

Person-Focused Care at Kaiser Permanente

Jim Bellows, PhD; Scott Young, MD; Alide Chase, MS

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Abstract

Patient-focused care has been described as an extension of patient-centered care, recognizing that patients' medical needs are best understood and addressed in the context of their entire lives, including their life goals and social, economic, emotional, and spiritual functioning. Kaiser Permanente is expanding its ability to care for members as whole persons, not just as patients, with sensitivity to nonmedical factors in planning and delivering care. We describe emerging examples in several areas: interdisciplinary care planning, behavior change, social care, patient-reported outcome measures, and Total Health. Realizing the vision of person-focused care requires taking every opportunity to fully recognizing that each patient we serve is first and foremost a person.

Introduction

In the article by Tuso et al¹ on page 38, they describe a series of efforts to reduce heart failure readmissions. Initial interventions focused on clinical issues; later, multidisciplinary case conferences revealed the importance of psychosocial factors for some patients. The authors provide valuable information about preventing heart failure readmissions, but their broader contribution is providing an example of extending "patient-centered care" to become "person-focused care."

Starfield² described person-focused care as care "provided to patients over time independent of care for particular diseases" and "based on accumulated knowledge of people, which provides for better recognition of health problems and needs over time and facilitates appropriate care for these needs *in the context of other needs*" [emphasis added].² Both Tuso et al and Starfield

distinguish between patients and persons: individuals are persons in every part of their lives, but they are only patients in the context of health care. Person-focused care addresses patients' health needs, risks, and preferences by recognizing that health and health care are interwoven in the fabric of individuals' entire lives, including life goals, work, friends and families, education, recreation, communities, and environment, and interact with social, economic, emotional, and spiritual functioning.^{1,2}

Tuso et al¹ describe case conferences that take into account individual patients' life and health trajectories in addition to their clinical needs. This reflects a broader, exciting trend at Kaiser Permanente (KP) in which we more explicitly and intentionally care for members as persons who are also, for some period of time, patients. Some examples follow.

Care Planning

Traditional treatment plans, written from a clinical perspective by a physician or nurse, document planned diagnostics or therapies. Demonstration projects in the Northwest and Colorado Regions aim to dramatically improve care for members, many elderly, with complex needs. At the center of each project are interdisciplinary, person-focused care plans including patient preferences, motivations, and goals, in addition to anticipated medical treatment. A communication tool for members, physicians, and other providers such as case managers and social workers, person-focused care plans summarize the results of shared decision making and describe how providers will work together to address patient needs. Providers considering new treatment can refer to the shared plan to ensure coordination with other care and check alignment with the person's preferences, goals, and circumstances.

Behavior Change

The whole person is also at the heart of new approaches to help members improve health-related lifestyle behaviors. Traditional models of behavior change focus on behaviors carrying the greatest risk, such as tobacco use or physical inactivity, and seek to motivate change by educating patients about the risks and consequences of lifestyle choices. However, substantial evidence indicates that behavior change is most effective when based on personal goals and embedded into personal routines, rather than originating from externally defined goals or instructions.³ Accordingly, three facets of KP's developing person-focused approach to behavior change reflect the importance of context. First, members identify and address health-related behaviors they are most ready to improve, even if these are not their highest risks, with the understanding that success can build self-efficacy and lead to changes in higher-risk behaviors. Second, members are encouraged to link positive behaviors with "triggers" occurring in daily life, using them to prompt desired healthy behaviors. Third, members are encouraged to build "optimal defaults" into their routines; such that healthy choices become default choices and less-healthy choices require extra effort. Person-focused behavior change was featured at the 2012 annual meeting of KP's Care Management Institute (CMI), which is working with several Regions to translate these concepts into their health education and behavior change programs.

Social Care

Life circumstances provide important context in providing care for any person but can impose real constraints in caring for those with unmet needs for housing, transportation, healthy food, or personal care. Care often fails if it does not address

Jim Bellows, PhD, is the Senior Director, Evaluation and Analytics for the Kaiser Permanente Care Management Institute in Oakland, CA. E-mail: jim.bellows@kp.org. **Scott Young, MD**, is the Associate Executive Director, Clinical Care and Innovation of The Permanente Federation in Oakland, CA. E-mail: scott.s.young@kp.org. **Alide Chase, MS**, is the Senior Vice President, Medicare Clinical Operations and Population Care for Kaiser Permanente in Oakland, CA. E-mail: alide.l.chase@kp.org.

life circumstances, especially among those who are frail, have dementia or mental health disorders, or are socially or economically vulnerable. KP has a long history of addressing social health needs, eg, the Northwest Region's Social Health Maintenance Organization program that operated until Medicare discontinued funding in 2001.⁴ Recent awareness of the interrelationship of unmet social needs and high health care costs has led many Regions to attempt closer integration of health care and social services. Initial efforts include creating "navigator" or "integrator" roles: KP staff who help members connect with community-based social services. Institutional partnerships also reflect closer integration of health and social services. A simple example is KP medical care in assisted living facilities, improving access and allowing elders to receive care in a safe, familiar environment. Other partnerships to jointly address related health and social needs are under development.

Patient-Reported Outcome Measures

Measures gauging health care quality performance can influence the evolution of care delivery. In addition to measures of physiology or utilization, patient-reported outcome measures (PROMs)—patient self-reported outcomes, such as symptom management and functional status—can move care toward patient-centeredness. PROMs can also move care toward person-focus if they assess whether care is aligned with patient preferences and is yielding improved health and social function. Improvement teams in several KP Regions are implementing person-focused PROMs. For example, cancer patients in Orange County are asked, "Have you had any trouble meeting the needs of your family?" and in the Northwest and Hawaii Regions, complex care patients will soon be asked, "How often did the doctors and other staff help you with the things that worry you the most?" These steps, albeit small and early, add to our understanding of whether care supports social function, in addition to physical and behavioral function.

Total Health

At the broadest level, KP is enacting its commitment to person-focused care through the Total Health initiative, which

explicitly addresses the interconnectivity between health, health care, individual behaviors, environments, and social determinants of health. The Total Health initiative will bring together KP's work in health care delivery with resources and influence to mobilize programs and policies promoting health in schools, worksites, and communities; the goal is to align influences in personal behavior and environments. This approach brings the concept of "optimal defaults" to the societal level, reshaping food systems, transportation, and other services so that healthy choices are the easiest choices.

Conclusion

Fully realizing person-focused care by explicitly addressing members' health-related needs, preferences, and expectations will encounter three challenges. The first is complexity, a primary challenge to highly reliable and user-friendly health care. Planning and delivering health care is already characterized by extraordinary complexity—in patients' genetics and physiology, available treatments, technologies, data, organizational structures, payment systems, and interactions among these. Also considering patients' family, work, and life goals multiplies the complexity involved in creating optimal care plans and could strain operational efficiency. However, person-related complexity already exists whether we address it explicitly or leave patients to sort it out on their own. If we do not explicitly address the complexity of patients' lives, the result will likely be care plans that are not followed, behavior change efforts that fail, and the use of health care when social care might suffice.

Reimbursement mechanisms in the US, a second challenge to person-focused care, are still primarily based on fees for medically necessary services, making it harder to fund innovative efforts bridging health care and related services. Payment mechanisms in other systems provide more flexible alternatives. In the United Kingdom, for example, the National Health Service is experimenting with "integrated personal budgets" for health care and/or social care.⁵ Accountable care organizations in the US created under the Affordable Care Act⁶ may also have incentives and flexibility to provide person-focused care.

A third challenge lies in understanding how health care providers and systems can best add value for their patients. Some patients may prefer health care that is narrowly focused on health and medical issues, integrating health care with other services on their own. Others will prefer a more integrated solution, although their willingness to pay for integration is unknown. The needs and preferences of patients' caregivers—family, friends, and paid caregivers—will also influence integration of health and social services, especially for patients who are not capable of accessing and integrating services on their own.

Realizing the vision of person-focused care requires taking every opportunity—member by member and initiative by initiative—to broaden our understanding of how health and health care intersect with other aspects of people's lives, fully recognizing that each patient we serve is first and foremost a person. Tuso and his co-authors give us an example of how this can be done, and other examples are starting to bear fruit. These set a high new bar we can all aim to reach. ❖

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