



# Inspire



## The Critical Role of the Patient-Physician Relationship

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*“The importance of an intimate relationship between patient and physician can never be overstated, because in most cases an accurate diagnosis, as well as an effective treatment, relies directly on the quality of this relationship”.<sup>1</sup>*

### Introduction

Over the years, payers and regulators have tried any number of provider reimbursement arrangements, incentive programs, quality bonuses, etc. with the goal of steering physicians to make the most cost-effective healthcare decisions for their patients.

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<sup>1</sup>Hellín, T. (2002). *The physician–patient relationship: recent developments and changes*. Haemophilia.

Yet most of the systems and strategies put into place with the intent of managing or manipulating the healthcare decision-making process have not succeeded – why not?

Healthcare decision making is complex – there are rarely black and white / right and wrong answers. Fostering a quality relationship between a patient and a physician is fundamental to a successful healthcare system because that's where the decisions are made. In discussions between a patient and his physician, data is gathered (medical history, symptoms, concerns), diagnoses are made, treatment plans are developed, support and information is provided, personal situations and values are considered, etc.<sup>2</sup>

This article looks more deeply at the components of a successful patient/physician relationship (PPR) and how to address some of the challenges that exist in fostering those components.

## Components of a Successful PPR

A number of forces, both technological and social, have evolved the PPR in recent years, presenting both challenges and opportunities. Up until the last 20-30 years, a paternalistic PPR was fairly typical, where the physician's role was seen as “doing to” or “telling” and the patient's role was that of “following”. However, in more recent years, with the introduction of the internet the widespread availability of clinical articles and other on-line advice, a more informed and autonomous patient has emerged, seeking, desiring and often demanding a more collaborative PPR.

Within this new collaborative culture, the key elements of a successful PPR are:

1. A payment structure with limited impact on provider decision making
2. Access to comprehensive information on the patient
3. Physician knowledge/expertise to diagnose and treat/refer
4. Trust and open communication
5. Focused time

While advancing technology, access to information, and patient engagement has created a number of opportunities for improved care, a number of challenges have also arisen.

## Physician-side Challenges

With rising healthcare costs, multiple players trying to get providers to manage care at lower cost, and “enlightened” patients among other things, physicians are facing increasingly complex challenges as they try to treat their patients. While a doctor may know what an ideal PPR looks like, any number of issues can make that difficult to foster.

- Lack of patient face-time due to other responsibilities
- Lack of actionable information on their patients
- Mixed and/or misaligned financial incentives
- Informed, empowered, and demanding patients

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<sup>2</sup>Lipkin M Jr, Putnam SM, Lazare A, editors. *The Medical Interview: Clinical Care, Education, and Research*. New York, NY: Springer-Verlag; 1995.

## Allocation of Physician Time

AIM study published in 2016 reports Ambulatory Physicians spend only 27.0% of time in direct clinical face time with patients compared to 49.2% spent on EMR and desk work.<sup>3</sup> A few drivers include:

- **Onerous record keeping for doctors** – resulting from various insurer pre-approval and review requirements. In the current free market system, every insurer has approached their pre-approval process (i.e., the information required from a provider office) and their copay/deductibles for the patient in a different way. They may also use different criteria or guidelines for their decision making as well as different formularies. Their forms, requirements, methods for records from the provider office vary greatly so on the provider's office is forced to work with a myriad of systems.
- **Electronic Medical Records (EMR)** – While EMR are a tool of great potential, they are still an evolving technology and can require a great deal of time getting used to as practices transition from paper record-keeping to entirely electronic.
- **Secondary responsibilities during a patient visit** – Including secondary conversations with family members, waiting for phone calls regarding the patient, management of office staff.

## Actionable Information

Physicians receive a lot of information from insurers, pharmaceutical companies, patients, etc. And, as more payers are partnering with providers in managing their patients' care, physicians are faced with myriad different definitions of quality, measurements of success, and structures of reports that are intended to help them improve their results. By necessity, most have learned to filter out reports with data that cannot be acted upon to provide higher quality or more cost-effective care. Sorting through pages and pages of reporting to find useful results is a time waste for physicians, and so oftentimes even helpful reports are simply ignored.

Some insurers are working towards providing truly actionable information to physicians by concisely relating their report findings to a clinical action that will help the doctor in making care decisions. For example, letting a physician know that one of his patients recently had an ER visit and should be followed-up with. This data can be challenging to provide, however, largely because much of the information needs to be real-time. By the time insurance companies receive the information that a patient has had an ER visit, the reasonable follow-up period has passed.

## Mixed Financial Incentives

How physicians are reimbursed can impact the treatment decisions a physician is incented to make, which affects the value of the care that is provided and the trust relationship between patient and physician. For example, historically, most physicians were paid on what is known as a Fee-for-Service (FFS) basis. That is, each time any service was performed, the physician was paid – more services, more pay. The patient needs to be able to trust the physician to do what is best for them (more is not necessarily better), not what will result in the most revenue.

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<sup>3</sup>Christine Sinsky, M., Lacey Colligan, M., Ling Li, P., Mirela Prgomet, P., Sam Reynolds, M., Lindsey Goeders, M., . . . George Blike, M. (2016). Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Annals of Internal Medicine*. Retrieved from [annals.org](https://annals.org)

With rising healthcare costs, other reimbursement methods have been tried in an attempt to manage overall population costs and improve quality. These methods often include incentive payments to the physician for achieving cost and quality targets for a member population. These mixed financial incentives may call into question the physician's priority to their patient versus the member population or their overall revenue.

The result may be an erosion of trust in the PPR. One way this trust can be improved is simply by disclosing to the patient any incentive arrangements that might be perceived as interfering with treatment decisions.<sup>4</sup> Another is for payers and regulators to work to develop reimbursement approaches that are largely neutral to physician decision-making.

### **The Informed, Empowered Patient**

The internet has proved valuable in making high quality health information available to nearly everyone. Additionally, we are an increasingly drug-fixated society where we want to take a pill to fix our problems, and we are constantly being inundated with information on available drugs or other treatment options. Patients increasingly trust what they see on TV/online or hear about through friends more than they trust their doctor.

One resulting challenge, however, is that much available information is unfiltered and may be intended for audiences with the medical and/or analytic skillset to understand it in its intended context. As a result, physicians may spend significant patient time clarifying or otherwise putting into perspective a patient's latest self-diagnosis relative to their individual circumstances. Informed with an open mind can be a good starting point for any PPR discussion, but unbending self-diagnosis or desire for a specific treatment creates a unique challenge for physicians.

## **Patient-side Challenges**

Looking at the other side of the PPR, there are many dynamics of the current healthcare environment that create challenges for patients as well.

- Complex benefit design
- Narrow network limiting provider choice
- Unrealistic expectations
- Lack of motivation to make lifestyle changes

### **Complex benefit design**

The insurer-insured relationship is typically based on a complex legal contract between the parties. Even well-written documents can be intimidating to the insured hoping to understand the ins and outs of their coverage. This complexity can lead to confusion regarding what is covered, what approval if any is required, and what the resulting cost will be. The physician is often caught in the middle of any misunderstanding, impacting the quality of the PPR. Additionally, recommended treatments may not align with what is affordable for the patient, which can be difficult to assess prior to receiving the bill.

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<sup>4</sup>Mark A. Hall, E. D. (2002). *How Disclosing HMO Physician Incentives Affects Trust*. *HealthAffairs*

More progressive insurers and health plans have created tools for members to use in projecting out of pocket costs for defined episodes of care. As these tools mature, patients will be able to better understand their options for treatment relative to the benefits they have.

### **Narrow Network Limiting Provider Choice**

In an effort to keep healthcare costs affordable, insurers may create limited access networks based on cost and quality characteristics of the included providers. The resulting challenge to insureds is that their long-term primary or specialty care provider is not part of the network and hence no longer a financially viable choice. As a result, long standing patient/physician relationships may be severed as the patient is required to establish a new set of physician relationships.

### **Unrealistic Expectations**

Physicians have long been held by society in high esteem. Unfortunately, this can result in unrealistic expectations regarding what can be delivered in every case.

### **Lack of Motivation**

Many treatment plans doctors provide are comprised at least partially of patient lifestyle changes. While few would argue the value of making healthier nutritional choices, quitting smoking, or increasing physical activity, these types of changes are difficult to make. Change requires motivation, support, accountability, knowledge, and time. While doctors can provide some support, accountability, and knowledge, only the patient herself can commit to making the necessary changes.

## **Best Practice PPR Case Study**

Despite numerous challenges in building strong PPRs in today's healthcare environment, a number of health plan systems have managed to excel in adapting new technology and other creative solutions to improve the relationship between their physicians and patients. We have selected Kaiser Permanente (Kaiser) to illustrate as what we believe is an example of best practice in the industry today. In California alone, Kaiser has over 8 million members, meaning their PPR success has been on a large-scale basis.

Kaiser has demonstrated the ability to effectively manage its members' costs, deliver high quality care, and keep its premiums below other commercial carriers in CA. A published comparative study<sup>5</sup> of Kaiser's California member population to that of the British National Health Plan (NHP), found that:

- Kaiser was able to provide care to its members at a monthly cost per member similar to that of the NHP.
- Kaiser members experience more comprehensive and convenient primary care services and much more rapid access to specialist services and hospital admissions than NHP members.
- Age-adjusted rates of use of acute hospital services in Kaiser were one-third of those in the NHS.

The Kaiser system equips the patient and physician in a way that leads to more informed decision-making from both sides. Providers have access to an EMR within each exam room, allowing them instant access to the patient's complete clinical record and current preventive care needs. They also have the ability to

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<sup>5</sup>Feachem, R. G., Sekhri, N. K., & White, K. L. (2002). *Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente*. The BMJ.



order necessary tests during the visit and review any pertinent care guidelines to support making optimal treatment decisions. The Kaiser system also allows communication to continue outside the exam room because of the email access the patient has to the physician. Additionally, from a patient's perspective, the Kaiser patient portal allows them to do things like review pre-op directions online, review their personal preventive care needs, access their physician as needed, review their own EMR, etc.

Here is an example of how an appointment under this kind of a system might go:

*A 65-year-old male with neck pain makes an appointment with his physician by telephone. Before the appointment, he receives an email reminding him to bring his old records and that he needs a flu shot. The man keeps his appointment and during the office visit has an x-ray done, which is discussed with the physician who reviews his films online digitally. During the visit, he also discusses his cholesterol and asks his physician about taking about statins. The physician retrieves the Kaiser guideline for using statins and tells the patient it is not indicated. The office sets up a physical therapy appointment for the patient for his neck pain and reminds him that he did not keep his DEXA scan appointment. He also gets a flu shot before he leaves the office. At the end of the visit all this information is completed in the EMR and available online.*

This system is not perfect but has gone a long way to improving the relationship between the provider and patient and relationship between the two. The improved, informed relationship results in decreased costs and value to the patient.

## Conclusion

The patient/physician relationship is a critical factor in the delivery of high quality, cost-effective healthcare. The PPR can be improved with the mutual effort of not only patients and providers, but also payers and regulators.

To-date, most efforts by payers and regulators have focused solely on the provider reimbursement component of the PPR. However, there are improvements to be made on the other aspects as well – information, expertise, communication, trust, and time. Investments in technology, sharing of best practices and care management guidelines, minimizing administrative burdens on physicians, supporting a culture of wellness, among many other things can help support the entirety of the PPR.

### 5 Key Components of an Effective PPR

1. Invisible payment structure
2. Access to patient information
3. Knowledge to diagnose and treat
4. Trust and open communication
5. Focused time

As we move forward seeking solutions to America's healthcare system challenges, addressing all five of these elements to create an effective patient/physician relationship is a core component of any solution.

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