

A Clinical Pathway to Well-Being: Putting Patient Priorities at the Center of Care

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ABSTRACT

Patient Priorities Care is a clinical framework designed to align primary and specialty care around each individual patient's goals. Using a patient's self-defined goals can be a powerful motivator for improving health outcomes. Our experience with this approach on a population of nearly 124,000 Medicare Advantage patients after 1 year indicates that this model of care is generating substantial improvements in clinical outcomes for patients with type 2 diabetes, congestive heart failure, and hypertension.

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The goal of primary care is to help patients live longer, healthier, and higher-quality lives. This leads primary care clinicians to often focus on objective disease outcomes and biomarkers such as hemoglobin A_{1c} levels, blood pressure, or body mass index. When working in a system that mostly ascribes value to disease metrics, it's difficult for clinicians to practice medicine in a way that prioritizes patient-defined goals and holistic health.¹

One approach gaining momentum is appropriately named Patient Priorities Care (PPC).² PPC is a clinical framework designed to align primary and specialty care around each patient's health priorities so that their individual values and preferences guide all aspects of their health care, supporting realistic health and life goals.

The PPC paradigm is designed for the specific needs of an aging population with multiple chronic conditions.³ This population faces some of the most complex health care challenges and drives most of the health care spending in the United States—with some estimates suggesting that 10% of the patient population accounts for nearly two-thirds of total costs. Implementing a person-centered approach not only helps drive toward the purpose, connection, and belonging essential to overall well-being, but also drives faster, better results across the baseline clinical markers that are foundational for health.⁴

Comprehensive care management (CCM) models have been widely implemented for chronically ill patients to help them and their caregivers better manage their medical and psychosocial conditions.⁵ These programs seek to improve patient self-reported outcomes and avoid unnecessary medical services, but results to date for CCM are mixed.⁶⁻⁸ One reason may be that patients of this complexity often have too many problems to solve, so patients sometimes lose momentum in a sea of care plan elements that can be overwhelming.

The primary perspective that PPC adds, beyond a typical CCM model, is that it may ignore key medical issues if they are not related to the patient's priority. This is anathema to

many clinicians, but truly focusing on only what matters to the patient—at least at first—builds connection and trust and engages the patient in taking the practical health-related steps toward their goal. Building momentum in this way brings a therapeutic alliance well beyond the achievement of these early practical steps toward real progress on multiple goals, including, in many cases, those that are beyond the patient’s initial priority.

In practice, providers using PPC make an initial effort to understand what motivates each patient and their goals. That sounds simple, but clinical training ingrains a mental model of identifying problems, tying them to a diagnosis, and creating a treatment plan without thoughtful consideration of how the resulting plan aligns with a patient’s ability or willingness to adhere to the plan. Providers and patients are left speaking different languages, leading to confusion among patients, lower adherence to treatment and medications, and poorer outcomes.

If you ask a patient what they most hope to accomplish this month, it probably won’t be lowering their systolic blood pressure by 5 to 10 mm Hg. They are much more likely to say “being able to dance on my wedding anniversary” or even just “feeling well enough to go to the grocery store.” Linking the ability to achieve those goals to the steps required to lower their blood pressure helps activate the patient in a new way and engage them in their health on terms that matter to them.

Putting PPC Into Practice

To date, most of the work around PPC has been foundational, either done at the academic level or in targeted pilots with small populations and/or isolated settings.⁹ The next step is bringing this model of care to scale in commercial settings so that it becomes integrated into the delivery system and can drive improved outcomes at the population level.

Devoted Medical, which provides virtual and in-home advanced primary care services to support patients supplementary to their existing primary care practices, has successfully implemented this model of care across 13 states and a population of nearly 124,000 Medicare Advantage members. This represents one of the first examples of a large-scale commercial application of PPC, and the model is instructive for how to maximize the power of this clinical framework. The results to date suggest that the costs and challenges of implementing PPC are more than offset by the efficacy of this approach to care, high patient satisfaction, and meaningful improvements in clinical outcomes.

All longitudinal clinical care delivered through Devoted Medical is guided by patient priorities. The top care priority articulated by the patient is identified and translated into “The One Thing,” the core goal driving all care decisions. For example, in Devoted’s interdisciplinary home-based care model, a community health worker (CHW) performs

an in-home visit to build on established trust with the goal of identifying a patient’s One Thing using the PPC framework. The CHW first identifies the patient’s values and then works with the patient to set SMART (specific, measurable, attainable, realistic, and time-bound) health outcome goals. Health care preferences, such as what care is helpful or burdensome, are identified. The conversation is summarized with the identification of The One Thing, which is the health problem or concern that the patient wants the health care team to address so that they can achieve the health outcome goal. Next, the nurse practitioner uses The One Thing as a communication tool and a decision guide to create a care plan aligned with the patient’s stated priorities. The ultimate output is a 6-month care plan designed to track toward the patient’s One Thing. To the extent that meaningful health care should seek to enable behavioral change, we believe this is only achievable when the changes will advance the patient’s core values.

Implementing the PPC framework is enabled by modifying electronic health record workflows. The most impactful changes are tracking patient priorities and progress toward achieving these priorities and creating a system for assigning tasks across the care team. For example, for patients with congestive heart failure, the provider will be prompted to collect both baseline and current weight, determine whether the patient has a scale, send the patient an LTE cellular network-enabled scale if needed, and identify whether the patient understands how and when to weigh themselves. These elements are often overlooked in routine documentation but are critical to understanding the current state and trajectory of the patient’s health, considering that weight gain can be an early indication of a heart failure exacerbation.

This combination of using the PPC model with an integrated care team and the technology to support new workflows is producing significant results for the patients. Devoted Medical’s internal data as of May 2023 reveal the following findings:

- Diabetes management program graduates have seen a mean per-member reduction in hemoglobin A_{1c} of 2.1% in 83 days.
- Hypertension management program graduates have seen a mean per-member reduction in systolic blood pressure of 15.2 mm Hg in 40 days.
- Congestive heart failure management program enrollees have seen a 37% reduction in acute events after only 1 month, and only 1.8% of patients have had a subsequent acute event.
- Enrollees in the Intensive Home Care program, the home-based complex care model, showed a mean reduction in acute events and medical costs of more than 20% from the baseline 6 months prior to enrollment to the 12 months following.

Box. Patient Story

After a recent hospitalization, Mr FS had a home visit by a nurse practitioner in our home-based complex care program. A festering wound in his foot had spread into his bloodstream, leading to abscesses in his spine that required neurosurgical interventions (C3-C6/L2-S1 laminectomies and evacuation of epidural abscesses). His medical history included a stroke, diabetes, hypertension, and amputated toes from prior foot wounds. His mobility was limited because his neck had to be stabilized after spinal surgery, he had an ongoing active wound in his left foot, and he was receiving antibiotics through a peripherally inserted central catheter line. He had a Foley catheter because he couldn't void urine on his own and required a diaper for stool incontinence. During her home visit, the nurse practitioner learned that The One Thing for the patient (the core goal driving all care decisions) centered on treatment of his wounds so that he could walk in the Veterans Day parade.

Mr FS was medically complex with many options for a plan of care, but because he had clearly defined goals in place, the team stayed focused on what would lead to wound healing, including treatment for the wounds and tighter diabetic control. For example, when his infectious disease doctor wanted to switch him from intravenous to oral antibiotics, the prescribed regimen would cost him \$800 per month. The cost would have been prohibitively expensive, so he was not going to take the antibiotics. Whereas he may have been labeled "nonadherent" for not taking his antibiotics, the team worked with the health plan's pharmacy to identify an equivalent antibiotic with minimal cost burden. Because Mr FS had limited capacity for managing his health, the team made the difficult choice to have him check his glucose twice a day (because that would affect his wound healing) but not his blood pressure, lest asking him to do too much would lead to lower adherence to the steps required to achieve the goals most important to him.

In all subsequent visits, the care team relentlessly helped Mr FS manage his wounds and work toward improving his mobility. When the nurse practitioner would identify new wounds requiring attention during home visits, the community health worker would mobilize to coordinate specialized transportation to appointments and necessary wound management. They paid extra attention to the nuances of his care plan, such as fitting of prostheses for his amputations. Additionally, the Intensive Home Care team taught him about prevention of pressure ulcers, coached him on managing his wounds, and educated him on how to recognize signs of infection. Equally importantly, they did not spend time on the details of other issues that may have otherwise distracted from advancing his priorities. For example, the team did not have him tightly monitoring his blood pressure multiple times a day when it was out of range or ask him to engage with his gastroenterologist for his stable diagnosis of gastroesophageal reflux disease. Any treatment of the diabetes was discussed as a means to improve wound healing.

Once his wounds healed, his prostheses fit, and he had his specialized shoes, he could resume bearing weight, and he started physical and occupational therapy. With mobility, the team was able to start working on bladder and bowel training to make him continent again.

Although the Veterans Day parade was canceled in 2022 because of a hurricane, by September he was walking with a 4-prong cane, and by October he had gone on a camping trip with his wife.

Arguably, the standard pattern of care in which we would focus on solving all his medical issues in our priority order—and not linking them to his priority—was likely to fail, as it had for him previously. By constantly focusing on what he cared about, the team was able to engage him on solving key issues, which allowed him to meet his goal and subsequently work on his other medical issues.

The costs of PPC are chiefly that this model of care is time and resource intensive and only works if the providers delivering care have the training, time, and space to build trust with their patients. By having lower-cost resources such as CHWs invest the greatest share of time in eliciting and documenting PPC, these costs are partially mitigated but are somewhat offset by all staff spending additional time centering care on PPC. PPC also requires a fixed investment in technological infrastructure, usually in the form of modification to an electronic health record system, to support documentation and ongoing monitoring of the patient's priorities by all staff members. Although these costs may add slightly to the per-member cost of a care management program, the benefits of a higher success rate on the various clinical metrics noted above far outweigh

the marginally higher cost of delivering care using PPC, given how costly the care for these patients can be.

This initial evidence suggests that implementing the PPC clinical framework in a commercial setting can achieve the vision of reengineering care systems around older adults' priorities and, in so doing, results in better health outcomes. Applying this more broadly across American health care may require continued expansion of value-based care models, design and implementation of technological systems that can support value-based care and patient-reported outcomes, and the adoption of care teams that can address patients' unique clinical and nonclinical needs. If the US health care system makes the commitment to invest in this clinical model, we believe that it is possible to improve clinical outcomes and lower the total cost of care.

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