Listening to Learn:
Engaging Your Workforce and Healthcare Warriors to Improve Health Outcomes Through Person-Centered Care

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The National Council of Urban Indian Health (NCUIH) is the national non-profit organization devoted to the support and development of quality, accessible, and culturally-competent health and public health services for American Indians and Alaska Natives (AI/ANs) living in urban areas.

NCUIH is the only national representative of the 41 Title V Urban Indian Organizations (UIOs) under the Indian Health Service (IHS) in the Indian Health Care Improvement Act (IHCIA). NCUIH strives to improve the health of the over 70% of the AI/AN population that lives in urban areas, supported by quality health care centers.

This presentation was made possible by Award Number H723IHS0007-01-00 from Indian Health Service. "This publication is solely the responsibility of the National Council for Urban Indian Health and does not necessarily represent the official views of the Indian Health Service or the Department of Health and Human Services."
Agenda

- Welcome & Introductions
- Opening Remarks
- Objectives
- Presentation
- Moment of Reflection/Closing
- Evaluation
Welcome!

Please join us for additional on-demand sessions in this Community of Learning Series focused on Person-Centered Care

- **Health Literacy and Essential Component of Communication Strategy for Person-Centered Care**, Lyzbeth Best, MPH, MA Technical Assistance Manager | NCUIH, Molly Siegel, MPH, CPH, Public Health Associate | NCU

- **Navigating a Person-Centered Team Approach to Chronic Disease Management**, Vanessa Alvarez, American Indian Health Service of Chicago, MSN, APRN, FNP-BC, Cynthia Gourneau, American Indian Health Service of Chicago, Diabetes Educator/Pharmacist, Shandiin Begay, American Indian Health Service of Chicago, MSW, Behavioral Health Counselor/Intake Coordinator
Objectives

1. Understand the **key elements** of person-centered care

2. Identify what is being done around person-centered care already in Native communities and **why it matters** in UIOs

3. Identify **strategies** to empower patients to be active participants in health decisions

4. Learn how a patient-centered care model can be an **effective strategy** in **fostering trust** between patient, provider and health care systems
Opening Remarks:
Tips for Learning

Listen
Pause
Reflect
Patient-Centered Care (PCC)

“Patient- and family-centered care encourages the active collaboration and shared decision-making between patients, families, and providers to design and manage a customized and comprehensive care plan.”

Source: NEJM Catalyst (catalyst.nejm.org)
DISEASE-CENTERED CARE vs. PATIENT-CENTERED CARE

Which Makes Sense for Patients & the Health Care System?

DISEASE-CENTERED CARE

- Defines patients by their disease.
- Sorts patients into rigid treatment pathways.
- Takes a one-size-fits-all approach based on the lowest-cost care.

PATIENT-CENTERED CARE

- Treats patients as individuals.
- Relies on a strong clinician-patient relationship built on trust and shared decision-making.
- Gives patients and health care providers a voice in treatment decisions.

Source: Alliance for Patient Access - AfPA (https://admin.allianceforpatientaccess.org)
Disease-centered care leaves patients:
- Sick
- Frustrated
- More apt to need emergency health care services

Patient-centered care promotes:
- Patient collaboration
- Personalized treatment
- Integrated and coordinated care

RESULTS IN
- Better health outcomes
- Satisfied patients
- Lower overall costs

Source: Alliance for Patient Access - AfPA (https://admin.allianceforpatientaccess.org)
Native people have been practicing key elements of “PCC” for generations.

Traditional healing incorporates social, moral, environmental contributions & causes of health concerns.

Healers as facilitators to help patients heal themselves.

Source: Native Voices (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913884/)
Importance of PCC in AI/AN Communities Today

- Mistrust in medicine and the healthcare system
  - PCC builds trust between care providers and the patient
  - Patients live with their “disease” 24/7
    - Their story can reveal answers to their chief medical complaint
- Promoting self-governance
  - Make decisions in their own health
- Patient and Family Centered Care
  - Kinship and familial role in AI/AN communities
In 2008, the Indian Health Service launched a patient-centered medical home (PCMH) initiative to improve the quality of care in its clinics.

Source: (https://www.ihs.gov/office-of-quality/ipc/for-patients/)
Patient-Centered Medical Home (PCMH) Model

“PCMH model encourages patients and their provider teams to work closely together to ensure care is more comprehensive, coordinated and consistent”

Source: (https://www.ihs.gov/office-of-quality/ipc/for-patients/)
IHS Care Model

Based on PCMH model and defines the delivery of medical services throughout all stages of care

Source: (https://www.ihs.gov/office-of-quality/ipc-for-patients/)
Moment of Reflection/Story
Implementation Strategies for PCC

Structural Strategies

• Creating person-centered culture
• Management’s commitment for team coordination and promoting teamwork
• Motivational mechanisms -> Appreciation and encourage of positive staff work

Process Strategies

• Promoting communication
• Respectful and compassionate care
  • Responding to the patient’s preferences, needs and values

Outcome Strategies

• Creating empowerment in the patient
  • Involving patient in managing their illness and establishing continuous care

Source: (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8641711/)
Empowering Patients

What can we do as healthcare workers

- Active listening
  - Learn by Listening
- Ask the right questions (Open-ended)
- Take a moment to pause in your busy day and listen to the patient’s story
  - Build trust and connections so patients open up and share
- Native people are resilient
  - Empower our patients to be involved and take control over their health and treatment plans
- Encourage the presence of family members/relatives in the care setting
  - Especially for our elders and youth

Source: NEJM Catalyst (catalyst.nejm.org)
Empowering Staff

**LISTEN to LEARN**

- Empathy, two-way communication, and eye-to-eye contact
- **Holistic approach and considering broader needs:**
  - Think beyond the medical setting including:
    - Emotional, spiritual, mental health, environmental, social factors, medical literacy.
- Use laymen terms when discussing complex medical terminology

Source: NEJM Catalyst (catalyst.nejm.org)
1. What do you call your problem? What name does it have?
2. What do you think has caused your problem? Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. What do you fear the most about your sickness?
5. What are the chief problems your sickness has caused for you?
6. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?

Source: https://ojin.nursingworld.org/
Benefits of a PCC Model

- **Person- and Family-centered**: Focuses on the whole person — physical, emotional, psychological and spiritual wellbeing, as well as cultural, linguistic and social needs.

- **Continuous**: Dynamic, trusted, respectful and enduring relationships

- **Team-based and Collaborative**: Interdisciplinary teams, including individuals and families, work collaboratively and dynamically toward a common goal of better health.

- **Coordinated and Integrated**: Primary care integrates the activities of those involved in an individual’s care, across settings and services.

- **Accessible** for all individuals

*Improved patient outcomes, experiences and trust with providers*

Source: [https://www.ihs.gov](https://www.ihs.gov)
Barriers and Facilitators of PCC

**Barriers/Challenges**

To the implementation of person-centered care covered three themes:

- Traditional practices and structures
- Skeptical, stereotypical attitudes from professionals;
- Factors related to the development of person-centered interventions.

**Facilitators**

- Organizational factors
- Leadership and training
- Enabling attitude and approach by professionals

Empower your workforce and engage them through creating a culture of person-centered care at your facility

Source: (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8641711/)
IHS Improving Patient Care and the Patient Centered Medical Home (PCMH)

Source: IHS (https://www.youtube.com/watch?v=RO-rWlxp6l0)
Key Takeaways

1. Patient is at the heart of the care continuum
2. PCC happens at all stages of care and should take a holistic approach
3. PCC develops strong patient clinician relationships and can improve patient outcomes and experiences
4. Aim to create person-centered culture at your facility
5. Your patient is a person, listen to learn their story
Listen and consider the patient’s story in their medical journey
Thank you!

Please take a moment to fill out our brief survey and let us know how we can better serve you!
References

2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8641711/
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