matters to you? Frontline Magazine: Chartered Society of Physiotherapy, 24(8).

Retrieved from: <http://www.csp.org.uk/frontline/article/sharing-decisions-what-matters-you>

(WMTY) movement last year changed everything for me, my team and the people we work with. I was inspired by discovering that a simple yet powerful question is the key to truly patient-centred care: what matters to you? Writing in the New England Journal of Medicine, Michael Barry and Susan Edgman-Levitin discussed implementing shared decision-making with patients.

Healthcare staff should not only ask 'What's the matter with you?', but also 'What matters to you?' That may seem obvious because we all strive to deliver patient-centred, holistic care. However, in my experience, we often assume we know the answer before the patient speaks; or we're too caught up in our own agenda to even ask. We may also be afraid that if we ask, we may not be able to deal with what we hear. We can easily fall into the habit of thinking we know what's best for patients and what goals are important to them. I've discovered that, often, what we think matters most to the patient, is less of a priority for them than it is for us. I've seen how asking this simple question – what matters to you? – can help us to be more effective and to give more meaningful therapy because we have a deeper understanding of what the patient really wants. Word is spreading quickly about WMTY. The third annual WMTY day will be held on 6 June. It will give health and social care professionals opportunities to have a WMTY conversation with those they support or care for. The idea is that we don't just ask what matters, but we listen to what they say matters to them – then act on it. Last year, more than 1,000 people and teams from 30 countries registered to take part and set up WMTY conversations in their areas. That was a 76 per cent increase in registrations and double the number of countries that took part in 2016, the year it all began.

Valaitis, R. K., Carter, N., Lam, A., Nicholl, J., et al. (2017). Implementation and maintenance of patient navigation programs linking primary care with community-based health and social services: a scoping literature review. *BMC Health Services Research*, 17(1): 116.

Retrieved from: <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2046-1>

BACKGROUND: Since the early 90s, patient navigation programs were introduced in the United States to address inequitable access to cancer care. Programs have since expanded internationally and in scope. The goals of patient navigation programs are to: a) link patients and families to primary care services, specialist care, and community-based health and social services (CBHSS); b) provide more holistic patient-centered care; and, c) identify and resolve patient barriers to care. This paper fills a gap in knowledge to reveal what is known about motivators and factors influencing implementation and maintenance of patient navigation programs in primary care that link patients to CBHSS. It also reports on outcomes from these studies to help identify gaps in research that can inform future studies.

METHODS: This scoping literature review involved: i) electronic database searches; ii) a web site search; iii) a search of reference lists from literature reviews; and, iv) author follow up. It included papers from Canada, the United States, the United Kingdom, Australia, New Zealand, and/or Western Europe published between January 1990 and June 2013 if they discussed navigators or navigation programs in primary care settings that linked patients to CBHSS.

RESULTS: Of 34 papers, most originated in the United States ($n = 29$) while the remainder were from the United Kingdom, Canada and Australia. Motivators for initiating navigation programs were to: a) improve delivery of health and social care services; b) support and manage specific health needs or specific population needs, and; c) improve quality of life and wellbeing of patients. Eleven factors were found to influence implementation and maintenance of these patient navigation programs. These factors closely aligned with the Diffusion of Innovation in Service Organizations model, thus providing a theoretical foundation to support them. Various

positive outcomes were reported for patients, providers and navigators, as well as the health and social care system, although they need to be considered with caution since the majority of studies were descriptive.

CONCLUSIONS: This study contributes new knowledge that can inform the initiation and maintenance of primary care patient navigation programs that link patients with CBHSS. It also provides directions for future research.

Van Citters, A. (2017) Experience-Based Co-Design of Health Care Services. Cambridge, Massachusetts: Institute for Healthcare Improvement

Retrieved from: <http://www.ihi.org/resources/Pages/Publications/Experience-Based-Co-Design-Health-Care-Services-Innovation-Case-Study.aspx>

Patients' experiences of care are an important focus for the health systems that serve them, yet few health care organizations deeply involve patients in improving or redesigning services. Experience-based co-design (EBCD), developed in the UK, brings together narrative-based research with service design methods to improve patient and staff experiences of care. Patients and staff are filmed, interviewed, and/or observed to understand positive and negative care experiences. These shared experiences catalyze a change process where patients and staff sit side-by-side to design, implement, and test improvements to health care services. The EBCD method has been used in more than 60 projects in six countries; it has led to improvements in patients' experiences as well as transformations in health care workforce culture, values, and behaviors. EBCD efforts have been associated with reductions in formal complaints in a mental health ward; increases in the percent of patients with cancer who report always being treated with respect and dignity; and greater emergency department staff appreciation for how health care practices and environments affect patients, and how to work with patients to co-design and implement health care services. Successful EBCD requires effective facilitation, an openness to work with uncertainty and creative methods, and six to twelve months to complete a full cycle of improvement. EBCD is adaptable to different health care contexts and is supported by implementation resources.

Wimmers, P.F. and Stuber, M.L. (2010) Assessing medical students' empathy and attitudes towards patient-centered care with existing clinical performance exam (OSCE). Procedia Social and Behavioral Sciences, 2:1911–3.

This research was performed to study the ability of an existing 8-station Objective Structured Clinical Examination (OSCE) to capture the degree of students' patient-centeredness and empathy as measured by the 18-item Patient-Practitioner Orientation Scale (PPOS) and the 20-item Jefferson Scale of Empathy (JSE). A cohort of 101 year-3 students completed the OSCE, PPOS, and JSE. Results showed that students' level of empathy had a moderate association with students' score on the patient-provider interaction component of the OSCE. Simulated patients in clinical encounters can be used for identifying the level of students' empathy.

Wright, B., McKendree, J., Morgan, L., Allgar, V.L., and Brown, A. (2014). Simulated patients' ratings of empathy in medical student final year clinical examination: Are they useful? BMC

Medical Education, 14:199.

BACKGROUND: Many medical schools state that empathy is important and have curricular learning outcomes covering its teaching. It is thought to be useful in team-working, good bedside manner, patient perspective taking, and improved patient care. Given this, one might expect it to be measured in assessment processes. Despite this, there is relatively little literature exploring how measures of empathy in final clinical examinations in medical school map onto other examination scores. Little is known about simulated patient (actors) rating of empathy in examinations in terms of inter-rater reliability compared with clinical assessors or correlation with overall examination results.

METHODS: Examiners in final year clinical assessments in one UK medical school rated 133 students on five constructs in Objective Structured Long Examination Record (OSLER) with real patients: gathering information, physical examination, problem solving, managing the diagnosis, and relationship with the patient. Scores were based on a standardized well-established penalty point system. In separate

OBJECTIVE: Structured Clinical Examination (OSCE) stations, different examiners used the same penalty point system to score performance in both interactional and procedural stations. In the four interaction-based OSCE stations, examiners and simulated patient actors also independently rated empathy of the students.

RESULTS: The OSLER score, based on penalty points, had a correlation of -0.38 with independent ratings of empathy from the interactional OSCE stations. The intra-class correlation (a measure of inter-rater reliability) between the observing clinical tutor and ratings from simulated patients was 0.645 with very similar means. There was a significant difference between the empathy scores of the 94 students passing the first part of the sequential examination, based on combined OSCE and OSLER scores (which did not include the empathy scores), and 39 students with sufficient penalty points to trigger attendance for the second part (Cohen's $d = 0.81$).

CONCLUSIONS: These findings suggest that empathy ratings are related to clinical performance as measured by independent examiners. Simulated patient actors are able to give clinically meaningful assessment scores. This gives preliminary evidence that such empathy ratings could be useful for formative learning, and bolsters the call for more research to test whether they are robust enough to be used summatively.

Chapter 7

Assessment of What Matters to Patients

Barr, P., Thompson, R., Walsh, T., Grande, S.W., Ozanne, E.M., and Elwyn, G. (2014) The psychometric properties of CollaboRATE: A fast and frugal patient-reported measure of the shared decision-making process. *Journal of Medical Internet Research*, 16(1):e2. doi: 10.2196/jmir.3085

BACKGROUND: Patient-centered health care is a central component of current health policy agendas. Shared decision making (SDM) is considered to be the pinnacle of patient engagement and methods to promote this are becoming commonplace. However, the measurement of SDM continues to prove challenging. Reviews have highlighted the need for a patient-reported measure of SDM that is practical, valid, and reliable to assist implementation efforts. In consultation with patients, we developed CollaboRATE, a 3-item measure of the SDM process.

OBJECTIVE: There is a need for scalable patient-reported measure of the SDM process. In the current project, we assessed the psychometric properties of CollaboRATE.

METHODS: A representative sample of the US population were recruited online and were randomly allocated to view 1 of 6 simulated doctor-patient encounters in January 2013. Three dimensions of SDM were manipulated in the encounters:(1) explanation of the health issue, (2) elicitation of patient preferences, and (3) integration of patient preferences. Participants then completed CollaboRATE (possible scores 0-100) in addition to 2 other patient-reported measures of SDM: the 9-item Shared Decision Decision Making Questionnaire (SDM-Q-9) and the Doctor Facilitation subscale of the Patient's Perceived Involvement in Care Scale (PICS). A subsample of participants was resurveyed between 7 and 14 days after the initial survey. We assessed CollaboRATE's discriminative, concurrent, and divergent validity, intrarater reliability, and sensitivity to change.

RESULTS: The final sample consisted of 1341 participants. CollaboRATE demonstrated discriminative validity, with a significant increase in CollaboRATE score as the number of core dimensions of SDM increased from zero (mean score: 46.0, 95% CI 42.4-49.6) to 3 (mean score 85.8, 95% CI 83.2-88.4). CollaboRATE also demonstrated concurrent validity with other measures of SDM, excellent intrarater reliability, and sensitivity to change; however, divergent validity was not demonstrated.

CONCLUSIONS: The fast and frugal nature of CollaboRATE lends itself to routine clinical use. Further assessment of CollaboRATE in real-world settings is required.

Beaumont, J. (2011). "Measuring national well-being: a discussion paper on Chapters and measures."

Retrieved from:

<http://webarchive.nationalarchives.gov.uk/20160105183649/http://www.ons.gov.uk/ons/reI/wellbeing/measuring-national-well-being/discussion-paper-on-Chapters-and-measures/measuring-national-well-being---discussion-paper-on-Chapters-and-measures.html>

This paper discusses proposals for Chapters and headline measures of national well-being and is published in order to obtain your views. These proposals build on the responses to the national debate on measuring national well-being in 2010-11, research into well-being and related international initiatives. The proposals are part of the Office for National Statistics Measuring National Well-being (MNW) Program. The consultation will be open until 23 January 2012.

Blank, A. E., Ryerson-Espino, S.L., Eastwood, B., et al. (2013). The HIV/AIDS women of color initiative improving access to and quality of care for women of color. *Journal of Health Care for the Poor and Underserved*, 24(1): 15-26.

Retrieved from:

https://www.researchgate.net/profile/Arthur_Blank/publication/235397931_The_HIVAIDS_Women_of_Color_Initiative_Improving_Access_to_and_Quality_of_Care_for_Women_of_Col or/links/56b0d63008ae8e372151f902.pdf

In September 2009, the Health Resources and Services Administration, (HRSA) HIV-AIDS Bureau funded 11 programs to engage and retain women of color (WoC) living with HIV in care. This field report describes the rationale for this Special Project of National Significance (SPNS) initiative, the 11 programs in terms of their theoretical frameworks as well as the contexts and mechanism of care, and outlines some factors that may influence engaging and retaining WoC in care.

Bodenheimer T., Lorig K., Holman H., and Grumbach K. (2002) Patient self-management of chronic disease in primary care. *JAMA*, 288:2569-75.

Retrieved from: <https://jamanetwork.com/journals/jama/fullarticle/195525>

Patients with chronic conditions make day-to-day decisions about—self-manage—their illnesses. This reality introduces a new chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education. Self-management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs. Self-management education for chronic illness may soon become an integral part of high-quality primary care.

**Franciosi, J.P., Hommel, K.A., DeBrosse, C.W., Greenberg, A.B., Greenler, A.J., Abonia, J.P., Rothenberg, M.E., and Varni, J.W. (2012). Quality of life in Pediatric Eosinophilic Esophagitis: What is important to patients? *Child: Care, Health and Development*, 38(4), 477–483.
doi:10.1111/j.1365- 2214.2011.01265.x**

BACKGROUND AND AIMS: Current research outcomes in pediatric Eosinophilic Esophagitis (EoE) are directed toward histologic improvement with no attention to health-related quality of life (HRQOL). The primary objective of this study was to identify key patient-reported and parent proxy-outcome (PROs) elements of EoE disease-specific HRQOL.

METHODS: The research team comprised clinical Allergists and Gastroenterologists with expertise in pediatric EoE as well as two Ph.D. psychologists with extensive experience in qualitative research. Focused interview techniques were adapted from the PedsQL 4.0™ methodology and the consolidated criteria for reporting qualitative research (COREQ). A semi-structured interview guide of open-ended questions was developed, and extensive review of audiotaped transcripts was performed.

RESULTS: A total of 42 focus interviews were conducted. Child self-reports were obtained for patients in the 5-7, 8-12, and 13-18 year old age groups, and parent proxy-reports were obtained in the 2-4, 5-7, 8-12, and 13-18 year old age groups. We discovered that patients and parents often had different concerns, illustrating unique aspects of EoE-specific HRQOL that were not captured in generic HRQOL instruments. Specific themes that emerged from these interviews included, but are not limited to: feelings of being different than family and peers, diet and medication adherence, difficulties with eating food, and worry about symptoms and illness.

CONCLUSION: Pediatric EoE patient and parent proxy interviews revealed many EoE-specific aspects of HRQOL that are not captured in generic HRQOL instruments. Outcome measures that reflect patient and parent proxy-reported HRQOL are a critical need in pediatric EoE.

Garg, A., Sheldrick, R.C., and Dworkin, P.H. (2018). "The inherent fallibility of validated screening tools for social determinants of health." *Academic Pediatrics*, 18(2): 123-124.

Retrieved from: [https://www.academicpedsjnl.net/article/S1876-2859\(17\)30606-X/pdf](https://www.academicpedsjnl.net/article/S1876-2859(17)30606-X/pdf) (see also Chapter 4)

Addressing the social and living circumstances of children and families has been a central tenet of pediatrics since its inception. Consistent with this, the American Academy of Pediatrics became the first medical organization to recommend that health care providers screen for social determinants of health (i.e., social circumstances in which people live and work) during patient encounters.¹ In 2016, a subgroup of the Academic Pediatric Association Task Force on Child Poverty published a guide for clinicians on social determinants of health screening.

Katz, A. M., Conant, L., Inui, T., Baron, D., and Bor, D. (2000). A council of elders: creating a multi-voiced dialogue in a community of care. *Social Science & Medicine*, 50(6): 851-860.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S027795369900341X>

In an era of 'medical care delivery systems', there is an increasing need for the patient's voice to be heard, for it to be invited, listened to, and taken seriously. This challenge is particularly evident in geriatrics education, a Chapter of clinical training in which educators and clinicians alike must struggle to overcome adverse attitudes towards the elderly ('ageism'). In this paper we introduce a 'Council of Elders' as an educational innovation in which we invited community elders to function as our 'Senior Faculty', to whom medical residents present their challenging and heartfelt dilemmas in caring for elder patients. In the conversations that ensue, the elders come

to function not simply as teachers, but collaborators in a process in which doctors, researchers, and elders together create a community of resources, capable of identifying novel ways to overcome health-related difficulties which might not have been apparent to either group separately. Using the first meeting of the Council as an exemplar, we describe and discuss the special nature of such meetings and also the special preparations required to build a dialogic relationship between participants from very different worlds--different generations, different cultures (including the professional culture and the world of lived experience). Meetings with the council have become a required part of the primary care residency program--a very different kind of 'challenging case conference' in which moral dilemmas can be presented, discussed and reflected upon. It is not so much that elders give good advice in their responses--although they often do--as that they provide life world and value orientation as young residents gain a better sense of the elder's experience and what matters most to them. This project has been particularly worthwhile in addressing the problem of ageism--a way to render visible stereotypes and adverse physician values, with implications for decision-making with the patient, not for the patient.

Koch, T. and Kralik, D. (2009). Participatory action research in health care, John Wiley & Sons.
Retrieved from:

[https://books.google.com/books?hl=en&lr=&id=aS57hxrEd9YC&oi=fnd&pg=PR4&dq=Koch,+T.+and+D.+Kralik+\(2009\).+Participatory+action+research+in+health+care,+John+Wiley+%26+Sons.+&ots=NR5JXYohYh&sig=bjdezPOFtBgXTkLfzZGX-Zlu9xE#v=onepage&q=Koch%2C%20T.%20and%20D.%20Kralik%20\(2009\).%20Participatory%20action%20research%20in%20health%20care%2C%20John%20Wiley%20%26%20Sons.&f=false](https://books.google.com/books?hl=en&lr=&id=aS57hxrEd9YC&oi=fnd&pg=PR4&dq=Koch,+T.+and+D.+Kralik+(2009).+Participatory+action+research+in+health+care,+John+Wiley+%26+Sons.+&ots=NR5JXYohYh&sig=bjdezPOFtBgXTkLfzZGX-Zlu9xE#v=onepage&q=Koch%2C%20T.%20and%20D.%20Kralik%20(2009).%20Participatory%20action%20research%20in%20health%20care%2C%20John%20Wiley%20%26%20Sons.&f=false)

Participatory Action Research in Health Care Participatory Action Research in Healthcare provides a guide to participatory action research in the community health setting. It draws upon the authors' experiences working, researching and engaging with people utilizing collaborative, participatory approaches. The authors position participatory action research as a vital, dynamic and relevant approach that can be engaged by practitioners and health service providers. It is argued that participating with people is the way to move forward toward sustainable services that evoke human flourishing. Participatory Action Research in Healthcare explores the key issues surrounding participatory action research, and examines the benefits of this approach for community development and health promotion. It includes detailed guidelines on data generation and analysis.

Li, Y. and Rapkin, B.D. (2009). Classification and regression tree uncovered hierarchy of psychosocial determinants underlying quality-of-life response shift in HIV/AIDS. *Journal of Clinical Epidemiology*, 62(11): 1138-1147.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S0895435609001139>

OBJECTIVES: Rapkin and Schwartz define response shift as otherwise unexplained, discrepant change in health-related quality of life (HRQOL) that is associated with change in cognitive appraisal. In this article, we demonstrate how a recursive partitioning (rpart) regression tree analytic approach may be used to explore cognitive changes to gain additional insight into

response-shift phenomena.

STUDY DESIGN AND SETTING: Data are from the "Choices in Care Study," an evaluation of HIV+ Medicaid recipients' experiences and outcomes in care (N=394). Cognitive assessment was based on the QOL appraisal battery. HRQOL was measured by the SF-36 Health Survey, version 2 (SF-36v2).

RESULTS: We used rpart to examine 6-month change in SF-36v2 mental composite score as a function of changes in appraisal, after controlling for patient characteristics, health changes, and intervening events. Rpart identified nine distinct patterns of cognitive change, including three associated with negative discrepancies, four with positive discrepancies, and two with no discrepancies.

CONCLUSION: Rpart classification provides a nuanced treatment of response shift. This methodology has implications for evaluating programs, guiding decisions, and targeting care.

Morganstern, B. A., Bochner, B., Dalbagni, G., Shabsigh, A. et al. (2011). The psychological context of quality of life: a psychometric analysis of a novel idiographic measure of bladder cancer patients' personal goals and concerns prior to surgery. *Health and Quality of Life Outcomes*, 9(1): 10.

Retrieved from: <https://hqlo.biomedcentral.com/articles/10.1186/1477-7525-9-10>

BACKGROUND: Over the past two decades, there has been an increasing focus on quality of life outcomes in urological diseases. Patient-reported outcomes research has relied on structured assessments that constrain interpretation of the impact of disease and treatments. In this study, we present content analysis and psychometric evaluation of the Quality of Life Appraisal Profile. Our evaluation of this measure is a prelude to a prospective comparison of quality of life outcomes of reconstructive procedures after cystectomy.

METHODS: Fifty patients with bladder cancer were interviewed prior to surgery using the Quality of Life Appraisal Profile. Patients also completed the EORTC QLQ-C30 and demographics. Analysis included content coding of personal goal statements generated by the Appraisal Profile, examination of the relationship of goal attainment to content, and association of goal-based measures with QLQ-C30 scales.

RESULTS: Patients reported an average of 10 personal goals, reflecting motivational themes of achievement, problem solving, avoidance of problems, maintaining desired circumstances, letting go of roles and responsibilities, acceptance of undesirable situations, and attaining milestones. 503 goal statements were coded using 40 different content categories. Progress toward goal attainment was positively correlated with relationships and activities goals, but negatively correlated with health concerns. Associations among goal measures provided evidence for construct validity. Goal content also differed according to age, gender, employment, and marital status, lending further support for construct validity. QLQ-C30 functioning and symptom scales were correlated with goal content, but not with progress toward goal attainment, suggesting that patients may calibrate progress ratings relative to their specific goals. Alternately, progress may reflect a unique aspect of quality of life untapped by more standard scales.

CONCLUSIONS: The Brief Quality of Life Appraisal Profile was associated with measures of motivation, goal content and progress, as well as relationships with demographic and standard

quality of life measures. This measure identifies novel concerns and issues in treating patients with bladder cancer, necessary for a more comprehensive evaluations of their health-related quality of life.

Panepinto, J. A., Torres, S., & Varni, J. W. (2012). Development of the PedsQL™ Sickle Cell Disease module items: Qualitative methods. *Quality of Life Research, 21*(2), 341-357.

PURPOSE: The objective of this qualitative study was to develop the items and support the content validity of the PedsQL™ Sickle Cell Disease Module for pediatric patients with sickle cell disease (SCD).

METHODS: The iterative process included multiphase qualitative methodology. A literature review on SCD was conducted to generate Chapters of interest for the individual in-depth interviews. Ten healthcare experts with clinical experience in SCD participated in the development of the conceptual framework. A total of 13 pediatric patients with SCD ages 5–18 and 18 parents of patients ages 2–18 participated in the individual in-depth interviews. A total of 33 pediatric patients with SCD ages 5–18 and 39 parents of patients ages 2–18 participated in individually conducted cognitive interviews that included both think aloud and cognitive debriefing techniques to assess the interpretability and readability of the item stems.

RESULTS: Six Chapters were derived from the qualitative methods involving patient/parent interviews and expert opinion, with content saturation achieved, resulting in 48 items. The six Chapters consisted of items measuring Pain Intensity/Location (9 items), Pain Interference (11 items), Worry (7 items), Emotions (3 items), Disease Symptoms/Treatment, (12 items), and Communication (6 items).

CONCLUSIONS: Qualitative methods involving pediatric patients and parents in the item development process support the content validity for the PedsQL™ SCD Module. The PedsQL™ SCD Module is now undergoing national multisite field testing for the psychometric validation phase of instrument development.

Patel, S., Weiss, E., Chhabra, R., Ryniker, L., et al. (2008). The Events in Care Screening Questionnaire (ECSQ): A new tool to identify needs and concerns of people with HIV/AIDS. *AIDS Patient Care and STDs, 22*(5): 381-393.

Retrieved from: <https://www.liebertpub.com/doi/pdfplus/10.1089/apc.2007.0105>

The purpose of this paper is to present validation data on the Events in Care Screening Questionnaire (ECSQ), which was designed to identify the needs and concerns of people living with HIV/AIDS (PLWHA) in nine specific Chapters: adherence to medical instructions; medical problems; specialty and inpatient hospital care; preventive health care and screening and behavioral health; sexual risk behavior; family planning; psychological symptoms; substance use; and life circumstances and demands. The ECSQ is the anchor for a more comprehensive measure called "The Dynamics of Care," and was administered in the context of a longitudinal study to evaluate New York State's HIV Special Needs Plan (HIV SNP), a Medicaid managed care model for PLWHA. Participants in the study, which began in March 2003 and closed recruitment in January 2007, were NYC PLWHA who were enrolled in either a Medicaid HIV SNP or Fee-For-Service plan. Participants were recruited through HIV SNP enrollment lists, direct on-site recruitment, and

fliers. The specific event Chapters covered in the ECSQ were selected based on the purpose of the HIV SNP and the literature describing the needs and challenges that PLWHA face. Analyses are based on data from 628 study respondents over two times points. Results suggest that the concerns identified by PLWHA were largely consistent with their health care situation, health status, risk behavior, and personal characteristics. Findings presented here lend support for the construct validity of the ECSQ and demonstrate its value as a starting point for inquiring more fully about the experiences of patients and improving the care they receive.

Paul-Savoie E., Bourgault, P., Gosselin, E., Potvin,S., and Lafrenaye, S. (2015). Assessing Patient-Centered Care: Validation of the French Version of the Patient-Practitioner Orientation Scale (PPOS). European Journal for Person-Centered Healthcare. 3(3), Retrieved from: <http://ubplj.org/index.php/ejpch/article/view/956>

RATIONALE, AIMS AND OBJECTIVES: Patient-centered care (PCC) is widely acknowledged as a central component of high-quality health care and it has been associated with many positive outcomes for patients. Although many studies support the benefits of PCC, the style of practice may vary from a caregiver to another. To measure PCC and investigate the factors that may be related to this concept, it is necessary to have rigorous instruments. Thus, the aim of this study was to adapt and validate a French version of the PPOS (F-PPOS) for the assessment of PCC in both nurses and physicians who work with chronic pain patients.

METHOD: The PPOS was translated and validated in a French population of nurses and physicians according to the Hébert methodological recommendations for translation and validation. The final version of the F-PPOS was distributed to 21 nurses and 21 physicians working with chronic pain patients. The content validity and the internal consistency were assessed.

RESULTS: The expert panel was satisfied with the content validity of this instrument. The internal consistency was acceptable for the total score for all participants (Cronbach's alpha = 0.60), for nurses (Cronbach's alpha = 0.62) and for physicians (Cronbach's alpha = 0.54). The F-PPOS showed good content validity and acceptable internal consistency.

CONCLUSIONS: The F-PPOS could be used in future studies in French populations, in both nurses and physicians. This instrument can also be used to compare the type of approach between caregivers in worldwide since it is available in several languages.

Sepucha, K.R., Borkhoff, C.M., Lally, J., Levin, C.A., et al. (2013). Establishing the effectiveness of patient decision aids: key constructs and measurement instruments. BMC Medical Informatics and Decision Making, 13 (Suppl 2):S12.

Retrieved from: <https://doi.org/10.1186/1472-6947-13-S2-S12>

BACKGROUND: Establishing the effectiveness of patient decision aids (PtDA) requires evidence that PtDAs improve the quality of the ***decision-making process*** and the quality of the choice made, or ***decision quality***. The aim of this paper is to review the theoretical and empirical evidence for PtDA effectiveness and discuss emerging practical and research issues in the measurement of effectiveness.

METHODS: This updated overview incorporates: a) an examination of the instruments used to measure five key decision-making process constructs (i.e., recognize decision, feel informed

about options and outcomes, feel clear about goals and preferences, discuss goals and preferences with health care provider, and be involved in decisions) and decision quality constructs (i.e., knowledge, realistic expectations, values-choice agreement) within the 86 trials in the Cochrane review; and b) a summary of the 2011 Cochrane Collaboration's review of PtDAs for these key constructs. Data on the constructs and instruments used were extracted independently by two authors from the 86 trials and any disagreements were resolved by discussion, with adjudication by a third party where required.

RESULTS: The 86 studies provide considerable evidence that PtDAs improve the decision-making process and decision quality. A majority of the studies (76/86; 88%) measured at least one of the key decision-making process or decision quality constructs. Seventeen different measurement instruments were used to measure decision-making process constructs, but no single instrument covered all five constructs. The Decisional Conflict Scale was most commonly used ($n = 47$), followed by the Control Preference Scale ($n = 9$). Many studies reported one or more constructs of decision quality, including knowledge ($n = 59$), realistic expectation of risks and benefits ($n = 21$), and values-choice agreement ($n = 13$). There was considerable variability in how values-choice agreement was defined and determined. No study reported on all key decision-making process and decision quality constructs.

CONCLUSIONS: Evidence of PtDA effectiveness in improving the quality of the decision-making process and decision quality is strong and growing. There is not, however, consensus or standardization of measurement for either the decision-making process or decision quality. Additional work is needed to develop and evaluate measurement instruments and further explore theoretical issues to advance future research on PtDA effectiveness.

Shay, L. and Lafata, J. (2015). Where Is the Evidence? A Systematic Review of Shared Decision Making and Patient Outcomes. *Medical Decision Making*, 35(1), 114-131.

Retrieved from: <http://journals.sagepub.com/doi/pdf/10.1177/0272989X14551638>

BACKGROUND: Despite widespread advocacy for shared decision making (SDM), the empirical evidence regarding its effectiveness to improve patient outcomes has not been systematically reviewed. The purpose of this study was to systematically review the empirical evidence linking patient outcomes and SDM, when the decision-making process has been explicitly measured, and to identify under what measurement perspectives SDM is associated with which types of patient outcomes (affective-cognitive, behavioral, and health).

DATA SOURCES: PubMed (through December 2012) and hand search of article bibliographies.

STUDY SELECTION: Studies were included if they empirically 1) measured SDM in the context of a patient-clinician interaction and 2) evaluated the relationship between SDM and at least 1 patient outcome.

DATA EXTRACTION: Study results were categorized by SDM measurement perspective (patient-reported, clinician-reported, or observer-rated) and outcome type (affective-cognitive, behavioral, or health).

DATA SYNTHESIS: Thirty-nine studies met inclusion criteria. Thirty-three used patient-reported measures of SDM, 6 used observer-rated measures, and 2 used clinician-reported measures. Ninety-seven unique patient outcomes were assessed; 51% affective-cognitive, 28% behavioral, and 21% health. Only 43% of assessments ($n = 42$) found a significant and positive relationship

between SDM and the patient outcome. This proportion varied by SDM measurement perspective and outcome category. It was found that 52% of outcomes assessed with patient-reported SDM were significant and positive, compared with 21% with observer-rated and 0% with clinician-reported SDM. Regardless of measurement perspective, SDM was most likely to be associated with affective-cognitive patient outcomes (54%), compared with 37% of behavioral and 25% of health outcomes.

LIMITATIONS: The relatively small number of studies precludes meta-analysis. Because the study inclusion and exclusion criteria required both an empirical measure of SDM and an assessment of the association between that measure and a patient outcome, most included studies were observational in design.

CONCLUSIONS: SDM, when perceived by patients as occurring, tends to result in improved affective-cognitive outcomes. Evidence is lacking for the association between empirical measures of SDM and patient behavioral and health outcomes.

Sopczak, N., Aguilar, C., Nykiforuk, C. I., O'Brien, M., et al. (2017) Patients' perspectives on BETTER 2 prevention and screening: qualitative findings from Newfoundland & Labrador. BJGP Open 1(3)

Retrieved from: DOI: [10.3399/bjgpopen17X101037](https://doi.org/10.3399/bjgpopen17X101037)

BACKGROUND: Chronic disease prevention and screening (CDPS) has been identified as a top priority in primary care. However, primary care providers often lack time, evidence-based tools, and consistent guidelines to effectively address CDPS. Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Primary Care (BETTER) is a novel approach that introduces a new role, that of the prevention practitioner; the prevention practitioner meets with patients, one on one, to undertake a personalised CDPS visit. Understanding patients' perspectives is important for clinicians and other stakeholders aiming to address and integrate CDPS.

AIM: To describe patients' perspectives regarding visits with a prevention practitioner in BETTER 2, an implementation study that was carried out after the BETTER trial and featured a higher proportion of patients in rural and remote locations.

DESIGN & SETTING: Qualitative description based on patient feedback surveys, completed by patients in three primary care clinics (urban, rural, and remote) in Newfoundland and Labrador, Canada.

METHOD: Patients' perspectives were assessed based on responses from 91 feedback forms. In total, 154 patients (aged 40–65 years) received 1 prevention visit(s) from a prevention practitioner and were asked to provide written feedback. In addition to demographics, patients were asked what they liked about their visit(s), what they would have liked to be different, and invited to make any other comments. Qualitative description was used to analyse the data.

RESULTS: Four main themes emerged from patients' feedback: value of visit (patients appreciated the visit with a prevention practitioner); visit characteristics (the visit was personalised, comprehensive, and sufficiently long); prevention practitioners' characteristics (professionalism and interpersonal skills); and patients' concerns (termination of the programme and access to preventative care).

CONCLUSION: Patients appreciated the visits they received with a prevention practitioner and expressed their desire to receive sustained CDPS in primary care.

Tulsky, D. S., Kisala, P. A., Tate, D. G., Spungen, A. M., & Kirshblum, S. C. (2015). Development and psychometric characteristics of the SCI-QOL Bladder Management Difficulties and Bowel Management Difficulties item banks and short forms and the SCI-QOL Bladder Complications scale. *The Journal of Spinal Cord Medicine, 38*(3), 288-302.

CONTEXT/OBJECTIVE: The Spinal Cord Injury – Quality of Life (SCI-QOL) measurement system was developed to address the shortage of relevant and psychometrically sound patient reported outcome (PRO) measures available for clinical care and research in spinal cord injury (SCI) rehabilitation. Using a computer adaptive testing (CAT) approach, the SCI-QOL builds on the Patient Reported Outcomes Measurement Information System (PROMIS) and the Quality of Life in Neurological Disorders (Neuro-QOL) initiative. This initial manuscript introduces the background and development of the SCI-QOL measurement system. Greater detail is presented in the additional manuscripts of this special issue.

DESIGN: Classical and contemporary test development methodologies were employed. Qualitative input was obtained from individuals with SCI and clinicians through interviews, focus groups, and cognitive debriefing. Item pools were field tested in a multi-site sample ($n = 877$) and calibrated using item response theory methods. Initial reliability and validity testing was performed in a new sample of individuals with traumatic SCI ($n = 245$). Setting: Five Model SCI System centers and one Department of Veterans Affairs Medical Center across the United States.

PARTICIPANTS: Adults with traumatic SCI.: Interventions: n/a: Outcome Measures: n/a. Results: The SCI-QOL consists of 19 item banks, including the SCI-Functional Index banks, and 3 fixed-length scales measuring physical, emotional, and social aspects of health-related QOL (HRQOL).

CONCLUSION: The SCI-QOL measurement system consists of psychometrically sound measures for individuals with SCI. The manuscripts in this special issue provide evidence of the reliability and initial validity of this measurement system. The SCI-QOL also links to other measures designed for a general medical population.

Vackerberg, N., Levander, M.S., and Thor, J. (2016) What Is Best for Esther? Building Improvement Coaching Capacity With and for Users in Health and Social Care—A Case Study. *Quality management in healthcare, 25*(1): 53-60.

Retrieved from:

https://journals.lww.com/qmhcjournal/Fulltext/2016/01000/What_Is_Best_for_Esther_Building_Improvement.8.aspx

Abstract: While coaching and customer involvement can enhance the improvement of health and social care, many organizations struggle to develop their improvement capability; it is unclear how best to accomplish this. We examined one attempt at training improvement coaches. The program, set in the Esther Network for integrated care in rural Jönköping County, Sweden, included eight 1-day sessions spanning 7 months in 2011. A senior citizen joined the faculty in all training sessions. Aiming to discern which elements in the program were essential for assuming the role of improvement coach, we used a case-study design with a qualitative approach. Our focus group interviews included 17 informants: 11 coaches, 3 faculty members, and 3 senior

citizens. We performed manifest content analysis of the interview data. Creating will, ideas, execution, and sustainability emerged as crucial elements. These elements were promoted by customer focus—embodied by the senior citizen trainer—shared values and a solution-focused approach, by the supportive coach network and by participants' expanded systems understanding. These elements emerged as more important than specific improvement tools and are worth considering also elsewhere when seeking to develop improvement capability in health and social care organizations.

Wasson, J.H., Ho, L., Soloway, L., and Moore, L.G. (2018) Validation of the What Matters Index: A brief, patient-reported index that guides care for chronic conditions and can substitute for computer-generated risk models. *PLoS ONE* 13(2): e0192475.

Retrieved from: <https://doi.org/10.1371/journal.pone.0192475>

Introduction Current health care delivery relies on complex, computer-generated risk models constructed from insurance claims and medical record data. However, these models produce inaccurate predictions of risk levels for individual patients, do not explicitly guide care, and undermine health management investments in many patients at lesser risk. Therefore, this study prospectively validates a concise patient-reported risk assessment that addresses these inadequacies of computer-generated risk models. Methods Five measures with well-documented impacts on the use of health services are summed to create a "What Matters Index." These measures are: 1) insufficient confidence to self-manage health problems, 2) pain, 3) bothersome emotions, 4) polypharmacy, and 5) adverse medication effects. We compare the sensitivity and predictive values of this index with two representative risk models in a population of 8619 Medicaid recipients. Results The patient-reported "What Matters Index" and the conventional risk models are found to exhibit similar sensitivities and predictive values for subsequent hospital or emergency room use. The "What Matters Index" is also reliable: akin to its performance during development, for patients with index scores of 1, 2, and 3, the odds ratios (with 95% confidence intervals) for subsequent hospitalization within 1 year, relative to patients with a score of 0, are 1.3 (1.1–1.6), 2.0 (1.6–2.4), and 3.4 (2.9–4.0), respectively; for emergency room use, the corresponding odds ratios are 1.3 (1.1–1.4), 1.9 (1.6–2.1), and 2.9 (2.6–3.3). Similar findings were replicated among smaller populations of 1061 mostly older patients from nine private practices and 4428 Medicaid patients without chronic conditions. Summary In contrast to complex computer-generated risk models, the brief patient-reported "What Matters Index" immediately and unambiguously identifies fundamental, remediable needs for each patient and more sensibly directs the delivery of services to patient categories based on their risk for subsequent costly care.

Chapter 8:

Assessment of Patients' Satisfaction with Care

Abrahamsen Grøndahl, V., Hall-Lord, M.L., Karlsson, I., et al. (2013). "Exploring patient satisfaction predictors in relation to a theoretical model." *International journal of health care quality assurance*, 26(1): 37-54.

Retrieved from:

https://www.researchgate.net/profile/Vigdis_Grondahl/publication/236085633_Exploring_patient_satisfaction_predictors_in_relation_to_a_theoretical_model/links/56b3290208aed7ba3feeaa76c.pdf

PURPOSE: The aim is to describe patients' care quality perceptions and satisfaction and to explore potential patient satisfaction predictors as person-related conditions, external objective care conditions and patients' perception of actual care received ("PR") in relation to a theoretical model.

DESIGN/METHODOLOGY/APPROACH: A cross-sectional design was used. Data were collected using one questionnaire combining questions from four instruments:

QUALITY FROM PATIENTS' PERSPECTIVE: Sense of coherence; Big five personality trait; and Emotional stress reaction questionnaire (ESRQ), together with questions from previous research. In total, 528 patients (83.7 per cent response rate) from eight medical, three surgical and one medical/surgical ward in five Norwegian hospitals participated. Answers from 373 respondents with complete ESRQ questionnaires were analyzed. Sequential multiple regression analysis with ESRQ as dependent variable was run in three steps: person-related conditions, external objective care conditions, and PR ($p < 0.05$).

FINDINGS: Step 1 (person-related conditions) explained 51.7 per cent of the ESRQ variance. Step 2 (external objective care conditions) explained an additional 2.4 per cent. Step 3 (PR) gave no significant additional explanation (0.05 per cent). Steps 1 and 2 contributed statistical significance to the model. Patients rated both quality-of-care and satisfaction highly. Originality/value: The paper shows that the theoretical model using an emotion-oriented approach to assess patient satisfaction can explain 54 per cent of patient satisfaction in a statistically significant manner.

Austin, C., Mohottige, D., Sudore, R., Smith, A., and Hanson, L. (2015). Tools to Promote Shared Decision Making in Serious Illness: A Systematic Review. *JAMA Internal Medicine*, 175(7), 1213–1221

IMPORTANCE: Serious illness impairs function and threatens survival. Patients facing serious illness value shared decision making, yet few decision aids address the needs of this population.

OBJECTIVE: To perform a systematic review of evidence about decision aids and other exportable tools that promote shared decision making in serious illness, thereby (1) identifying tools relevant to the treatment decisions of seriously ill patients and their caregivers, (2) evaluating the quality of evidence for these tools, and (3) summarizing their effect on outcomes and accessibility for clinicians. **EVIDENCE**

REVIEW: We searched PubMed, CINAHL, and PsychInfo from January 1, 1995, through October

31, 2014, and identified additional studies from reference lists and other systematic reviews. Clinical trials with random or nonrandom controls were included if they tested print, video, or web-based tools for advance care planning (ACP) or decision aids for serious illness. We extracted data on the study population, design, results, and risk for bias using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria. Each tool was evaluated for its effect on patient outcomes and accessibility.

FINDINGS: Seventeen randomized clinical trials tested decision tools in serious illness. Nearly all the trials were of moderate or high quality and showed that decision tools improve patient knowledge and awareness of treatment choices. The available tools address ACP, palliative care and goals of care communication, feeding options in dementia, lung transplant in cystic fibrosis, and truth telling in terminal cancer. Five randomized clinical trials provided further evidence that decision tools improve ACP documentation, clinical decisions, and treatment received.

CONCLUSIONS AND RELEVANCE: Clinicians can access and use evidence-based tools to engage seriously ill patients in shared decision making. This field of research is in an early stage; future research is needed to develop novel decision aids for other serious diagnoses and key decisions. Health care delivery organizations should prioritize the use of currently available tools that are evidence based and effective.

Barry, M. and Edgman-Levitan, S. (2012). Shared Decision Making – The Pinnacle of Patient-Centered Care. *New England Journal of Medicine*, 366:780-781.

Retrieved from:

https://www.nejm.org/doi/full/10.1056/NEJMp1109283#article_citing_articles.

Caring and compassion were once often the only “treatment” available to clinicians. Over time, advances in medical science have provided new options that, although often improving outcomes, have inadvertently distanced physicians from their patients. The result is a health care environment in which patients and their families are often excluded from important discussions and left feeling in the dark about how their problems are being managed and how to navigate the overwhelming array of diagnostic and treatment options available to them. In 1988, the Picker/Commonwealth Program for Patient-Centered Care (now the Picker Institute) coined the term “patient-centered care” to call attention to the need for clinicians, staff, and health care systems to shift their focus away from diseases and back to the patient and family.¹ The term was meant to stress the importance of better understanding the experience of illness and of addressing patients' needs within an increasingly complex and fragmented health care delivery system.

The Beryl Institute. (2018) Consumer Perspectives on Patient Experience 2018 Report.

Retrieved from: <https://www.theberylinstitute.org/page/PXCONSUMERSTUDY2018>

Healthcare professionals have taken major steps to understand, measure, and improve the Patient & Family Experience. But do consumers really care about this? How do they see and define a positive patient/family experience? What matters most to them when they think about their own health and using healthcare resources? The full research report from the inaugural study, Consumer Perspectives on Patient Experience 2018 is now available. The first of its kind

global research, the study engaged 2,000 respondents across four continents. It shares the perspectives of consumers of healthcare on the patient experience, its importance, the critical factors that impact its success and how it will influence individual choices in healthcare. According to the research:

- 91% of consumers confirm patient experience is extremely/very important to them overall and is significant to the healthcare decisions they will make
- 78% of consumers identify their personal health and wellbeing as the primary reason that patient experience is important
- 69% of consumers believe a good experience contributes to their healing/good health outcomes
- Consumers affirm that human interactions are most important to them in assessing patient experience, followed by the processes they encounter and then the place in which they receive care
- Consumers offer that being listened to, communicated to in a way they can understand and treated with dignity and respect are the three most important factors influencing their experiences
- 72% of consumers identify recommendations of family and friends as important in their decisions about healthcare

The Beryl Institute (2018). Written by Palmer, S., Cooley, L., Hudson, J., and Chou, C. Interconnected: An Exploration of Improvement Efforts Connecting Patient Experience and Communication.

Retrieved from: <https://www.theberylinstitute.org/store/ViewProduct.aspx?id=11297001>
 Published in collaboration with the [Academy of Communication in Healthcare](#), this paper explores the state of interpersonal communication practices in relationship to the patient experience outcomes in U.S. healthcare organizations from data collected through an online survey with 112 respondents and qualitative insights from selected phone interviews. The paper focuses on understanding the present state of communication effectiveness within the patient experience context for doctors, nurses and teams, evaluates the success of efforts to address communication and elaborates on key points addressed in this study, including:

- Perceived barriers to effective communication for clinicians
- Impact of culture and diversity on organizational communication outcomes
- Identified communication solutions

The paper also provides considerations for action as healthcare organizations seek to drive positive patient, family, staff and caregiver experience through communication improvements.

Carman, K.L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., and Sweeney, J. (2013). Patient and Family Engagement: A Framework for Understanding The Elements And Developing Interventions And Policies. *Health Affairs*, 32(2).

Retrieved from: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1133>

Patient and family engagement offers a promising pathway toward better-quality health care, more-efficient care, and improved population health. Since definitions of patient engagement

and conceptions of how it works vary, we propose a framework. We first present the forms engagement can take, ranging from consultation to partnership. We discuss the levels at which patient engagement can occur across the health care system, from the direct care setting to incorporating patient engagement into organizational design, governance, and policy making. We also discuss the factors that influence whether and to what extent engagement occurs. We explore the implications of our multidimensional framework for the development of interventions and policies that support patient and family engagement, and we offer a research agenda to investigate how such engagement leads to improved outcomes.

Chang, A. and Ritchie, C. (2015). Patient-centered models of care: Closing the gaps in physician readiness. *Journal of General Internal Medicine*, 30, (870–872).

Nearly every medical student and practicing physician aspires to provide the best possible patient-centered care. They went into medicine to do so and are trained to place patients' wellbeing at the center of their work. What physicians are not trained to do, however, is to engage with and change the powerful systems that shape their ability to provide patient-centered care: funding models, organizational structure, information technology, and others. The messy business of leading change is, more often than not, handled by managers, accountants and legislators, most of whom are adept at looking at the bottom line, but are ill-equipped to understand the reality of providing patient-centered medical care. Physicians can play a key role in delivery system reform, and must now achieve fluency in Chapters beyond medical knowledge and technical skills.¹ In this issue of JGIM, Fontaine and colleagues describe six success factors critical to front-line implementation of the patient-centered medical home (PCMH): leadership, organizational culture, finances, quality improvement, information technology, and patient involvement.² These factors likely not only facilitate PCMH implementation, but also characterize knowledge and skills that physicians need to lead any meaningful systems change. How is medical education doing in addressing these Chapters of knowledge and skill? We will briefly examine the current state of medical education through the lens of the six areas identified by Fontaine.

Charmel, P.A. and Frampton, S.B. (2008) Building the business case for patient-centered care. *Healthcare Financial Management* 62(3):80-5.

Retrieved from: <http://pqcnc-documents.s3.amazonaws.com/fpe/fperesources/BuildingBusinessCasePCCCharmelFrampton2008.pdf>

Hospitals that provide patient-centered care reap a number of financial benefits, including: 1. Reduced length of stay, 2. Lower cost per case, 3. Decreased adverse events, 4. Higher employee retention rates 5. Reduced operating costs, 6. Decreased malpractice claims, and 7. Increased market share.

Cleary, P. D. and McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25(1): 25-36.

Retrieved from: https://www.researchgate.net/profile/Paul_Cleary/publication/20190384_Patient_Satisfacti

on as An Indicator of Quality for Care/links/53d2c9f10cf220632f3cb4c0.pdf

In this review of the theoretical and empirical work on patient satisfaction with care, the most consistent finding is that the characteristics of providers or organizations that result in more "personal" care are associated with higher levels of satisfaction. Some studies suggest that more personal care will result in better communication and more patient involvement, and hence better quality of care, but the data on these issues are weak and inconsistent. Further research is needed to measure specific aspects of medical care and the ways in which patient reports can complement other sources of information about quality. In addition, more research on the determinants of satisfaction and the relationship between quality and satisfaction among hospitalized patients is recommended.

Larsson, G. and Wilde-Larsson, B. (2010). Quality of care and patient satisfaction: a new theoretical and methodological approach. *International journal of health care quality assurance*, 23(2): 228-247.

PURPOSE: The paper's purpose is to develop a care-context adapted version of the emotional stress reaction questionnaire (ESRQ), which is based on the cognitive-phenomenological writings of Lazarus, and, using this instrument, to explore the relationship between quality of care from a patient perspective and patient satisfaction while taking key antecedent conditions into account.

DESIGN/METHODOLOGY/APPROACH: Data were collected from 624 patients at 16 Swedish out-patient clinics (75 percent response rate). Patients responded to the ERSQ, the quality from the patient's perspective questionnaire (QPP), the single-item measures of personality (SIMP), and questions related to the outcome of the visit. Dimensionality of the ESRQ was analyzed using exploratory factor analysis and structural equation modelling. The relationship between the theoretical concepts was explored with logistic regression analysis.

FINDINGS: A care-context adapted version of the ESRQ was developed with meaningful factors and satisfactory psychometric properties. Care-episode specific appraisal and coping processes covaried as predicted with emotional responses. The theoretical model was partly confirmed when assessed against two outcome criteria: intention to follow the doctor's advice and hesitation to visit the same out-patient clinic again.

PRACTICAL IMPLICATIONS: The scales used are easy to administer and interpret.

ORIGINALITY/VALUE: The suggested theoretical model of the relationship between quality of care from a patient perspective and patient satisfaction is new, as is the emotion-oriented approach to assessing patient satisfaction.

Lounsbury, D., Levine, R., and Ostroff, J. (2007). Episode-of-Care Analysis and Tobacco Treatment in Primary Care Settings. Presented at the 25th International Conference of the Systems Dynamics Society.

Retrieved from:

https://s3.amazonaws.com/academia.edu.documents/38219251/LOUNS280.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1530905721&Signature=frHCd538ykqli79GSMmXAE6V8NQ%3D&response-content-disposition=inline%3B%20filename%3DEpisode-of-Care_Analysis_and_Tobacco_Tre.pdf

Episode-of-Care Analysis and Tobacco Treatment in Primary Care Settings Economists and health services researchers have long been faced with the problem of how to effectively unitize and assess cost and quality of health care delivery across diverse practice settings. One such approach is episode-of-care analysis, first theorized and applied by Hornbrook and his colleagues in the mid-1980s. A health care episode is defined as a series of health-related events with a beginning, an end, and a course, all related to a given health problem that exists over a specific time period (i.e., time horizon). In our research we have adapted an episode-of-care framework to the topic of treating tobacco use and dependence. Further reductions in tobacco use calls for increased readiness and capacity of primary care physicians to treat tobacco dependence (CDC 2002). However, Primary care providers face considerable pressure to address multiple patient care concerns during increasingly brief clinical visits (Cabana et al. 1999). Efforts to encourage adaptation of well-established clinical practice guidelines must address the tension between time limitations and best practices. We need techniques and tools to support sustainable change in practice related to tobacco dependence in diverse primary care settings, particularly those located in medically underserved communities (Davis and Taylor-Vaisey 1995; Hellinger 1996; Stone et al. 2002; Swartz et al. 2002; Wandersman 2003). Our efforts are focused on how to improve dissemination and implementation of the U.S. Public Health Service Guideline for Treating Tobacco Use and Dependence in primary care practices (Foire et al. 1996). This line of work is especially timely, as the PHS Guidelines for Treating Tobacco Dependence are currently under revision and innovations to support dissemination are of especially high priority. Our system dynamics modeling will show the interdependent process of patients and providers cycling through various stages of tobacco use and treatment, and it will need to represent a patient's stage of readiness to quit or likelihood to avoid relapse.

Menichetti, J., Libreri, C., Lozza, E., and Graffigna, G. (2014). Giving patients a starring role in their own care: a bibliometric analysis of the on-going literature debate. *Health Expectations*, 19(3), 516-526.

Retrieved from: [doi: 10.1111/hex.12299](https://doi.org/10.1111/hex.12299).

Background: Patient-centred care has been advocated as a key component of high-quality patient care, yet its meanings and related actions have been difficult to ascertain.

OBJECTIVE: To map the use of different terms related to the process of giving patients a starring role in their own care and clarify the possible boundaries between terms that are often mixed.

METHODS: A literature search was conducted using different electronic databases. All records containing the search terms 'patient engagement', 'patient activation', 'patient empowerment', 'patient involvement', 'patient adherence', 'patient compliance' and 'patient participation' were collected. Identified literature was then analysed using the Statistical Package for Social Science (SPSS). The number of yearly publications, most productive countries, cross-concepts articles and various scientific fields dealing with the multi-disciplinary concepts were identified.

RESULTS: Overall, 58 987 papers were analysed. Correspondence analysis revealed three temporal trends. The first period (2002–2004) focused on compliance and adherence, the second period(2006–2009) focused on the relationship between participation and involvement, and the third one (2010–2013) emphasized empowerment. Patient activation and patient engagement followed the temporal development trend connected to the 'immediate future'.

DISCUSSION AND CONCLUSIONS: The bibliometric trend suggests that the role of patient in the health-care system is changing. In the last years, the patient was viewed as a passive receptor of medical prescription. To date, the need to consider patients as active partners of health-care planning and delivery is growing. In particular, the term patient engagement appears promising, not only for its increasing growth of interest in the scholarly debate, but also because it offers a broader and better systemic conceptualization of the patients' role in the fruition of health care. To build a shared vocabulary of terms and concepts related to the active role of patients in the health-care process may be envisaged as the first operative step towards a concrete innovation of health-care organizations and systems.

Rapkin, B.D., Weiss, E., Chhabra, R., Ryniker, L., et al. (2008). Beyond satisfaction: Using the Dynamics of Care assessment to better understand patients' experiences in care. *Health and Quality of Life Outcomes*, 6(20) doi:10.1186/1477-7525-6-20

BACKGROUND: Patient perceptions of and satisfaction with care have become important indicators of the quality of services and the relationship of services to treatment outcomes. However, assessment of these indicators continues to be plagued by measurement problems, particularly the lack of variance in satisfaction data. In this article, we present a new approach to better capture patient perceptions of experiences in care, the Dynamics of Care (DoC) assessment. It is an in-depth approach to defining and assessing patients' perspectives at different junctures in care, including their decisions about whether and where to seek care, the barriers encountered, and the treatments and services received.

METHODS: The purpose of this article is to describe, validate, and discuss the benefits and limitations of the DoC, which was administered as part of a longitudinal study to evaluate the New York State HIV Special Needs Plan (SNP), a Medicaid managed care model for people living with HIV/AIDS. Data are from 426 study respondents across two time points.

RESULTS: The results demonstrate the validity and value of the DoC. Help seeking decisions and satisfaction with care appear to be situation-specific, rather than person-specific. However, barriers to care appear to be more cross-situational for respondents, and may be associated with clients' living situations or care arrangements. Inventories in this assessment that were designed to identify potential deterrents to help seeking and difficulties encountered in care demonstrated clear principal component structures, and helped to explain satisfaction with care. The problem resolution index was found to be independent from satisfaction with care and the data were more normally distributed. DoC data were also associated with subsequent utilization and change in quality of life.

CONCLUSION: The DoC was designed to be a flexible, integrated measure to determine individuals' salient service needs, help seeking and experiences in care. One of the many strengths of the assessment is its focus on specific problems in context, thus providing a more sensitive and informative way to understand processes in care from the patient's perspective. This approach can be used to direct new programs and resources to the patients and situations that require them.

Scholl, L., Kriston, J. Dirmaier, Buchholz, A., and Harter, M. (2012). Development and psychometric properties of the shared decision making questionnaire–physician version (SDM-Q-Doc), *Patient Education and Counseling*, 88(2), 284–290.

ABSTRACT: Objective: To develop and psychometrically test a brief instrument for assessing the physician's perspective of the shared decision-making process in clinical encounters.

METHODS: We adapted the 9-item Shared Decision Making Questionnaire (SDM-Q-9) for patients to generate a new version for physicians (SDM-Q-Doc). The physician version was tested in clinical encounters between 29 physicians and 324 patients in German outpatient care contexts. Analyses of the extent to which the instrument was accepted, the reliability of the instrument, and the factorial structure of the scale were performed.

RESULTS: Physicians showed a high level of acceptance toward the SDM-Q-Doc. Item discrimination parameters were above .4 for all but one item. An analysis of internal consistency yielded a Cronbach's α of .88. Factor analysis confirmed a one-dimensional structure.

CONCLUSION: The results of this study suggest that the SDM-Q-Doc is a well-accepted and reliable instrument for assessing the physician's perspective during SDM processes in clinical encounters. To our knowledge, the SDM-Q-Doc is the first psychometrically tested scale available for assessing the physician's perspective. Practice implications: The SDM-Q-Doc can be used in studies that analyze the effectiveness of the implementation of SDM and as a quality indicator in quality assurance programs and health service assessments.

Simmons, L., Wolever, R., Bechard, E., and Snyderman, R. (2014). Patient engagement as a risk factor in personalized health care: a systematic review of the literature on chronic disease. *Genome Medicine*, 6(2):16.

Retrieved from: [doi: 10.1186/gm533](https://doi.org/10.1186/gm533).

ABSTRACT: Background: The role of patient engagement as an important risk factor for healthcare outcomes has not been well established. The objective of this article was to systematically review the relationship between patient engagement and health outcomes in chronic disease to determine whether patient engagement should be quantified as an important risk factor in health risk appraisals to enhance the practice of personalized medicine.

METHODS: A systematic review of prospective clinical trials conducted between January 1993 and December 2012 was performed. Articles were identified through a medical librarian-conducted multi-term search of Medline, Embase, and Cochrane databases. Additional studies were obtained from the references of meta-analyses and systematic reviews on hypertension, diabetes, and chronic care. Search terms included variations of the following: self-care, self-management, self-monitoring, (shared) decision-making, patient education, patient motivation, patient engagement, chronic disease, chronically ill, and randomized controlled trial. Studies were included only if they: (1) compared patient engagement interventions to an appropriate control among adults with chronic disease aged 18 years and older; (2) had minimum 3 months between pre- and post-intervention measurements; and (3) defined patient engagement as: (a) understanding the importance of taking an active role in one's health and health care; (b) having the knowledge, skills, and confidence to manage health; and (c) using knowledge, skills and confidence to perform health-promoting behaviors. Three authors and two research assistants independently extracted data using predefined fields including quality metrics.

RESULTS: We reviewed 543 abstracts to identify 10 trials that met full inclusion criteria, four of which had 'high' methodological quality (Jadad score ≥ 3). Diverse measurement of patient engagement prevented robust statistical analyses, so data were qualitatively described. Nine studies documented improvements in patient engagement. Five studies reported reduction in clinical markers of disease (for example HbA1C). All studies reported improvements in self-reported health status.

CONCLUSIONS: This review suggests patient engagement should be quantified as part of a comprehensive health risk appraisal given its apparent value in helping individuals to effectively self-manage chronic disease. Patient engagement measures should include assessment of the knowledge, confidence and skills to prevent and manage chronic disease, plus the behaviors to do so.

Zhang, Y., Graffigna, G., Bonanomi, A., Choi, K., Barello, S., Mao, P., and Feng, H. (2017). Adaptation and validation of a Chinese version of Patient Health Engagement Scale for patients with chronic disease. *Frontiers in Psychology*, 8(104).

Retrieved from: URL=<https://www.frontiersin.org/article/10.3389/fpsyg.2017.00104>

DOI=10.3389/fpsyg.2017.00104

The Patient Health Engagement Scale (PHE-s) was designed to assess the emotional and psychological attitudes of patients' engagement along their healthcare management journey. The aim of this study was to validate a culturally adapted Chinese version of the PHE-s (CPHE-s). Three hundred and seventy-seven participants were recruited from eight community health centers in a sample of patients with chronic disease in Hunan Province, China. The original Italian PHE-s was translated into Mandarin Chinese using a standardized forward-backward translation. The Rasch model was utilized and presented uni-dimensionality and good items fitness of the PHE-s. The internal consistency was 0.89 and the weighted Kappa coefficients of the items (test-retest reliability) ranged from 0.52 to 0.79. Both principal component analysis and confirmatory factor analysis supported a single-factor structure of the PHE-s. In testing the external validity, the PHE-s showed a significant moderate correlation with patient activation but not with medicine adherence behavior, which requires further exploration. The result suggested that the PHE-s is a reliable and valid instrument to assess the level of patient engagement in his or her own health management among chronic patients in China. Further analysis of reliability and validity should be assessed among other patient cohorts in China, and future directions for testing changes after patient engagement interventions should be developed by exploring some clinical relevance.

Chapter 9:

Assessment of Provider Empathy and Skill at Addressing WMTY

Apker, J., Propp, K.M., Zabava Ford, W.S., and Hofmeister, N. (2006) Collaboration, credibility, compassion, and coordination: Professional nurse communication skill sets in health care team interactions. *Journal of Professional Nursing*, 22(3): 180-189.

Retrieved from: <https://www.sciencedirect.com/science/article/pii/S8755722306000561>

This study explored how nurses communicate professionalism in interactions with members of their health care teams. Extant research show that effective team communication is a vital aspect of a positive nursing practice environment, a setting that has been linked to enhanced patient outcomes. Although communication principles are emphasized in nursing education as an important component of professional nursing practice, actual nurse interaction skills in team-based health care delivery remain understudied. Qualitative analysis of interview transcripts with 50 participants at a large tertiary hospital revealed four communicative skill sets exemplified by nursing professionals: collaboration, credibility, compassion, and coordination. Study findings highlight specific communicative behaviors associated with each skill set that exemplify nurse professionalism to members of health care teams. Theoretical and pragmatic conclusions are drawn regarding the communicative responsibilities of professional nurses in health care teams. Specific interaction techniques that nurses could use in nurse-team communication are then offered for use in baccalaureate curriculum and organizational in-service education.

Axelson, D. J., Stull, M.J., and Coates, W.C. (2018). Social Determinants of Health: A Missing Link in Emergency Medicine Training. *AEM Education and Training*, 2(1): 66-68.

Retrieved from: <https://onlinelibrary.wiley.com/doi/pdf/10.1002/aet2.10056>

The health of a population depends upon several factors, including disease, public health initiatives, and the social determinants of health (SDH). These factors often converge in the emergency department (ED) where the impact of social conditions such as homelessness, low-literacy, and poverty lead to recidivism and may contribute to provider burnout. Inclusion of SDH topics in EM residency curricula can provide needed background information and effective strategies for coping with these patients in the clinical setting. Exercises that simulate poverty, the development of and familiarity with meaningful community partnerships, and inclusion of SDH topics in standard ED conferences (e.g., mortality and morbidity conference) can promote understanding and outline a detailed plan for treating patients facing these challenges. By incorporating educational interventions aimed at identifying and intervening on issues of SDH in the ED we may be able to better serve those patients who need us the most.

Benbassat, J. and Baumal, R. (2004). What is empathy, and how can it be promoted during clinical clerkships? *Academic Medicine*, 79(9): 832-839.

Retrieved from:

https://journals.lww.com/academicmedicine/Fulltext/2004/09000/SeniorResidents_Views_on_the_Meaning_of.4.aspx

The ability of medical students to empathize often declines as they progress through the curriculum. This suggests that there is a need to promote empathy toward patients during the clinical clerkships. In this article, the authors attempt to identify the patient interviewing style that facilitates empathy and some practice habits that interfere with it. The authors maintain that (1) empathy is a multistep process whereby the doctor's awareness of the patient's concerns produces a sequence of emotional engagement, compassion, and an urge to help the patient; and (2) the first step in this process—the detection of the patient's concerns—is a teachable skill. The authors suggest that this step is facilitated by (1) conducting a “patient-centered” interview, thereby creating an atmosphere that encourages patients to share their concerns, (2) enquiring further into these concerns, and (3) recording them in the section traditionally reserved for the patient's “chief complaint.” Some practice habits may discourage patients from sharing their concerns, such as (1) writing up the history during patient interviewing, (2) focusing too early on the chief complaint, and (3) performing a complete system review. The authors conclude that sustaining empathy and promoting medical professionalism among medical students may necessitate a change in the prevailing interviewing style in all clinical teaching settings, and a relocation of a larger proportion of clinical clerkships from the hospital setting to primary care clinics and chronic care, home care, and hospice facilities, where students can establish a continuing relationship with patients.

Ellman, M. S., & Fortin, A. H. (2012). Benefits of Teaching Medical Students How to Communicate with Patients Having Serious Illness: Comparison of Two Approaches to Experiential, Skill-Based, and Self-Reflective Learning. *The Yale Journal of Biology and Medicine*, 85(2), 261–270.

Innovative approaches are needed to teach medical students effective and compassionate communication with seriously ill patients. We describe two such educational experiences in the Yale Medical School curriculum for third-year medical students: 1) Communicating Difficult News Workshop and 2) Ward-Based End-of-Life Care Assignment. These two programs address educational needs to teach important clinical communication and assessment skills to medical students that previously were not consistently or explicitly addressed in the curriculum. The two learning programs share a number of educational approaches driven by the learning objectives, the students' development, and clinical realities. Common educational features include: experiential learning, the Biopsychosocial Model, patient-centered communication, integration into clinical clerkships, structured skill-based learning, self-reflection, and self-care. These shared features — as well as some differences — are explored in this paper in order to illustrate key issues in designing and implementing medical student education in these areas.

Fields, S. K., Hojat, M., Gonnella, J.S., Mangione, S., et al. (2004). Comparisons of nurses and physicians on an operational measure of empathy. *Evaluation & the health professions*, 27(1): 80-94.

In view of many changes taking place in today's health care marketplace, the theme of empathy in health provider-patient relations needs to be revisited. It has been proposed that patients benefit when all members of the health care team provide empathic care. Despite the role of empathy in patient outcomes, empirical research on empathy among health professionals is scarce partly because of a lack of a psychometrically sound tool to measure it. In this study, we

briefly describe the development and validation of the Jefferson Scale of Physician Empathy (JSPE), an instrument that was specifically developed to measure empathy among health professionals (20 Likert-type items). The purpose of this study was to compare nurses and physicians on their responses to the JSPE. Study participants were 56 female registered nurses and 42 female physicians in the Internal Medicine postgraduate medical education program at Thomas Jefferson University Hospital. The reliability coefficients (Cronbach's coefficient alpha) were 0.87 for the nurses and 0.89 for physicians. Results of t test showed no significant difference between nurses and physicians on total scores of the JSPE; however, multivariate analyses of variance indicated statistically significant differences between the two groups on 5 of 20 items of the JSPE. Findings suggest that the JSPE is a reliable research tool that can be used to assess empathy among health professionals including nurses.

Hirshfield, L.E. and Underman, K. (2017) Empathy in Medical Education: A Case for Social Constructionism. *Patient Education & Counseling*, 100(4): 785-787. PMID: 27839888.

Retrieved from: [https://www.pec-journal.com/article/S0738-3991\(16\)30496-7/fulltext](https://www.pec-journal.com/article/S0738-3991(16)30496-7/fulltext)

In this brief review, we build upon suggestions in Pedersen's [1] excellent critical review of empathy research in medical education and make the case for an increase in social constructivist scholarship related to emotions and empathy within medical education contexts. In the process, we define social construction, as well as provide several key opportunities in which these types of theories could provide insights for medical educators.

Hojat, M., Gonnella, J.S., Nasca, T.J., Mangione, S. et al. (2002) Physician empathy: definition, components, measurement, and relationship to gender and specialty. *American Journal of Psychiatry*, 159:9, 1563-1569

OBJECTIVE: There is a dearth of empirical research on physician empathy despite its mediating role in patient-physician relationships and clinical outcomes. This study was designed to investigate the components of physician empathy, its measurement properties, and group differences in empathy scores.

METHOD: A revised version of the Jefferson Scale of Physician Empathy (with 20 Likert-type items) was mailed to 1,007 physicians affiliated with the Jefferson Health System in the greater Philadelphia region; 704 (70%) responded. Construct validity, reliability of the empathy scale, and the differences on mean empathy scores by physicians' gender and specialty were examined.

RESULTS: Three meaningful factors emerged (perspective taking, compassionate care, and standing in the patient's shoes) to provide support for the construct validity of the empathy scale that was also found to be internally consistent with relatively stable scores over time. Women scored higher than men to a degree that was nearly significant. With control for gender, psychiatrists scored a mean empathy rating that was significantly higher than that of physicians specializing in anesthesiology, orthopedic surgery, neurosurgery, radiology, cardiovascular surgery, obstetrics and gynecology, and general surgery. No significant difference was observed on empathy scores among physicians specializing in psychiatry, internal medicine, pediatrics, emergency medicine, and family medicine.

CONCLUSIONS: Empathy is a multidimensional concept that varies among physicians and can be

measured with a psychometrically sound tool. Implications for specialty selection and career counseling are discussed.

Hojat, M., Gonnella, J.S., Nasca, T.J., et al. (2002). The Jefferson Scale of Physician Empathy: further psychometric data and differences by gender and specialty at item level. Academic Medicine, 77(10): S58-S60.

Retrieved from:

https://journals.lww.com/academicmedicine/fulltext/2002/10001/the_jefferson_scale_of_physician_empathy_further.19.aspx

Researchers agree that empathy has a positive role in clinical outcomes^{2–4} and in improving interpersonal relationships,² but they are divided on its definition and components. In the context of health care, we define empathy as “a cognitive (as opposed to affective) attribute that involves an understanding of the inner experiences and perspectives of the patient, combined with a capability to communicate this understanding to the patient.” With the exception of the affective Chapter, this definition is similar to the conceptualization of empathy by Feighny and colleagues.⁵ The key feature of empathy, according to our definition, is understanding, rather than affective involvement with patients’ experiences. The affective Chapter is a key component of sympathy, rather than empathy. The Association of American Medical College’s Medical School Objectives Project (MSOP)⁶ lists empathy among the educational objectives by emphasizing that medical schools should strive to educate altruistic physicians who are “compassionate and empathetic in caring for patients” and who can understand a patient’s perspective by demonstration of empathy.^{6,p.13} Medical educators concede that empathy is a significant factor in patient care that must be cultivated during medical education and can be assessed at admission to medical school.⁷ Likewise, empathy is an important component of “professionalism” in medical practice. Yet, empirical research on empathy among medical students and physicians is scarce. One reason for this dearth of empirical research is the absence of a psychometrically sound and specific research instrument. A few empathy scales for the general population exist that we previously described^{8,9} but to the best of our knowledge there is no psychometrically sound tool available for measuring empathy among medical students and physicians. There is a need for an operational measure of empathy for medical students and physicians. Such a measure can be used to evaluate the effectiveness of educational interventions aimed at promoting empathy.⁵ In response to this need, we developed the Jefferson Scale of Physician Empathy.^{8,9} In our previous studies with students, we found that total empathy scores were significantly associated with clinical competence ratings in medical school, but not with licensing examination scores.¹⁰ A significant overlap between empathy and clinical competence constitutes key validity evidence for the empathy scale. In another study, we noticed a significant decline in mean empathy scores during the third year of medical school.¹¹ Such a decline was also observed among internal medicine residents, but it did not reach the conventional level of statistical significance.¹² Overall, we found that female students and physicians scored higher in empathy than males.^{8–10} In our studies with physicians, we noted that physicians in “patient-oriented” specialties obtained a significantly higher average empathy score than those in “technology-oriented” specialties.¹³ Psychiatrists obtained the highest mean empathy score and anesthesiologists, orthopedists, neurosurgeons, and radiologists received the

lowest.⁹ Although we found no significant difference in the total empathy scores between physicians and nurses, the two groups differed significantly on some items.¹⁴ Some of these findings that were consistent with our expectations can be considered as evidence in support of the validity of the empathy scale. This study was designed to further examine the psychometric properties of the Jefferson Scale of Physician Empathy, and to investigate differences on individual items between men and women and between physicians in specialty areas defined as “people-oriented” and “technology-oriented.”

Hojat, M., Mangione, S., Nasca, T.J., Rattner, S., et al. (2004). An empirical study of decline in empathy in medical school. *Medical Education*, 38(9): 934-941.

Retrieved from:

<https://pdfs.semanticscholar.org/b3e6/322e8c2dd2a39b37d88462ccc7a8c15a9c99.pdf>

CONTEXT: It has been reported that medical students become more cynical as they progress through medical school. This can lead to a decline in empathy. Empirical research to address this issue is scarce because the definition of empathy lacks clarity, and a tool to measure empathy specifically in medical students and doctors has been unavailable.

OBJECTIVE: To examine changes in empathy among medical students as they progress through medical school.

MATERIALS AND SUBJECTS: A newly developed scale (Jefferson Scale of Physician Empathy [JSPE], with 20 Likert-type items) was administered to 125 medical students at the beginning (pretest) and end (post-test) of Year 3 of medical school. This scale was specifically developed for measuring empathy in patient care situations and has acceptable psychometric properties.

METHODS: In this prospective longitudinal study, the changes in pretest/post-test empathy scores were examined by using t-test for repeated measure design; the effect size estimates were also calculated.

RESULTS: Statistically significant declines were observed in 5 items ($P < 0.01$) and the total scores of the JSPE ($P < 0.05$) between the 2 test administrations.

CONCLUSIONS: Although the decline in empathy was not clinically important for all of the statistically significant findings, the downward trend suggests that empathy could be amenable to change during medical school. Further research is needed to identify factors that contribute to changes in empathy and to examine whether targeted educational programs can help to retain, reinforce and cultivate empathy among medical students for improving clinical outcomes.

Rapkin, B.D., and Fischer, K. (1992). Personal goals of older adults: issues in assessment and prediction. *Psychology and Aging*, 7(1):127-137.

Identifies dimensions of individual difference in the content of older adults' personal goals and examines demographic, loss-related, and contextual influences on these goals. Results are based on the responses of 179 elders to a 112-item inventory designed to tap achievement, maintenance, disengagement, and coping goals in 16 life Chapters. Factor analyses yielded 10 dimensions that describe themes of global motivation, concerns about support and desired pace, and complexity of life. Demographic disadvantages and age-related transitions were related to greater desire for disengagement, support, and stability. Elders who were married and healthy

were more likely to report a desire for an energetic lifestyle. Results are discussed in terms of implications for future research on elders' goals as a context for understanding the meaning of self-evaluation and environmental influences on aging.

Rapkin, B.D. and Fischer, K. (1992) Framing the construct of life satisfaction in terms of older adults' personal goals. *Psychology and Aging, 7(1)*:138.

Older adults' life satisfaction can be better understood in light of their personal goals. This study of 179 elders examined (1) how goals correlate with satisfaction, (2) whether elders maintain satisfaction by accommodating goals to past losses, and (3) how correlations between satisfaction and key predictors differ among groups with different goals. Satisfaction was related positively to social maintenance and energetic lifestyle goals and negatively to concerns for improvement, disengagement, stability, and reduced activity. Past losses were correlated with current goals but not with satisfaction, consistent with the notion of accommodation. A cluster analysis identified 5 patterns of goals: high demand, age prescribed, self-focused, socially engaged, and low demand. Correlations between satisfaction and other predictors differed by cluster, suggesting that the determinants of elders' satisfaction depend on personal goals.

Rapkin, B.D., Smith, M.Y., DuMont, K., Correa, A., Palmer, S., and Cohen, S. (1993) Development of the ideographic functional status assessment: a measure of the personal goals and goal attainment activities of people with AIDS. *Psychological Health, 9*:111-129.

This study presents the development of the Idiographic Functional Status Assessment (IFSA), an interview to assess functional status according to each person's unique point of view. This idiographic method asks people to state their personal goals in terms of things they want to accomplish, problems they want to solve, situations they hope to avoid, roles and relationships they want to maintain, and pursuits they want to relinquish. After describing their goals, respondents rate goal attainment activities they have pursued in the past month in terms of level of difficulty, dependence and other performance dimensions. In a study of 224 people with AIDS, the idiographic measure provided functional status scales that were relatively stable over time, and that correlated well with other subjective well-being measures and health status criteria. Goal content measures derived from the interview can be used to distinguish sub samples that differ in terms of the determinants of quality of life.

Rudawska, I. (2013). Methodology of assessing patient service quality in integrated healthcare—a preliminary framework. *Актуальні проблеми економіки(9)*: 481-491.

Retrieved from: http://www.ribis-nbuv.gov.ua/cgi-bin/ribis_nbuv/cgiribis_64.exe?C21COM=2&I21DBN=UJRN&P21DBN=UJRN&IMAGE_FILE_DOWLOAD=1&Image_file_name=PDF/ape_2013_9_62.pdf

This paper presents the methodology for assessing patient service quality in the systemic concept named integrated healthcare. The author describes the background of integrated healthcare model and presents the patient service provider relationship in this context. Next, patient service quality and its measurement methods have been discussed. Finally, the author presents the preliminary framework of a new approach to assessing patient service quality in integrated

healthcare settings.

Sharp, M. and Burkart, K. (2017). Trainee wellness: why it matters and how to promote it. *Annals of the American Thoracic Society*, 14(4), pp. 505-512

Wellness is critical to physicians in training and the general physician workforce. At present, physicians in general and especially intensive care unit physicians are experiencing high rates of depression and burnout. The prevalence of burnout is greatest in resident and fellow trainees. The Accreditation Council for Graduate Medical Education has recognized the importance of physician wellness by proposing Common Program Requirements that pertain to trainee and faculty well-being. Several individual-focused, organizational, and structural strategies have been described in the literature as helpful in decreasing burnout. Successful implementation of a trainee wellness program requires institutional resources and collaborative efforts between the institution, leadership, faculty, and trainees. To ensure the greatest effect in reducing burnout, training programs and institutions should create programs that intervene at both the organizational and individual levels. Additional steps to implement a trainee wellness program include the following: (1) establish support from institutional and divisional leadership; (2) create a wellness committee; (3) perform a needs assessment; (4) assess trainee wellness and burnout; (5) perform targeted interventions; and (6) routinely reassess trainee wellness and burnout. More research is needed to identify and refine strategies that improve wellness and decrease burnout among physicians and trainees. As a community, we must take on the challenge of improving wellness among physicians for the benefit of our trainees, ourselves, and our patients.

Strandberg-Larsen, M. and Krasnik, A. (2009). Measurement of integrated healthcare delivery: a systematic review of methods and future research directions. *International journal of integrated care* 9(1).

Retrieved from: <https://ijic.ubiquitypress.com/articles/10.5334/ijic.305/>

BACKGROUND: Integrated healthcare delivery is a policy goal of healthcare systems. There is no consensus on how to measure the concept, which makes it difficult to monitor progress.

PURPOSE: To identify the different types of methods used to measure integrated healthcare delivery with emphasis on structural, cultural and process aspects.

METHODS: Medline/Pubmed, EMBASE, Web of Science, Cochrane Library, WHOLIS, and conventional internet search engines were systematically searched for methods to measure integrated healthcare delivery (published – April 2008).

RESULTS: Twenty-four published scientific papers and documents met the inclusion criteria. In the 24 references we identified 24 different measurement methods; however, 5 methods shared theoretical framework. The methods can be categorized according to type of data source: a) questionnaire survey data, b) automated register data, or c) mixed data sources. The variety of concepts measured reflects the significant conceptual diversity within the field, and most methods lack information regarding validity and reliability.

CONCLUSION: Several methods have been developed to measure integrated healthcare delivery; 24 methods are available and some are highly developed. The objective governs the method best used. Criteria for sound measures are suggested and further developments should be based on

an explicit conceptual framework and focus on simplifying and validating existing methods.

van Berkout, E. T., & Malouff, J. M. (2015, July 20). The Efficacy of Empathy Training: A Meta-Analysis of Randomized Controlled Trials. Journal of Counseling Psychology. Advance online publication. <http://dx.doi.org/10.1037/cou0000093>

High levels of empathy are associated with healthy relationships and prosocial behavior; in health professionals, high levels of empathy are associated with better therapeutic outcomes. To determine whether empathy can be taught, researchers have evaluated empathy training programs. After excluding 1 outlier study that showed a very large effect with few participants, the meta-analysis included 18 randomized controlled trials of empathy training with a total of 1,018 participants. The findings suggest that empathy training programs are effective overall, with a medium effect ($g = 0.63$), adjusted to 0.51 after trim-and-fill evaluation for estimated publication bias. Moderator analyses indicated that 4 factors were statistically significantly associated with higher effect sizes: (a) training health professionals and university students rather than other types of individuals, (b) compensating trainees for their participation, (c) using empathy measures that focus exclusively on assessing understanding the emotions of others, feeling those emotions, or commenting accurately on the emotions, and (d) using objective measures rather than self-report measures. Number of hours of training and time between preintervention assessment and postintervention assessment were not statistically significantly associated with effect size, with 6 months the longest time period for assessment. The findings indicate that (a) empathy training tends to be effective and (b) experimental research is warranted on the impact of different types of trainees, training conditions, and types of assessment.

Chapter 10:

Impact of “Asking”, “Listening” and “Doing” What Matters

Berg, S. February 8, 2018. To understand patient health priorities, ask: “What Matters to You? AMA Wire: Practice Management.

Retrieved from: <https://wire.ama-assn.org/practice-management/ask-patients-what-matters-you-uncover-social-determinants-health>

When patients are engaged with their health care decisions, it can greatly improve chronic conditions such as type 2 diabetes and hypertension. Through health coaching, a team-based approach, physicians and their teams can help patients become active participants in their care. One health care collaborative has incorporated health coaching that goes beyond just asking “what’s the matter?” At the Montefiore Hudson Valley Collaborative (MHVC) partner organizations, health coaching means asking, “What matters to you?” MHVC is a network of multiple organizations including hospitals, FQHCs, primary care providers, skilled nursing facilities, behavioral health and substance use providers in New York’s Hudson Valley. Together they work to improve outcomes and reduce costs as part of the NY State Delivery System Reform Incentive Payment Program. Network partners at MHVC committed to begin asking patients in diverse clinical settings, “What matters to you?” (WMTY) to uncover the social determinants of health and identify priority concerns the patient is dealing with. Engagement requires asking what matters, listening attentively to what the patient says and collaboratively designing care plans that address what is most important to the patient. The AMA’s STEPS Forward™ collection of practice improvement strategies offers a health coaching module to guide physicians and their teams. Depending on the state, health coaches can include registered nurses, licensed practical nurses, medical assistants (MA), health educators and community health workers. Damara Gutnick, MD, an internist and medical director at MHVC, first tried WMTY by asking the question to a few of her patients. She was amazed at how shifting the question from “What’s the matter?” to “What matters to you?” opened up the conversation. It also saved her time because she quickly identified the real issues that were most important to her patients. “It’s changing the dialogue and the feeling in the room [when we] think about what we can do together rather than what barriers are getting in the way,” Dr. Gutnick said.

Coulmont, M., Roy, C., and Dumas, L. (2013). Does the Planetree Patient-Centered Approach to Care Pay Off? A Cost-Benefit Analysis. *The Health Care Manager*, 32(1); p. 87–95.

Retrieved from:

https://journals.lww.com/healthcaremanagerjournal/Abstract/2013/01000/Does_the_Plane_tree_Patient_Centered_Approach_to.12.aspx.

Although the Planetree patient-centered approach to care is being implemented in many institutions around the world, its impact is still the subject of some debate. On the one hand, it is viewed as the most cost-effective way to provide care and create a positive work environment that reduces staff burnout. On the other hand, it is argued that it requires higher staffing ratios and a substantial infusion of financial resources and is time consuming, which in turn results in

more work. The present study addresses the economic agenda of the Planetree patient-centered approach to care and has been designed to answer the following question: do the advantages of the Planetree patient-centered approach outweigh its costs? This question is of considerable interest for healthcare administrators and managers because the relevant authorities the world over have limited resources to allocate to health care organizations. Using a trend analysis approach to cost-benefit analysis in a rehabilitation center, this study shows that the revenues the model generates are greater than the costs of implementing it. Fewer grievances and vacant positions, an improved employee retention rate, a better working atmosphere, and a high level of employee satisfaction (higher than in similar establishments) were also noted.

DiGloia, A.M., Clayton, S.B., and Giarrusso, M.B. (2016) "What Matters to You?": A pilot project for implementing patient-centered care, *Patient Experience Journal*, 3(2):17.

Retrieved from: [hAp://pxjournal.org/journal/vol3/iss2/17](http://pxjournal.org/journal/vol3/iss2/17)

This project was intended to enhance the delivery of patient-centered care by asking patients what matters to them before and after total joint replacement (TJR) surgery. In Phase 1, pre-operatively, patients undergoing total joint replacement (TJR) surgery were asked, "What matters to you before surgery, during your hospital stay, and in the first 3 months following surgery?" and "What matters to you moving forward after you've recovered from your joint replacement?" Four weeks post-operatively they were asked, "Now that that you've been through the surgery and first 4 weeks of recovery, can you identify new concerns that you didn't have before?" and "What matters to you moving forward after you've recovered?" In Phase 2, 49 patients were asked pre-operatively, "Thinking ahead in this process...what matters to you?" Four weeks post-operatively, they were told, "Now that you've gained experience from going through a joint replacement, rank the categories in terms of how important it would have been to know in your pre-operative interview what you know now." In Phase 1, 98% of patients answered the questions the same way pre and post-operatively. The 2% who did not reported greater than expected surgical pain. In Phase 2, patients ranked the 3 most important categories pre- and post-operatively surgical results, quality of life, and reduction in pain. The WMTY project may increase patients' engagement in their care, show providers how to better understand what matters to their patients, and help surgeons to define outcomes more broadly.

Durand, M.A., Carpenter, L., Dolan, H., Bravo, P., Mann, M., Bunn, F, and Elwyn, G. (2014) Do Interventions Designed to Support Shared Decision-Making Reduce Health Inequalities? A Systematic Review and Meta-Analysis. *PLoS ONE*, 9(4): e94670.

Retrieved from: <https://doi.org/10.1371/journal.pone.0094670>

BACKGROUND: Increasing patient engagement in healthcare has become a health policy priority. However, there has been concern that promoting supported shared decision-making could increase health inequalities.

OBJECTIVE: To evaluate the impact of SDM interventions on disadvantaged groups and health inequalities. Design: Systematic review and meta-analysis of randomised controlled trials and observational studies.

DATA SOURCES: CINAHL, the Cochrane Register of Controlled Trials, the Cochrane Database of Systematic Reviews, EMBASE, HMIC, MEDLINE, the NHS Economic Evaluation Database, Open SIGLE, PsycINFO and Web of Knowledge were searched from inception until June 2012. Study Eligibility Criteria: We included all studies, without language restriction, that met the following two criteria: (1) assess the effect of shared decision-making interventions on disadvantaged groups and/or health inequalities, (2) include at least 50% of people from disadvantaged groups, except if a separate analysis was conducted for this group.

RESULTS: We included 19 studies and pooled 10 in a meta-analysis. The meta-analyses showed a moderate positive effect of shared decision-making interventions on disadvantaged patients. The narrative synthesis suggested that, overall, SDM interventions increased knowledge, informed choice, participation in decision-making, decision self-efficacy, preference for collaborative decision making and reduced decisional conflict among disadvantaged patients. Further, 7 out of 19 studies compared the intervention's effect between high and low literacy groups. Overall, SDM interventions seemed to benefit disadvantaged groups (e.g. lower literacy) more than those with higher literacy, education and socioeconomic status. Interventions that were tailored to disadvantaged groups' needs appeared most effective.

CONCLUSION: Results indicate that shared decision-making interventions significantly improve outcomes for disadvantaged patients. According to the narrative synthesis, SDM interventions may be more beneficial to disadvantaged groups than higher literacy/socioeconomic status patients. However, given the small sample sizes and variety in the intervention types, study design and quality, those findings should be interpreted with caution.

Gray, B.H., Winblad, U., and Sarnak, D.O. (September 15, 2016) Sweden's Esther Model: Improving Care for Elderly Patients with Complex Needs. *The Commonwealth Fund*.

Retrieved from:

<https://www.commonwealthfund.org/publications/case-study/2016/sep/swedens-esther-model-improving-care-elderly-patients-complex-needs>

KEY FEATURES: Improving care and experiences for seniors by persistently focusing on what is best for elderly patients with complex needs, symbolically known as "Esthers."

TARGET POPULATION: Elderly patients with complex care needs in Jönköping County, Sweden.

WHY IT'S IMPORTANT: Elderly patients may see a multitude of providers at various settings. Creating a persona—that is, Esther—for such patients helps caregivers focus on their needs, preferences, hopes, and concerns.

BENEFITS: Potentially reduced hospital admissions, readmission, and lengths of stay; improved experiences for patients.

CHALLENGES: The model requires committed leadership; instilling changes across organizations is difficult, as is bringing together multiple people at various levels of different organizations; privacy laws complicate information-sharing; finding ongoing funding is difficult.

Lang, D., Hoey, C., Whelan, M., and Price, G. (2017) The introduction of "What Matters to You": a quality improvement initiative to enhance compassionate person-centered care in

hospitals in Ireland. *International Journal of Integrated Care, 17(5): A445, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.3765*

RATIONALE FOR THIS INITIATIVE: On admission and throughout the acute hospital stay, the main focus of the healthcare professional is the medical model of care, which revolves around the physical status of the patient (Dewar & Nolan 2013). Hospital staff work in a system where patient flow and lengths of stay are indicators of effective organisations (Shahin & Mahood 2007). The emphasis appears to centre on “What’s the matter with you” (Doyle et al. 2010). While the presenting health issue is a concern to the patient, their experience of hospital care is measured by the level of dignity, compassion and respect with which they are treated (HSE & Age Friendly Ireland 2015). The Service Plan explicitly emphasises that people’s experience of the health service must be “safe, of high quality, but also caring and compassionate” (HSE 2015 p. 3). Compassionate care involves knowing the patient as a person (Lown et al. 2011) and developing a relationship of equals where the carer conveys an understanding of the patient’s suffering in a way that alleviates some of that suffering (von Dietze & Orb 2000). There is a critical link between services who regard the patient as an equal contributor to their care, where their opinions are sought and valued, and the provision of compassionate care (NHS 2014). The “What Matters to You” (WMTY) initiative supports this concept. It is a process that seeks to identify the concerns of the individual admitted to hospital and, thereby, facilitates the delivery of person-centered, compassionate care.

Lee, T. (May, 2017) How U.S. Healthcare Got Safer by Focusing on the Patient Experience. *Harvard Business Review.*

Retrieved from: <https://hbr.org/2017/05/how-u-s-health-care-got-safer-by-focusing-on-the-patient-experience>

Before 1999, the assumption was that quality in health care was basically pretty good – and, in any case, was difficult, if not impossible, to measure. The financial health of an organization was the most important metric for management and governance to follow. But 1999 was the year the Institute of Medicine released *To Err is Human*, the first line of which was “Health care in the United States is not as safe as it should be ...” The second sentence estimated that as many as 98,000 people die in hospitals each year as a result of preventable errors. Two years later, the follow-up IOM report, *Crossing the Quality Chasm*, reviewed other types of disappointing quality, including gaps in efficiency, effectiveness, timeliness and patient-centeredness. Some IOM reports are quickly forgotten; these two changed the world. There are still plenty of opportunities for improvement in health care today, but the fact is that care is better and safer and more efficient than it used to be. But some organizations are clearly leading the charge, and research shows that organizations with better patient experience also have better safety records and report better financial margins.

Sharieff, G.Q. (2018). Improving Hospitalist Patient Experience Scores: The Importance of Physician-to-Physician Coaching and Medical Director Engagement:

Case Study: NEJM Catalyst

With a goal of improving hospitalist percentile rankings for HCAHPS scores, this case study highlights Scripps Health hospitalists implementation of Knock, Sit and Ask as a strategy to improve patient experience and identifies key drivers of success. The “Knock, Sit and Ask” intervention includes: (1) Knocking before entering the room or approaching the bedside to show that the healthcare team respects the patient’s privacy. (2) Sitting at the bedside to demonstrate active listening, convey that the provider is not rushed, and also because studies have shown that patients actually overestimate time spent at the bedside if the clinician is sitting and (3) Asking the patient what their greatest concern for the day is, which focuses the physician’s attention on the patient’s needs and not solely on their medical agendas. Step #3 of the Knock, Sit and Ask strategy closely aligns with “What Matters to You?” because it elicits what matters most to the patient in a way that is actionable.

The author reports that implementation of the Knock, Sit and Ask strategy within multiple hospitalists groups in their health system, demonstrated significant improvements in HCAPHS scores. The hospitalist groups with the most medical director-level engagement and passion for patient experience had the best results. Measuring the aggregate group hospitalist HCAHPS survey scores, they found that Hospitalist Group A went from the 31st percentile to the 70th percentile; Group B improved from 21st to 63th percentile; and Group D went from 15th to 31st percentile, despite significant physician turnover during the year. Group C began its training later than the others but improved from 3rd percentile to 25th percentile in just 6 months. Group E initially had poor medical director buy in, however after the 1-year study period, Group E contacted the physician lead seeking engagement and training and has since improved their overall physician-related HCAHPS communication scores by 11 percentile units.

There was no improvement in Hospitalists Group F whose physician lead did not meaningfully implement the program.

The study highlights the importance of ongoing attention to the data, the role of direct physician lead support and the buy-in from the hospitalist medical directors. The provision of practical and easy-to-implement tips as well as a focus on monthly individual physician-specific feedback reinforced that small behavioral changes can dramatically improve percentile rank.

Uchino, R., Yanagawa, F., Weigand, B., Orlando, J.P., Tachovsky, T.J., Dave, K.A., and Stawacki, S.P. (2015). Focus on emotional intelligence in medical education: From problem awareness to system-based solutions. International Journal of Medicine 1:9-20.

OBJECTIVE: To review emotional intelligence (EI) literature in the context of how its application can help mediate various stressors among medical students, physicians-in-training, and faculty. Also, discussed are potential barriers to why EI-based programs face challenges to full implementation in medical education.

LITERATURE SEARCH: MEDLINE, PsychINFO, EMBASE, Google Scholar, and Web of Science were searched for English language articles using various combinations of the following terms: EI, medical students, medical education, graduate medical education, trainees (including intern, resident, and residency), practitioners, and physicians. Electronic publications and printed books

referenced by primary sources were also included.

RESULTS: Although there is increasing evidence for EI implementation being favorably associated with physician wellness, decreasing burnout, building better physician-patient relationships, and even better patient outcomes, there has so far not been a large scale movement to integrate EI into medical school curricula. The main barriers to wider implementation of EI are general lack of awareness, insufficient time and resources, and paucity of qualified faculty.

CONCLUSIONS: Despite a number of associated potential benefits, EI has been facing various implementation hurdles in the medical education setting. Increasing awareness of EI and its benefits could help medical schools and residency programs around the globe to more actively engage in the implementation of EI training into medical school and residency curricula. We expect that such interventions would have several desirable outcomes, including improved overall physician wellness, enhanced patient experience, and perhaps even improved patient outcomes. The following core competencies are addressed in this article: Practice-based Learning and Improvement, Patient care, Professionalism, Interpersonal and communication skills, Systems-based practice.

Williams, E.S., Baier, L., Manwell, L., Konrad, T.R., and Linzer, K. M. (2007) The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: Results from the MEMO study. *Health Care Management Review*, 32(3), 203-212.

Retrieved from:

https://journals.lww.com/hcmrjournal/fulltext/2007/07000/the_relationship_of_organizational_culture,.3.aspx?casa_token=nf4LoUZwxNkAAAAA:uGPR1oT-NKbXXVH1vkMTLeNdwoJ4ec_Eh6ennR1dSnbqOe5g4uYs_PBOg_iAq5QnfIKlqRW8mNyXuhfVRTThCQ

BACKGROUND: A report by the Institute of Medicine suggests that changing the culture of health care organizations may improve patient safety. Research in this area, however, is modest and inconclusive. Because culture powerfully affects providers, and providers are a key determinant of care quality, the MEMO study (Minimizing Error, Maximizing Outcome) introduces a new model explaining how physician work attitudes may mediate the relationship between culture and patient safety.

RESEARCH QUESTIONS: (1) Which cultural conditions affect physician stress, dissatisfaction, and burnout? and (2) Do stressed, dissatisfied, and burned out physicians deliver poorer quality care?

METHODS: A conceptual model incorporating the research questions was analyzed via structural equation modeling using a sample of 426 primary care physicians participating in MEMO.

FINDINGS: Culture, overall, played a lesser role than hypothesized. However, a cultural emphasis on quality played a key role in both quality outcomes. Further, we found that stressed, burned out, and dissatisfied physicians do report a greater likelihood of making errors and more frequent instance of suboptimal patient care.

PRACTICE IMPLICATIONS: Creating and sustaining a cultural emphasis on quality is not an easy task, but is worthwhile for patients, physicians, and health care organizations. Further, having

clinicians who are satisfied and not burned out or stressed contributes substantially to the delivery of quality care.