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The Leading Edge

Relationship-centered care: A new paradigm for population health management

Shantanu Nundy, John Oswald *

Evolent Health, United States

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ABSTRACT

At the center of population health management services are the relationships between the patient and their care providers. The spread of relationship-centered care has resulted from the need to develop and nurture these relationships. As a model of coordinated and team-based care, relationship-based care is able to strengthen population health management. This paper explores why relationship-centered care is fundamental to population health management, describes compatibilities with patient-centered care and discusses examples of early applications of this paradigm. Using our experience in a population health management organization, we describe applications and lessons learned using this paradigm.

1. Overview of the paradigms of population health management and relationship-centered care

The overall concept of population health and the specific strategies of population health management have come into vogue for health care delivery systems and ACOs. As part of the Triple Aim developed by the Institute for Health Improvement, the aim for "improving the health of populations" has been embraced by ACOs and health systems in their health care services for their patient and enrollee populations.[1]

Population health management is focused on health care delivery, utilization and outcomes, taking into account the roles of primary care providers and engaged patients. In addition, population health management activities need to be implemented as a part an overall framework of population health in its use of analytics, stratification and care management activities in a defined group of individual patients. These activities result in the highest risk patients receiving targeted services from a comprehensive care team, while lower risk patients receive physician services augmented by self-management support.

We posit at the center of these population health management services are a comprehensive set of relationships that care providers need to develop and maintain. Relationship-centered care is defined as health care that focuses on four types of relationships that the provider needs to address in the health care services that they provide: the relationship with the patient, relationships with other providers, relationships with the community and the provider's relationship to him- or herself.[2]

This paradigm of relationship-centered care is focused on all the actors in the delivery of health care services and population health management services. The relationship with the patient is the most important role in a way that is fully consistent with the theory and application of patient-centered care. It also includes the whole care team – not only the physician, but also the nurse, care coordinator, health coach, and other individual providers, as well as the clinic and the entire health care delivery system. Similarly, it extends beyond the patient to the community including family and peer patient support as well as community health resources. Finally, it includes the relationship of the provider with himself or herself in terms of professional and personal development along with his or her overall self-awareness as a medical professional.

In this paper, we make the normative argument for the need for all four components of relationship-centered care as a comprehensive paradigm to support population health management. Then, we explore relationship-centered care being entirely compatible with patient-centered care and other paradigms for practice transformation and population health. Although we acknowledge that patient-centered care and other conceptual frameworks stand on their own merits and do not require the rubric of relationship-centered care, the inclusion of all four types of relationships will complement other frameworks and strengthen the overall development of population health management.

* Corresponding author. Tel.: +1 763 438 4711.
E-mail address: joswald@evolenthealth.com (J. Oswald).

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2. Why relationship-centered care is central to population health management

As we move from individuals to populations, we need to strengthen provider relationships not only with patients, but also with other doctors and the extended care team, including those who sit outside of their clinic walls including doctors, specialists, clinics and hospitals. In terms of working with patients, there will be much greater emphasis on the medical home and the broader paradigm of patient-centered care. Patient-centered medical homes build upon the idea that the patient's relationship to his or her providers in the medical home is critical to high quality care.[3] As a result, the component of relationship-based care dealing with the physician's relationship to the patient is a perfect fit with the paradigm of patient-centered care.[4]

For the doctor's relationship with the care team, there is a major emphasis on coordination of care.[5] Coordination of care can be considered as the integration of patient care activities between two or more providers involved in a patient's care to facilitate the appropriate delivery of health care services.[6] Traditionally, coordination of care has focused on physicians, including primary care physicians, clinic-based staff, hospitalists, and specialists as well the crucial role of family members. For population health management, coordination must include members of the extended care team including nurse care managers, pharmacists, nutritionists, social workers, health coaches, and lay health workers. Moreover, care coordination involving health professionals is required for patients and their families with peer support networks including potentially virtual and online ones. Finally, the role of health information systems including electronic health records is becoming an essential component of continuity of care.

The relationship of the physician with the community is a broad yet vital component to supporting population health. The family members, caregivers and the full array of community resources all can offer various types of support to the patient and are key factors for the provider to consider in care planning. A major concern about population health management is that it has focused too much on the medical care delivery for a given subpopulation and not had a broader scope of addressing the social determinants of health in the communities where their population resides.[7] By promoting this relationship with the community, providers can support community health improvement initiatives and traditional public health responsibilities of disease control and prevention.

The relationship to self is the least understood component of relationship-based care. The Pew-Fetzer Task Force report which was the genesis of relationship-based care articulated the importance of the relationship to one's self as follows: “The biggest ‘psychosocial’ problem facing us may be the need for our own personal transformation – to understand and promote change within ourselves.”[8] From this perspective, the emphasis on self-awareness, leadership, and continuous learning stands out as one of the keys for supporting population health, as well as preventing stress, burn-out and turnover.[4] This culture of individual learning and change as a part of the health care team is one major aspect of the learning health system.[9] A more comprehensive agenda of continuing education of health professionals including self-awareness and leadership is a crucial tool in pursuing population health strategies.

3. Compatibility with other models

It should be emphasized that several other leading models of health care transformation are completely valid on their own terms and are not dependent on the paradigm of relationship-centered care. Nevertheless, relationship-based care is compatible with these other models and adds additional support for population health management.

Patient-Centered Care. As has been emphasized, the most important component of practice transformation is the patient-provider relationship and all of the aspects of patient-centered care. Therefore, the priority of developing a comprehensive relationship-based care approach must be to start with implementing patient-centered care.

Wagner Chronic Care Model. The Chronic Care Model emphasizes a comprehensive team-centered approach to addressing the needs of complex patients with prepared, productive interactions between the patient and health care team at the center.[5] By focusing on these interactions, rather than solely on the condition of the patient, the care goals are more likely to be achieved and maintained over time. For example, patients are more likely to take their medication if they have trust in their doctor.[10]

Shared decision making. Shared decision making is an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported in considering options based on informed preferences.[12] The decision making involves, at minimum a clinical provider and the patient, along with other health care providers, family members and peers possibly participating as well.[13]

4. Applications of relationship-centered principles

Relationship-centered care is not just a theoretical concept, but it is a salient framework for several key components of successful population health management strategies and a broader transformation of primary care practice. Two example applications, the Nuka System of Care in Alaska and the Stanford Coordinated Care Program are widely acknowledged as successful innovations in practice transformation. A third example is Indiana University Health, which is supported by Evolent Health, a technology-enabled operating partner that provides the clinical, analytical and financial capabilities required for care transformation. Evolent incorporates the approach of relationship-centered care into its work with healthcare delivery systems.

These innovative health systems are described in terms of the four components of relationship-based care for the purpose of providing specifics about their current applications.

4.1. Nuka System of Care Southcentral Foundation of Alaska

As the model for the patient-centered medical home of the Southcentral Foundation primarily serving the Alaska Native population, the Nuka System of Care has incorporated several key components which represent relationship-based care. [14,15]

Patient/provider relationships: the structure of patients as “customer owners” places a much greater priority on patient experience and the responsiveness of providers. In addition, the physical design of the clinic facility has been carefully constructed to allow for important considerations for the patient such as comfort, privacy and cultural sensitivity.

Other providers’ relationships: the workforce development and recruitment has been a major focus to assure that there is multidisciplinary team based care and supportive leadership decision making.

Community relationships: the close collaboration with the Alaskan Native community has been an essential success factor including close consultation with tribal leaders and care planning that involved culturally appropriate resources to support social determinants of health