How to best help those with chronic illness remains a pressing concern as we live longer and “acquire” more medical diseases. For many, separate specialists individually treat “their” problem, and there is no one figure to make decisions when one treatment may interfere with another. For example, a diuretic, a medication that increases the amount of urine you produce, is helpful in treating a failing heart but places stress on the kidneys. When you have both heart and kidney disease who decides on the diuretic? To combat this problem and increase patient engagement with their health, a new model with the patient at its center, has been offered. Here, the primary care physician in consultation with the specialists, and more importantly, with the patient, make the decision – it is designed to improve health by reducing confusing, contradictory treatments, give the patient’s a stronger voice and physician’s a patient-focus. It is another technique offered to personalize health care a model being studied as an alternative to less collaborative fee-for-service.

A study in Lancet sheds some light on how these programs are faring in the UK. Roughly 1500 patients, with three or more chronic conditions, in 33 primary care practices, were randomly assigned to receive their usual care or more intensive personalized care. The intensive care included six-month reviews of a patient’s health and treatments by a nurse, pharmacist, and physician. Among the goals, identifying patient concerns, screening for depression and dementia, a social service evaluation, simplification of medications and their schedules and the development of shared priorities and goals for the next six month period.

The study looked at about 15% of the eligible patients in these practices. They reflected a more substantially sicker population with 90% having cardiovascular or kidney disease, 50% having diabetes, 50% with asthma or chronic obstructive pulmonary disease and about a third having
some degree of depression. At the beginning of the study period, there was no difference between the groups concerning their self-reported quality of life. [1] As you would expect from the study’s design, the patients receiving more intensive care saw nurses and physicians more often. But more intensive care did not decrease deaths, hospital admissions or outpatient care; there was no better quality of care measures in the intensive care group compared to regular care. The same held true for the patient’s perception of their burden of diseases or its treatment. There was no change in their perceived quality of life. So what if anything did improve?

**Patient satisfaction**

An improvement was seen in measures of patient-centered care [2] as would be expected in a study requiring patient-centered care, and patients felt increased empathy from their physicians and nurses. Patients felt their treatments were more aligned with their needs and were 50% more likely to be “very satisfied” with their care. A closer look at the study itself showed only 75% of the intense care patients had their initial six-month review and only 50% had two reviews during the 16 month study period raising concern about whether the two groups really had different care; and the 16 month time frame, might be too short to see significant changes in healthcare outcomes.

One of the strengths of the study was that it was grounded in day-to-day care, not care from a unique and often academic site – this was from the real world. The 3-month delay in starting the study because of the additional training required, the 50% of patients who never got their required second six-month review and the 75% who did not receive the required written care plan all speak to the difficulties in changing our practice styles. It takes a great deal of effort to improve patient satisfaction in this way, especially if we are not improving their quality of life. And while the study is too short and underpowered to be definitive, it suggests we look to see the real-world improvements, not the theoretical ones before we commit to changing how we practice. We may get similar improvement in patient satisfaction by other less disruptive means.

[1] The measurement of quality of life in this manner is well established and correlates well with outside observation.


Source: Management of multimorbidity using a patient-centered care model: a pragmatic cluster-randomized trial of the 3D approach Lancet DOI: 10.1016/S0140-6736(18)31308-4

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