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## In This Issue:

In My Opinion, Lee Leer, MD .....	4
"Patent Engagement \$399"	
Welcome New Physicians.....	5
2017 Proposed Slate Officers, Directors, Committees.....	6
HDN Tattler .....	7
Coming, Going & Moving Around.....	7
Social Calendar / Friday PM Rounds .....	7
"Prescription Drug Misuse", Lee Snook, Jr. M.D.....	8
No-Cost Online Buprenorphine Waiver Courses.....	9
Trends in Late Stage Dx of Screenable Cancers.....	10
"Female Breast Cancer"	
CMA Practice Management "Tip of the Month".....	11
Public Health News, Donald Baird, M.D.....	12
"TB in CA and WNV Surveillance Updates"	
Member Physician Profiles: #CMAdocs.....	19
Continuing Medical Education/Grand Rounds Calendar	21
Classified Ads .....	22

### Cover Photo

**"AFTERNOON CLAMMERS"**  
**"STEPHEN KAMELGARN, M.D."**

*The Editorial and Publications Committee encourages our member's comments for publication.*

*Please submit electronically prior to the 15th of the month preceding publication.*  
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# Patient Engagement \$399

Lee Leer, M.D.



“Patient Engagement \$399/mo.” The is the sort of heading I immediately saw when doing a Google search for one of healthcare’s latest buzz phrases: “patient engagement.” Indeed, the top four lines of my search were paid ads, and of the top 20 hits, nearly half were paid ads. This has clearly become big business for healthcare consultants. This is so because of the guiding hand of the Affordable Care Act (ACA), which created the Center for Medicare and Medicaid Innovation, which is tasked with examining how support tools can be used to improve patients’ understanding of their treatment options. In addition, the ACA created the Patient-Centered Outcomes Research Institute, which is charged with funding research that will be useful in assisting stakeholders in making informed health decisions.

For those, like me, who don’t think about this stuff – at least not in a structured way – on a daily basis, let’s review some terminology. “Patient Activation” is defined as providing patients with the knowledge, skills, ability, and willingness to manage their own health problems. “Patient Engagement” adds to “Activation” by providing interventions that are intended to increase activation and promote positive behavior.

This helps to get us, presumably, closer to the “Triple Aim,” which is (1) improving patient satisfaction, (2) improving population health, and (3) lowering costs.

I don’t know about you, but a big part of the problem with all of this from my perspective is the jargon. In addition

to the above, let’s not forget the “Patient Centered Medical Home,” as well as “The Conversation Ready Project,” (intended to make practices and providers ready to engage patients in end of life conversations); “minimally disruptive medicine,” (doing what’s medically beneficial with the least disruption to the patient’s non-medical life as possible); and then there’s the Center for Clinical and Translational Science at the Mayo clinic, within which is housed the Late-Stage Translational Research team, sometimes called “T2” or “T3” research. The goal of which is to research ways to translate “proven interventions into practice and policy.” When I’ve followed this stuff at all, I’ve tended to wade into its jargon-filled minefield and drift off to sleep long before I could get to anything that might actually be useful in my practice.

Which is too bad, because patient engagement, shared decision-making, and the like, are where we should be going in patient care. Oddly, I had thought that I was always there, in that I had been trained back in the 1980’s that my goal was to help educate patients so they could make the best decision possible for themselves. So, some of my reluctance to delve further into this initially senseless jargon probably had to do with taking offense at the notion that I’d not always been doing what policy experts are saying I should now start doing. Plus, some of the advice and recommendations are frankly banal, and not the least bit new.

For example, the great take home message from the Conversation Ready Project is the following catchy phrase: “The 4R’s.”

Isn’t that great? The 4R’s are (1) Reach out, (2) Record, (3) Retrieve, and (4) Respect.

So, in the setting of end of life discussions, we clinicians are to (1) reach out and initiate a discussion with our patients and help them define their wishes, (2) record their wishes in the ubiquitous electronic medical record, (3) be able to retrieve said recording whenever necessary, and (4) to demonstrate respect for the patient and their decision. I’m missing the innovation behind this concept, which, with the exception of the electronic record part, is what anyone my age learned 30 years ago in medical school. But still, I guess it’s good to reinforce such basic concepts, although to behave as if this is something new under the sun does grate on me.

Moving beyond my petty peeves (to be clear, not my pet peeves, which I’ll reserve for another article), however, there really are great things that can come from thinking about better ways to get patients to participate in their care. There is convincing evidence that “engaged” patients have better outcomes at lower cost to the system. So how do we do it? Locally, we have a shining little example of our very own: the IPA’s Health Decisions Center, where patients can be referred to receive in depth information and coaching about a host of conditions with varied treatment options. To be clear, we’re not talking about engaging patients in an evidence based medicine discussion during their treatment for acute, life-threatening trauma, but rather prior to the patient deciding on their best option to treat a chronic condition with varied treatment options (e.g., knee osteoarthritis, low back

***“PATIENT”, Continued on Pg. 20***

***SOMETHING ON YOUR MIND? WANT TO SHARE YOUR THOUGHTS WITH YOUR COLLEAGUES?  
PLEASE SEND THOSE THOUGHTS FOR PUBLICATION IN THE NORTH COAST PHYSICIAN OR  
IF YOU’RE INSECURE ABOUT YOUR ABILITY TO WRITE - LET US HELP YOU.***

**“PATIENT”, Continued From Pg. 4**

pain, carotid artery stenosis). What never existed 30 years ago was (1) the spectrum of educational material now available, (2) coaches to help patients work through their decisions, and (3) adequate evidence-based outcomes data.

What still doesn't exist, sadly, is a clear understanding from the powers that be as to how such admirable goals as true patient activation are best accomplished... though, as I've pointed out, there are plenty of consultants ready to take our money to tell us what they think is best. Speaking of money, thus far many of these ideas being encouraged by the ACA are not just half-baked (albeit well intended), but unfunded half-baked ideas.

Back to our corner of the world, it really is nice that we have the Health Decisions Center to refer patients to. But I'd estimate that far fewer than 25% of the patients I refer there actually make contact... even though it's a free and excellent service. Lack of integration is the problem. Logically, we'd have a large integrated medical community, where all of us providers (inpatient and outpatient physicians, nurses, PCP's, non-primary care specialists, PT/OT, pharmacists) are all using the same electronic record; where we can immediately refer patients – right down the hall – to health decision coaches; where information is plentiful, accurate, and available in multiple formats appropriate to a given patient's needs and wishes (e.g., in the appropriate language, at the appropriate educational level, at the appropriate time, and in the format best suited to that patient's learning style: written/digital information to take home, vetted Web links, one on one or group educational sessions... whatever it takes). The Humboldt Diabetes Project is another case in point. Again, a great service, one that I am thrilled we have. But the patient needs to make contact, schedule an appointment, go to another facility separate

from my office, and meet a whole set of people they don't already know.

Until we accomplish true integration, I don't think any of these other really good ideas, like patient engagement, will ever really take off, even if we can move past the social scientist wonky jargon. So, maybe what we ought to first focus our time and energy and resources on – both locally and as a society – is integration across the spectrum of care. First and foremost, we providers ALL need to be using the same electronic record. Sure, it's obvious how we got to this fragmented situation in which we find ourselves. And I really don't want to give up the only EMR I'm vaguely comfortable with, but if when I retire the entire county isn't on the same system – or at least systems that can and do “talk” seamlessly with one another, then we'll have failed one of our biggest and most important challenges. Second, we need to have a community-wide (and society-wide) discussion about care integration. To accomplish this, all the stakeholders – large and small – will need to make sacrifices that they cannot now imagine making. Again: if this hasn't happened by the time I retire, then we'll have failed in yet another major challenge. And we'll have failed citizens of Humboldt County, the people whom we claim to be caring and working for.

Only after we've figured out the finer points of informational and structural integration will we be able to do a good job of activating, and using the “4R's.” Only then will we really be ready for all sorts of exciting, new, productive conversations with our patients. §

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442-2353  
ttaylor\_hdnems@sbcglobal.net

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