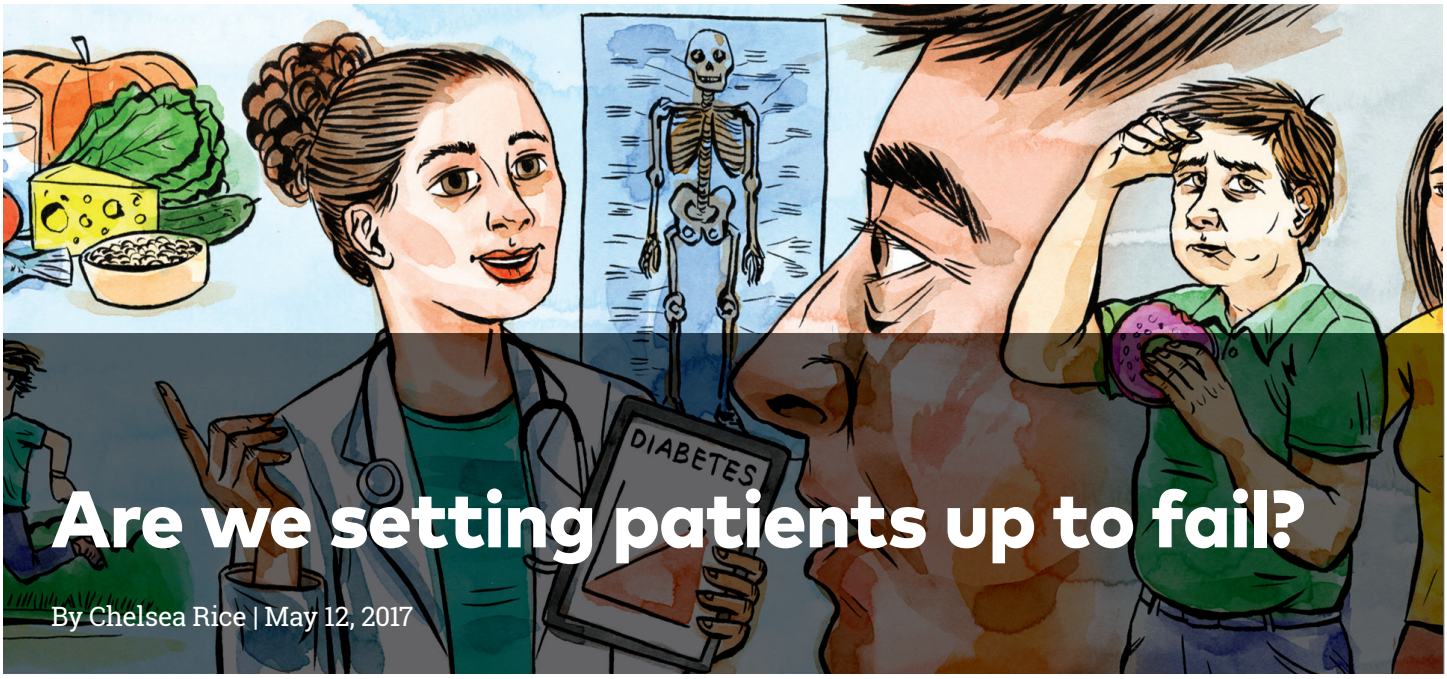

Are we setting patients up to fail?

By Chelsea Rice | May 12, 2017

Victor Montori, M.D., an endocrinologist and researcher at the Mayo Clinic, likes to tell the story of an obese patient with diabetes and high blood pressure — one of the 25 percent of Americans who suffer from multiple chronic conditions.

He has trouble managing his diabetes. His back pain limits his ability to sleep and work. But that's not the most stressful part of his life. His daughter has moved in after leaving an abusive relationship. His situation feels hopeless. Depression has set in.

Doctors often approach a situation like this with more treatment, Montori says — and with frustration when a patient fails to comply.

"The system doesn't respect the fact that patients have limited resources, including their attention, time, and energy," Montori says. "But we just ask them to keep doing all this work. And then, when they don't do it well, we get upset, and we sometimes fire them."

So, Montori offers a counterintuitive solution: What if, instead of intensifying treatment, a provider offers a simple task that addresses the patient's priorities? Instead of more medication to control high blood pressure and diabetes, consider nutritional counseling — with an initial goal of reducing soda intake — or occupational therapy to discuss sleep positions for back pain.

The approach is called "minimally disruptive medicine," and it is spreading to healthcare organizations across the country. And Montori believes it has significant potential to reshape care delivery for challenging patient populations. athenahealth's research into high-performing provider organizations finds that practices that excel in key financial and quality measures often acknowledge and intentionally design the work patients take on as they carry out treatment regimens — thus enabling patients to take better care of themselves.

Tailor care to individual patients

Montori's research began in 2009 at the Mayo Clinic's Knowledge and Evaluation Research Unit in Rochester, Minnesota. According to his team's findings, a patient's hard work, especially in the case of chronic conditions, is often under-appreciated — and under-estimated, demanding two hours or more of time and attention daily.

That obese diabetic patient, Montori notes, tests his blood sugar three to four times daily. He must adjust the level of insulin he injects, depending on the results of each test. And he must factor in the level of carbohydrates in his diet that day, along with his current or anticipated level of exercise.

When patients face other mental, social, financial, or environmental demands, Montori's research found, they quickly reach their capacity. Then they are likely to take the road of passive resistance: Stop taking their pills and checking their blood sugar, exacerbating conditions and wasting additional resources.

When these patients become non-compliant with clinical recommendations or payer-mandated quality metrics, healthcare organizations sometimes discontinue their care.

In these cases, Montori said in a TEDx Talk, the system "has stopped caring.... Money has displaced the patient as what matters most."

Instead, Montori urges doctors to tailor care to individual patients. Rather than asking patients to comply with complicated, standardized treatment regimens, he says, they should align treatment plans with patients' emotional, physical, and financial capacity to follow them.

He counsels physicians to ask patients, "What's most important to you right now?" to see what the clinical conversation can uncover beyond tests and quality metrics. Patients, he says, will prioritize the parts of their lives that are most meaningful to them.

Ideas in practice

Healthcare organizations have begun incorporating Montori's ideas into their care solutions. At Valley Medical Group, a top performer in key quality metrics on the athenahealth network, leaders say the principles of minimally disruptive medicine have informed the way they integrate behavioral health and nutritional counseling into patient encounters.

"The things we as clinicians used to think of as noncompliance have more to do with overwhelming people with trying to take care of themselves, and they can't do it," says Joel Feinman, Ph.D., president of the Valley Medical Group. "What we need is to focus the patient around what's reasonable for us to take on right now that will make a difference."

Valley, a multi-specialty network in western Massachusetts, embeds behavioral health providers into every primary care practice to allow on-the-spot consulting, helping patients identify what they want to change and what they are capable of taking on before the next visit.

Those simple, achievable directives build patients' confidence in their ability to manage complex conditions, Valley clinicians say.

"It's about making it easier for patients to get the right care, no more, no less, and in a way that addresses their particular needs while minimally disrupting their lives," says John Novo, the team leader for Valley's integrated behavioral health program.

Who determines value?

Widespread adoption of his approach has been stymied, Montori says, by a key structural challenge: In healthcare, value is often defined around reimbursable quality metrics. That means a single approach to a health condition tends to be universally applied to all patients.

Minimally disruptive medicine, by contrast, defines the value of a treatment based on improving quality, safety, health, and experience of the patient.

Montori hopes his ideas will gain traction as word of mouth spreads among clinicians. His team at the Mayo Clinic has put together tools and resources to facilitate physician-patient conversations, along with information on patient-reported outcome measures, community navigators, Lean healthcare delivery, and community resource registries.

All of these tools address the social determinants of health, Montori says, though he hesitates to use that term.

"When people refer to [social determinants], they unfortunately convey a sense to the clinician that, 'This is not my problem; these are social determinants, so let's get a social worker to work on this," he says. "It is not someone else's problem. And we can no longer think of ourselves as responsible for just what happens in the consultation or inside the hospital walls."

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