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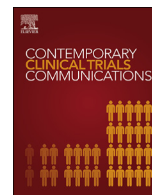

Customized Care: An intervention to Improve Communication and health outcomes in multimorbidity

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ABSTRACT

Introduction: Many primary care patients with multimorbidity (two or more chronic conditions) and depression or anxiety have day-to-day challenges that affect health outcomes, such as having financial or housing concerns, or dealing with social or emotional stressors. Yet, primary care providers (PCPs) are often unaware of patients' daily challenges coping with chronic disease. We developed Customized Care, an intervention, to address the barriers to effective communication about patient's day-to-day challenges.
Methods: In this report we describe the rationale and design of a randomized clinical pilot study to examine the effect of Customized Care on patient-PCP communication and patient health outcomes, including depression, anxiety and functional outcomes. Customized Care comprises two components: (1) a computer-based discussion prioritization tool (DPT) designed to empower patients to communicate their health related priorities; and (2) a customized question prompt list (QPL) tailored to these priorities. Primary care clinic patients and PCPs participated in the study, which consisted of in-person patient assessments, audio recording and transcription of the patient-PCP office visit, and follow-up patient assessments by phone.
Results: We describe study participant demographics and development of a coding manual to assess communication within the office visit. Participants were recruited from an urban primary care clinic. Sixty patients and 12 PCPs were enrolled over six months.
Conclusions: With better communication about everyday challenges, patients and PCPs can have more informed discussions about health care options that positively influence patient outcomes. We expect that Customized Care will improve patient-PCP communication about day-to-day challenges, which can lead to better health outcomes.
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1. Introduction

In the primary care setting, multimorbidity (2 or more chronic medical conditions) is increasingly common due to population aging and decreases in the age at which chronic diseases are diagnosed [1,2]. Multimorbidity is associated with worse health function and increased mental health needs and conditions [3–7]. Given that successful management of chronic disease hinges on patient-primary care provider (PCP) communication [8,9], prioritizing what to discuss in the medical encounter becomes increasingly important. When PCPs are unaware of the challenges patients face managing their health at home, they may offer treatment recommendations that make adherence difficult for the patient [10,11]. Moreover, if patients do not feel PCPs care about their day-to-day challenges, they may lose trust in the PCP, which can further affect patient outcomes [12,13]. Unfortunately, patients with multiple chronic diseases often report poor communications with PCPs [14,15], perhaps because PCPs rarely inquire about their day-to-day challenges (e.g., financial, housing, social or emotional concerns). In

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fact, the more medical and mental health conditions a patient has, the less likely the PCP is to recognize patients' health related priorities [16]. The brisk pace of the primary care visit leads many patients to experience time pressure. Patients often feel incompetent in the encounter, and fear being labeled "difficult." [17] These fears may be exacerbated in socioeconomically disadvantaged patients, such as those with low-income or lower educational attainment.

In order to help patients and primary care physicians discuss patient priorities, it is important to address three barriers patients face getting their needs met: 1. The arbitrary boundaries of medical care, which often marginalize if not ignore patient's life circumstances (e.g. emotional, financial and safety concerns) that affect their health; 2. The historical power asymmetry between PCPs and patients; and 3. The difficulty patients have of knowing what to prioritize for discussion with the PCP.

The tacit assumption that biomedical needs should be the primary focus of the patient visit can have profound effects on patient outcomes. For example, patients may assume that PCPs don't have time or interest to discuss patient's non-biomedical concerns [18] which could lead patients to avoid disclosing critical issues, such as family discord or financial strain; issues that can be barriers to treatment adherence and subsequent health outcomes [19]. PCPs for their part, do feel that day-to-day challenges, such as stress, housing and transportation are important to address, but they are uncertain about how and when to address these challenges in the encounter [20].

Communication around patient needs is further affected by power asymmetries between PCPs and patients because PCPs often drive the agenda [21]. Trained primarily to elicit patients' concerns in a manner that leads to diagnosis [22], PCPs frequently pay less attention to the patient's daily personal experiences and challenges, particularly when patients have multiple chronic diseases [11,23]. Over the last decade their has been a move to change the power dynamic in medicine, starting with the Institute of Medicine's call for more patient-centered care and the incorporation of patient preferences into treatment decisions [24]. However, empowering patients to discuss what is foremost on their minds requires the recognition that many patients worry about the consequences of being assertive and may need reassurance that PCPs will be able to respond to their concerns [17].

Finally, given the power asymmetries in the patient-physician relationship and the marginalization of patients' psychosocial concerns it is hardly surprising that their day-to-day challenges rarely rise to the fore. Even under the best of circumstances, patients with multimorbidity would have a hard time knowing how and when to discuss their day-to-day challenges in the primary care encounter. Moreover, many patients have multiple challenges. Knowing which particular challenge to discuss is a cognitively complex task [25]. It is difficult for patients to recognize or consider trade-offs between multiple competing challenges intuitively or quickly [26]. Methods are needed to help patients carefully consider their priorities and communicate them in a way that is supported by their PCPs.

In this report, we describe an intervention called Customized Care and the design of a pilot study to examine the effect of Customized Care on patient-PCP communication and patient health outcomes. We describe the rationale and design of our intervention and our proposed analytic plan, including developing a coding manual to assess communication about patients' day-to-day challenges.

As shown in Fig. 1, the primary goal of the Customized Care intervention is to help reduce the common barriers patients face in getting their needs met. Customized Care does so, first by prompting patients to consider health related concerns that are typically marginalized helping patients prioritize their day-to-day challenges secondly by helping to overcome power asymmetries with specific language for communicating about day-to-day challenges. We anticipate that Customized Care can lead to improvements in patient- PCP communication, specifically with regard to patients' day-to-day challenges. When communication about challenges improves, patients may subsequently also be more likely to utilize community resources, leading to improved health outcomes [27].

1.1. Development of the Customized Care intervention

Customized Care was developed to address key barriers to effective patient-PCP communication. The intervention builds on previous work assessing patient preferences for depression care

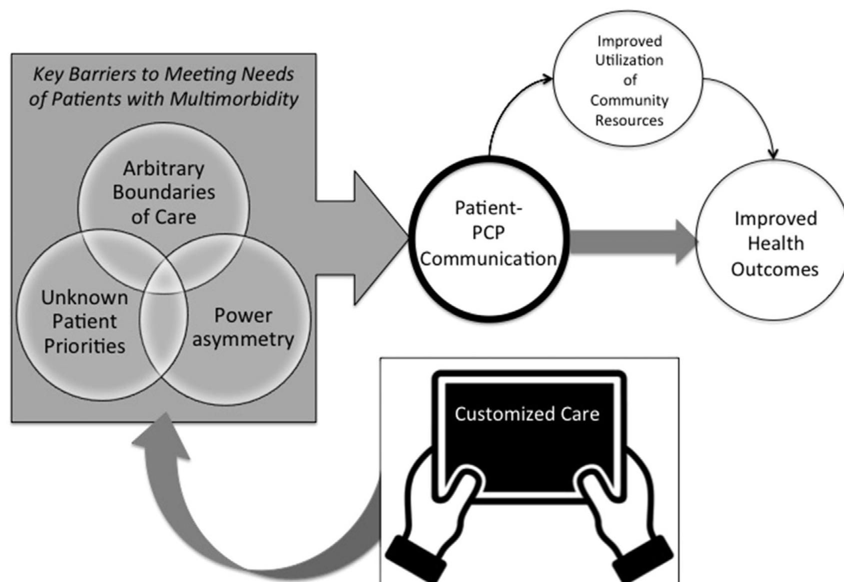

Fig. 1. Conceptual model, pathways to improved communications and health outcomes.

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