

CREATING CONSTANCY OF PURPOSE IN HEALTHCARE: A NEW DIRECTION FOR HEALTHCARE TEAM-PATIENT INTERACTION AT THE CLINICAL LEVEL

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Abstract

The present healthcare system is in a stable (predictable poor) state when it comes to treatment care planning strategies. Today, the system primarily divides responsibilities among healthcare professionals to achieve satisfactory patient outcomes. It is assumed that if nurses, therapists, administrators, MD's, etc. independently fulfill their respective professional obligations (i.e., they all do their jobs) to provide the highest level of care, the patient will naturally benefit optimum outcomes. Nothing could be further from truth. Patient-centered care, by definition, means that any treatment care planning must start with the concerns and goals of the patient upfront and not as an afterthought. What is missing is the perspective of "interaction" and direction of these disciplines working together as a system. To be effective, any system must have an aim. Similarly, a system without an aim is no system (i.e., independently pursuing self-centered goals of the discipline). Healthcare professionals (if they are really serious about achieving optimum outcomes) need to possess "constancy of purpose" when addressing patient needs and must adopt "the new philosophy" about functioning together as a team. We have observed that utilizing the Ozer Payton Nelson (OPN) Method facilitates improved interaction and is the basis for generating true patient-centered treatment planning.

Being Truly Patient Centered – A Paradigm Shift

Our primary focus as clinicians should be patient-centered in our approach to treatment, which means that we have taken the time to elicit from the patient his or her concerns and goals (upfront) that they want to achieve during the course of their rehabilitation. In addition, we then should communicate with them regularly about achievements made so that they feel they are making progress, and then involving them in the re-evaluation of the treatment plan. Once this foundation is laid and communicated to all team members, effort must be expended to establish a common vision for the team's general direction (i.e., following Deming's Constancy of Purpose principle; alignment of conflicting goals) and for the care of each patient.

Each member of the team can then examine his or her individual skill set to determine what the unique contribution their discipline will make toward attainment of the patient-centered goals. Discrepancies in views of the desired future state, either on a clinical or administrative level, tend to result in power struggles between members of the treatment team over whose view is correct or who will make the final decision. This approach only increases variation in patient outcomes, not decrease variation. By utilizing this "the new philosophy", we avoid prescriptive, cookie-cutter approaches to treatment and create constancy of purpose for our efforts and treat each patient as a unique individual with unique goals and concerns.

By What Method?

The OPN Method (1) is a cyclical, structured format that is process-driven and functions to create operational definitions for improvement in patient rehabilitation planning that nearly any clinician can perform in their daily duties. It also emulates the PDSA cycle.

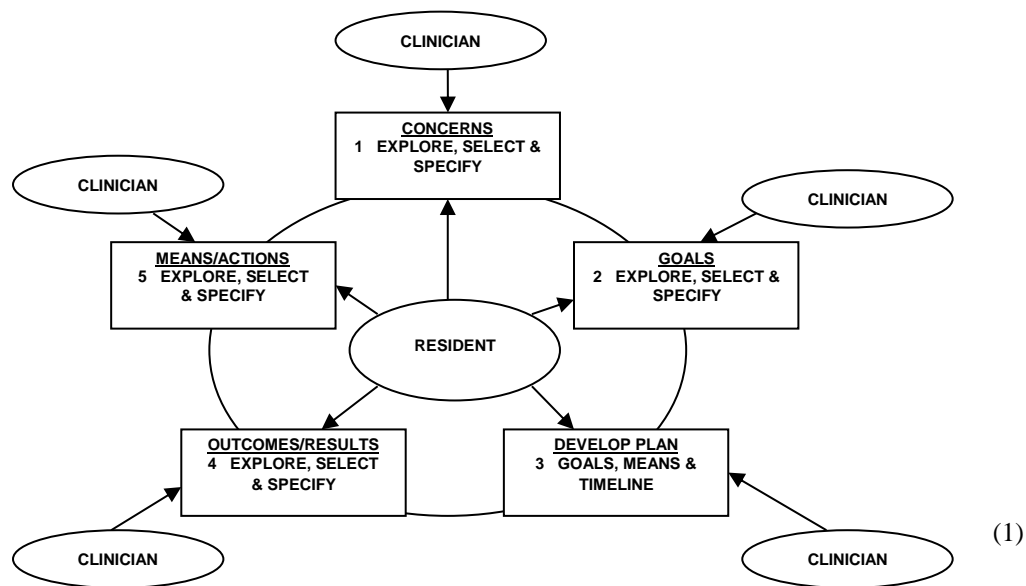
As Deming has stated, operational definitions help reduce variation (2). They create common understanding between parties. In the microcosm of communication and interpersonal relationships between clinicians and patients, operational definitions of goals equally understood by clinicians and patients help the patient to reach successful outcomes. In the OPN Method, goals are written in the patient's language, not the clinician's language. This

simplification and redirection increases the patient’s adherences to his or her goals since the patient’s words are being used to formulate the goals.

This technique also helps to maintain the integrity of the patient’s (customer’s) goal by not filtering out the essence of the patient’s expressed desires and needs. Clinicians tend to “paraphrase” the patients words in medical jargon which clouds the voice of the customer. Unfortunately, clinicians are trained to do this “paraphrasing” in their education. Old habits are hard to change.

The essential OPN Method comprises of four questions posed at different stages of treatment planning and three processes for each question. The cycle repeats itself when the patient’s elicited goals are met or revised, or the patient states he or she has new concerns. This cyclical strategy is the foundation for facilitating feedback to obtain both clinician and therapist short-term rehabilitation goals and measuring progress-made.

Diagram 1.



The OPN Method begins with eliciting information from the patient regarding his or her concerns about returning to their previous lifestyle. After those concerns are elicited from the patient, the clinician will repeat those concerns to the patient, ask him or her to select his or her most important concern, and that most important concern is then specified to drive out ambiguity (i.e., operational definitions). This specified concern now bridges the gap between concerns and goals.

The next step is to attach three functional, measurable and disability-related goals to the patient’s most important concern. The same processes are applied to goal setting. The clinician and patient explore three different goals, select the most important goal, and then specify that goal to create a consistent, explicit goal that any person who reads the medical records where the goal is recorded has a clear idea of the patient’s desired goal. Following the idea of patient participation, all statements the patient makes are recorded using the patient’s exact words. Medical jargon is not used by the clinician. (This phase of the process follows the “plan” part of the Plan-Do-Study-Act, also known as the PDSA cycle.)

After the concerns and goals are elicited, the clinician develops the initial treatment plan to correlate to the patient’s most important goal. This correlation improves the relevancy and meaningfulness of the plan; thereby creating common understanding, reducing redundancy, rework, and overall improvement in the patient’s motivation to accomplish goals. The plan is enacted and the patient participates in the treatment designed for their personal needs. (This is the “do” of the PDSA cycle.) Depending on the patient’s diagnosis and/or length of stay, the patient is asked

to analyze his or her progress within a few days or a week after the most important goal is specified. According to the literature, having specific short-term goals provide the necessary timely concurrent feedback which is necessary for patient's to recognize progress and evaluate the treatment plan. (3)

The clinician will ask the patient if he or she has made any progress, and the clinician will explore three or more instances of achievement. Progress-made (or achievements) are measured by what the patient was unable to do before his or her goal was elicited but now can perform. If the patient identifies a task that he or she can now perform better after he or she has received treatment, that progress is recorded. Achievements can be as momentous as walking a mile after a knee replacement, relearning how to put on a shirt after shoulder surgery, or simply sleeping through the night without interruption. No achievement is too big or too small to identify. The clinician will elicit at least three achievements, and then ask the patient to select his or her most important achievement, and finally the clinician will ask the patient to specify that achievement. (This is the “study” part of the PDSA cycle.)

After progress-made is identified, the clinician will ask the patient what actions he or she took to reach that level of achievement. This act links purpose to procedure. (4) The clinician implemented the procedure or means to achieve those goals (exercises, medicine, tools, etc.), and now the patient is asked to relate how those procedures helped achieve his or her purpose (goals). Then the clinician will cycle through selection and specification once again. This drives home the idea that exercises, medicine, or tools are not just done or used “for fun”, but rather to help achieve the goal the patient set. Many patients, particularly older adults, are not aware what a particular exercise is for, or why they are doing it. Knowing why you are performing a certain exercise or taking a certain medication that relates back to your goal creates a positive feedback loop for the patient. As Deming has stated, if I knew “why” I was doing something, then I can fully cooperate to achieve that common goal. (2)

After actions taken are elicited, the clinician will then cycle back to revised concerns and revised goals. The same cycle is performed again using the three processes, and five levels of patient participation. Each time this is done, the clinician helps the patient identify new patient concerns, or help the patient realize his or her concerns are alleviated. (This phase reflects the “act” of the PDSA cycle.) Refer to Diagram 1 on page 2.

Each iteration of the cycle assists with the ongoing discharge planning process. If a patient can no longer identify concerns and the clinician is unable to identify concerns he or she may have, it becomes evident to all that discharge planning is imminent. At this stage, it is conjectured by the therapist that the patient has moved into a stable state: further treatment using the same exercise routine will not yield further improvement. The patient has more control and has participated in making this decision, so it's likely the patient (or family) won't be surprised or worried about returning home unprepared when the patient discharges from the facility. Interestingly, Medicare is now assessing penalties to hospitals for patients who are re-hospitalized in certain time frames. (5) It is now more important than ever that first time treatment be as effective as possible regardless of the setting.

Clinician	Patient	Degree or Level	Level of Involvement
Asks open ended questions (does not suggest answers)	Free Choice Explores	A	100%
Asks questions and offers suggestions	Multiple Choice Selects	B	75%
Asks questions, provides an answer (recommendation) and asks for agreement and confirmation	Confirmed Choice Puts into own words what has been selected	C	50%
Asks questions, provides an answer (recommendation) and asks for agreement	Forced Choice Agrees (or disagrees) with what has been selected	D	25%
Does not ask; tells what to do. Prescribes.	No Choice Compliant or non-compliant	E	0%

As modified from Ozer MN, Payton OD, Nelson CE: Treatment planning for rehabilitation: a patient centered

The OPN Method uses hierarchical levels of patient participation to elicit and clarify concerns, goals, results achieved and actions taken. Clinicians trained in this method begin by initially asking patients open-ended questions, thus giving the patients control while not attempting to influence responses. If a patient is unable to answer an open-ended question at the free-choice level, the clinician can proceed to posing questions at three other levels (i.e., multiple choice, confirmed choice, forced choice). Clinicians ask for the patient's permission before descending down to a lower level, never skip a level, and return to the level of free choice for further questioning whenever possible. Moving from open-ended questions to these lower three levels means that planning and evaluating treatment are becoming less patient-centered and more clinician-centered. The goal is to cooperatively plan and evaluate with the patient at the highest level that the patient is capable of or desires; prescribing to the patient is to be avoided.

The clinical encounter cannot begin without input from the patient. Using the OPN Method provides a format for all other clinicians to follow (a repeatable process), and elicit one main goal that each clinician can use as a touch point. The person who starts the process (doctor, therapist, nurse, admissions director, social worker) will elicit concerns and goals that are relevant to the patient. The goals that are elicited are a reference point for each clinician (i.e., constancy of purpose and establishment of operational definitions).

For example, if a patient who is recovering from a hip replacement says his or her most important goal is to "make dinner for my family, in my kitchen at home, in 30 minutes, making chicken or steak, a vegetable, and a salad," the clinicians can all use that information to help plan their individual treatments. This overreaching goal can then bring the interdisciplinary team together under a singular focus, thereby diminishing barriers between departments and disciplines.

As Gipsie Ranney points out in her paper discussing *Transformation – You Can't Do Just One Thing*, recently presented at Pratt & Whitney Rocketdyne's InThinking Network webinar:

"In *Managing the Unexpected*, Weick and Sutcliffe write: "Teams composed of at least some individuals with different expertise are better able to grasp variations in their environments and to see specific changes that need to be made. They also are better at coping – especially when they think they have the capability to act on what they see. Moreover, generalist teams – teams that include at least some individuals who have had a broad range of experiences – are better at recombining existing knowledge, skills, and abilities into novel combinations. Because action and cognition are linked, as a team increases its capabilities for action it enhances the group's capabilities to register and handle complexity. This diversity enables people to see different things when they view the 'same' event." (7)

Physical therapists can help plan mobility, OTs will concentrate on activities of daily living, and doctors and nurses can help manage the health of the patient, all the while creating their individual treatment plans based on the patient's most important goal. This singularity leads to better, more coordinated, effective solutions and plans being implemented when compared to each department and discipline doing their best on their own, thus fulfilling the prediction in Ranney's point mentioned above.

Not all clinical encounters are conducted in a perfect state. Patients may suffer strokes, or have other cognitive difficulties that may affect their speech, reasoning, or memory. When this is the case, families or loved ones are invited to participate in the treatment planning process. The interdisciplinary team may now include social workers, speech therapists and other specialists. Each discipline has his or her own idea of what he or she may think is a successful recovery based on the diagnosis. Removing each individual clinician's biases and inserting what the family or loved one think would be a successful recovery by eliciting their goals for the patient creates a focused and personal touch point for the patient and family. Each clinician works from that central idea, and creates a treatment plan with it in mind.

Modern Methods of Training

The initial OPN Method training is ideally conducted over the course of 8 weeks, with 2 hour sessions per week (i.e., Deming's requirement for vigorous training.) Various adult learning techniques are used to accomplish clinician competency. (Additional training post-course is done individually with the instructor.) Each 2 hour session focuses on a primary aspect of the OPN Method. During the session, clinicians are asked to self-reflect on their barriers on involving patients in treatment planning and set goals to overcome those barriers before training concludes. The clinicians mirror the process of applying the OPN Method to their patients by first applying it themselves during training. This reinforces the method, as the participants are learning it in a classroom environment and then repeating it with patients. The participants also set a "class" goal to achieve, and which helps give direction on the topics the instructor should cover. Between the sessions, clinicians are asked to practice an individual component of the OPN Method with actual patients, and then report back their achievements, how they did and what new concerns they may have involving patients. The participants follow the OPN Method when analyzing their experiences in the field with patients too. The OPN Method follows the andragogical approach to teaching; the learner is an active participant throughout the process, it accommodates the individual participant's needs and learning style, and it immediately applies to the participant's life and work. (8)

When a scientific study was conducted and published in a peer reviewed journal on the OPN Method, the authors opted to measure the effectiveness of the training program using an audit tool called the Adapted Participation Methods Assessment Instrument (APMAI) that measures the clinician's ability to attempt certain patient-centered communication criteria items. (9) Measuring the clinician's attempts at involving the patient, and not the patient's results follows Deming's point of driving out fear and eliminating numerical quotas. Typically, clinicians are unwilling to write down patient goals that may be qualified as "unrealistic" because they fear that if they do not help the patient meet that goal, they have failed in their job. The OPN Method stresses the importance of capturing all goals, regardless of their feasibility. It is then the clinician's job to help the patient set short-term goals that can lead to achieving what may be considered long-term goal.

The Treatment Planning System Needs to Change

So how do we start to achieve this better state? The system needs to be changed to accommodate interaction of various disciplines in a constructive and meaningful manner, i.e., adopt a different method for collecting, analyzing, and interpreting ongoing results as the output of a system. Utilization of Deming's PDSA cycle for learning is also necessary as a common strategy for improvement of outcomes.

According to Gage, all interdisciplinary team members need to have a common understanding of how the desired future state differs from the current state. (10) They also need to realize that discrepancy between the present state and the desired future state results in creative tension. This tension establishes what Craig and Craig refer to as a motivating gap. (11) As long as the participants perceive that it is within their ability to bridge this gap, they will mobilize their creative energy toward reaching the desired future state. When all members of a team experience this motivating gap, the collective wisdom of the group can be tapped to establish synergistic solutions which will be much greater than what could have been achieved individually. If members of the team believe that it is impossible to achieve the desired future state, the less desirable status quo will continue.

When the desired level of team/patient interaction occurs, the patient provides the starting point of the work of the team. The literature on enabling patient involvement identifies a mismatch between the help that is sought and the help that is offered as a major reason for the failure of therapeutic initiatives. Thus, the adopting of the client vision as a focus for the work of the team will create a transcending purpose for the team as well as increased motivation and compliance on the part of the patient. Covey states, "As we come to a transcending purpose, common vision and shared mission in our relationships then we can afford to have many differences and they'll become strengths." (12)

Patients will often suggest that they be allowed to adopt visions of the future that are hopeful, rather than being limited by the professional's constricting view of what typically "is possible" for a client with a similar condition. This is consistent with the management goal-setting literature that suggests that the bigger the discrepancy between the current state and desired future state, the harder people committed to the goal will work to accomplish the goal. As stated earlier, however, there is a corollary to this phenomenon: goals that are perceived to be totally unattainable result in little or no effort on the part of the participants. (3)

Gage also states (13), healthcare professionals tend to develop their goals through a process of scientifically determining what the “average person” is likely to accomplish, whereas patients tend to base their goals on “returning to what is a normal state” for them. Through his work with patients with cancer, Bernie Siegel identified patients who are considered to be exceptional because they beat the odds and achieve what health professionals believe to be impossible (14) (The Galatea effect - this is what happens when high self-expectations lead to more positive outcomes) (15). Personal accounts of individual clients' illness experiences confirm that this phenomenon (Galatea Effect) occurs with other diagnoses as well.

The Treatment Systems Needs Change

Old Assumptions	New Assumptions
Identify & maximize my own department (silos)	Patient goals determine how the rest of the components will perform (constancy of purpose)
Clients are passive recipients of the healthcare team	Clients are equal members of the healthcare team
Maintain solos/territorial thinking	Break down barriers
Changing your mind is bad	Changing your mind is a natural evolution of the interactive nature of healthcare (PDSA)
Usually authority wins	The focus is on the patient, not who is in charge
Interdisciplinary approach – “Report off”	Now intra-disciplinary team approach

Results Achieved

We have learned from our experience towards improving the process of patient care by becoming more patient-centered (more in line with the SIPOC model) that quality (of the therapist services) cannot be delegated or mandated. The type of change we are promoting requires leadership from the top. No amount of exhorting people or using incentives to extrinsically "motivate" clinicians to be more patient-centered will be effective.

We have found that clinicians believe they attempt to involve patients in the goal setting process, however, the literature and our observations demonstrate just the opposite. Most clinicians involve patients at far less than optimal levels. (16-20) Some of the reasons for this appear in the table below:

Reasons for Therapist Control of Goal-Setting Process
<ul style="list-style-type: none"> • Perceived time limitations • Lack of preparation at the professional level of education • Inexperience dealing with unrealistic and irrelevant patient goals (e.g., those related to other disciplines) • Use of vague and inconsistently applied informal interview methods • Professional versus patient role beliefs (e.g., control, expectations, paternalism) • Limited or no awareness of patient-centered care standards and regulations

Adapted from Tripicchio et al 2009. (6,9)

It seems the professional academic educational process has failed to translate our professions' values into a formal set of procedures (or a standardized process) that could be used in clinical practice. Therapy textbooks or curricula offer few specifics as to how therapist should elicit patient goals. According to studies, including ours, (9) when therapists do attempt to assess patients priorities and goals the method used 95% of the time is "informal interview". (18)

The quality of involving patients in the goal setting and treatment planning process using informal interview varies from clinician to clinician due to differences in interviewing styles and skills, and therefore is not sufficient to identify patient's priorities and concerns in a consistent manner. (18-20) Clinicians of all disciplines should be trained in the OPN method if they want to deliver more effective patient-centered care. Clinicians have reported to the study's authors that by using the OPN method, it enables them to know how the illness or injury affects the patient's life. This new perspective in turn helps clinicians to design a more meaningful and effective treatment plan. Patients, on the other hand, appreciate the opportunity to tell their story and see the therapist as a person who really cares and not as someone wearing a white coat directing them on what to do.

Conclusions and Recommendations

Health professionals need to be more willing to accept and work toward a client's hopeful future vision, establish constancy of purpose in treatment planning and eliminate their biases as to what they think is "best" in order to most effectively meet the needs of the patients we treat. In the ever changing healthcare industry where there is an increased value on the voice of the customer, i.e., patient-centered care), improved clinical outcomes (quality) and reducing costs, Deming's tenets and principles are more relevant and timely than ever. A paradigm shift is required that will ensure the best healthcare practice for our customers.

Plans for the Future

As a business entity preparing for the future, Community Physical Therapy is committed to further application, study, and improvement for our customers. For example, the statement below will be instrumental in sustaining a vision of constancy of purpose now and in the future. It was crafted by the executive management team and is published as part of the company's business strategy for all therapists to see, assimilate, and practice.

CPT is committed to improving patient-centeredness and shared decision-making by actively involving each patient in the goal setting and treatment planning process. We believe that the Ozer Payton Nelson Method, an evidence-based professional communication model, improves patient collaboration, outcomes, and satisfaction. The process honors the uniqueness of how illness affects each individual differently and lends itself to more relevant treatment and self-management.

Footnotes

(1) Ozer et al 2000.

(2) Deming 2000.

(3) Locke et al 2002.

(4) Peloquin 1988.

(5) U.S. Department of Health and Human Services 2013.

(6) Guccione et al 2011.

(7) Weick et al 2007.

(8) Knowles et al 1998.

(9) Tripicchio et al 2009.

- (10) Gage 1994.
- (11) Craig et al 1974.
- (12) Covey 1995.
- (13) Gage 1998.
- (14) Siegel 1993.
- (15) CRM Learning 2001.
- (16) Gage et al 1997.
- (17) Payton et al 1998.
- (18) Neistadt 1995.
- (19) Northen et al 1995.
- (20) Baker et al 2001.

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