Creating Constancy of Purpose in Healthcare: A New Direction for Healthcare Treatment 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 achieve an optimal outcome. Nothing could be further from the 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.

Hypothesis

If treatment planning does not incorporate the voice of the patient [illegible] related concerns clarification and goal setting processes among multiple [illegible] you are not truly practicing patient-centered care.

Background and Current Environment

A vast majority of clinicians believe they attempt to involve patients in the [illegible] process; however, the literature demonstrates the opposite-most therapists involve patients at far less than optimal levels. [illegible] evidence exists in the literature that suggests increasing patient participation in concerns clarification, goal setting and treatment planning improves outcomes and patient satisfaction and, furthermore, is recommended or required in regulatory and practice guidelines.

The current healthcare state requires three tenants of reform:

- Improve clinical outcomes
- A healthier population
- Decrease delivery cost

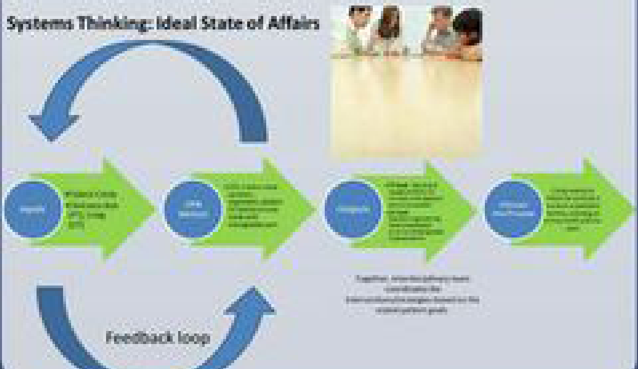
Silo Thinking: Current State of Affairs


Physical therapist
Impairment based goal:
Patient will ambulate 1,000 feet with a walker
Occupational therapist
Impairment based goal:
Patient will increase upper extremity strength
Nursing
Impairment based goal:
Patient will be independent in medication management

Patient Example: Cindy, 46 year old female, with a right hip replacement

Goals targeted at the level of impairment are not commensurate with the perceived goals of the patient. Our primary focus as clinicians should be patient-centered in our approach to treatment. This 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 involve patients regularly in evaluating their outcomes so treatment planning and goals can be fine tuned when necessary. 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 and for the care of each patient.

Systems Thinking: Ideal State of Affairs



Method

The OPN Method 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 possesses built-in validity and can be used by any clinician and for any patient. The OPN Method consists of 3 major components in the context of the Plan-Do-Study-Act Learning Cycle (PSDA):

- **4 Questions** (What are your concerns? What are your goals? What results have you achieved? What parts of the treatment [illegible]?)
- **3 Processes** [illegible]
- **5 Levels of Patient Participation** (Free Choice, Multiple Choice, Confirmed Choice, Forced Choice, [illegible] Choice or Prescription)

PDSA Learning Cycle & OPN Method

The APMAI

In order to identify clinicians' attempts to involve patients in treatment planning, an audit tool was adapted from the literature. Originally called the PPEF (Patient Participation Evaluation Form), it went on to become the PMAI (Participation Method Assessment Instrument). [illegible] called it the APMAI (Adapted Participation Method Assessment Instrument). [illegible] graded whether or not they attempt the criteria items. The criteria items are as follows:

Part A: Concerns Clarification

1. Introduces exploration of concerns.
2. Elicits patient's concerns using open-ended [illegible]
3. Tries to elicit two or more patient concerns.
4. Elicits patient's concerns until [illegible] there are no more.
5. Follows the correct [illegible] of the Patient Participation Scale.
6. Asks permission of the patient before moving down levels of the Patient Participation Scale.
7. Attempts to [illegible] specific information about concerns that patient has verbalized by asking [illegible] questions.
8. [illegible] to gain more specific information [illegible] verbalized by asking clarification questions.
9. Explores/explains additional concerns not identified by the patient by relevant to their rehabilitation.
10. Restates patient's concerns (i.e., confirmation process) in order to clarify them.
11. Asks patient to select their primary concern.

Part B: Goal Setting

12. Introduces exploration of goals.
13. Explains the cooperative role of the patient in goal identification.
14. Incorporates patient's stated concerns in or during the exploration of goals.
15. Collaborates with patient, family/significant other to establish goals using open-ended questions.
16. Seeks input from the patient when trying to specify the following components of the primary goal:
    a. Who
    b. What
    c. When
    d. Where
    e. To what degree/how often
17. Explores/explains additional goals not identified by the patient by relevant to their rehabilitation.
18. Follows the correct sequence of the Patient Participation Scale.
19. Asks the patient's permission before moving down levels of the Patient Participation Scale.
20. States goals to the patient, family/significant other.
21. States goals in a manner consistent with the patient, family/significant other's level of understanding.

Results

Ten of the 21 criteria items on the APMAI demonstrated statistically significant proportional differences ($P < .05$) in frequencies of therapists between pretest and posttest performance level of skills. Additionally, the average score of clinicians increased from 4 attempted criteria items pre training to 12 attempted criteria items 1-3 weeks post training. After six to eight weeks post training, the average score rose to 16 attempted criteria items.

We further improved these results by adopting the tenants of Dr. W. Edwards Deming: drive out fear for employees, create operational definitions for our processes, institute training for employees, break down barriers between disciplines, and continually work on improving the system.

Discussion

The system needs changing 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 [illegible] system. We learned from our experience that becoming patient-centered [illegible] Good intentions and superb clinical skills alone will not support [illegible]. The type of change we promote requires leadership from the top [illegible] people or using incentives to extrinsically "motivate" clinicians to be [illegible] 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. Some of the reasons for this appear in the table below:

Reasons Therapists Are Not Patient-Centered in the Goal Setting Process
• Perceived time limitations
• Lack of preparation at the professional level of education
• Inexperience at dealing with perceived unrealistic and irrelevant patient goals (e.g., goals related to other disciplines)
• Use of vague or 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
• Confusing goals with means

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.

Conclusion

Health professionals need to be more willing to accept and collaborate 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 they 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, Dr. W. Edwards Deming's tenets and principles, coupled with the Ozer Payton Nelson patient-centered communication method, are more relevant and timely than ever. A paradigm shift is required that will ensure the best healthcare practice for our customers.

Contact Information

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