Care that Fits 2023
Poster Presentations
Integrating Family Medicine Physicians as Hospice Medical Directors: A Minimally Disruptive Medicine Approach

Author(s):
Jared Stahlecker, MD FAAFP

Location:
MercyHealth Family Medicine Residency

Purpose:
To highlight the potential of family medicine physicians in the role of hospice medical directors, leveraging the principles of Minimally Disruptive Medicine (MDM) to enhance patient-centered end-of-life care.

Description:
Family medicine physicians, with their comprehensive understanding of patients' medical and personal histories, are uniquely positioned to champion the principles of MDM in hospice settings. Their holistic approach ensures care that aligns with patients' life goals and values, making end-of-life care both personalized and efficient.

Benefits of Integration:

- **Patient-Centered Care**: Drawing from the tenets of MDM, family medicine physicians can focus on achieving patient goals for life and health, ensuring care strategies that genuinely resonate with patients' life goals and values.

- **Enhanced Patient Understanding**: As primary care providers, family medicine physicians have a deep-rooted trust with patients, facilitating individualized end-of-life care plans.

- **Increased Home Visits**: Emphasizing the importance of minimizing treatment burdens, this approach reduces the need for patients to travel, offering them comfort during a crucial phase of life.

- **Therapeutic Procedures at Home**: Procedures like paracentesis, thoracentesis, and advanced wound care can be conducted at home, aligning with MDM's focus on minimizing disruptions to patients' lives and reducing hospital admissions.

Recommendation:
In light of the evidence supporting MDM's patient-centered approach, it's imperative to integrate family medicine physicians into the hospice care framework as medical directors. Their deep understanding of their patients, combined with their vast medical expertise, makes them ideal for this role.

Conclusions:
Integrating family medicine physicians as hospice medical directors and applying the principles of MDM can revolutionize end-of-life care. This approach not only prioritizes the patient's quality of life but also ensures their dignity and comfort are paramount.

Relevance to Minimally Disruptive Medicine:
This model underscores the core principles of MDM – reducing treatment burdens and enhancing patient capacity. By aligning care strategies with patients' life goals and values, we ensure truly individualized care.

References:
1. Minimally disruptive medicine: the evidence and conceptual... - PubMed
2. Hospice Medical Director Manual | AAHPM
3. Minimally Disruptive Medicine: A Pragmatically Comprehensive Model for...
4. Minimally disruptive medicine (MDM) in clinical practice: a qualitative...
5. PDF Quick Reference Guide HOSPICE PHYSICIANS 1 Hospice Medical Medical Director (HMD)
eHealth integration in blended care: towards Care that Fits

Author(s):

Purpose:
Innovative approaches are required to meet the demands presented by rapid changes in primary care practice (PCP), such as an aging population, the increasing complexity of care such as increased knowledge of genetics (e.g. familial hypercholesterolemia) and pharmacogenetics, changing patient-provider relationships, a shortage of personnel, rapid technological developments and the recent developments around COVID-19. The purpose of this Special Interest Topic is to support organizers of Continuing Professional Development (CPD) and teachers delivering medical vocational training by providing recommendations for eHealth education and effective patient communication. We describe what is required to help care professionals and trainees learn about eHealth. Second, we elaborate on how eHealth education might be provided in order to improve patient communication.

Description:
We consider four essential topics. First, an understanding of existing evidence-based eHealth applications and conditions for successful development and implementation. Second, required digital competencies of providers and patients. Third, how eHealth changes patient-provider and provider-provider relationships and finally, understanding the handling of digital data.

Summary/Recommendation:
Many PCPs are aware of the need to improve online communication with patients right now. Other examples include telemedicine and online mental health services. Uptake of eHealth could be encouraged by broadening the focus of eHealth education to encompass the entire PCP team, including nurse practitioners, practice assistants, PCPs involved in CPD, and trainees undergoing vocational training.

Conclusions including relevance to Care that Fits:
The impact of eHealth in daily practice is greater when it is integrated into usual care (blended care), which means enriching usual care with eHealth solutions rather than presenting eHealth as a stand-alone solution. This is relevant to Care that Fits for the aim of blended care is to help in shared decision making, minimally disruptive medicine and patient centered care. Greater impact is achieved when the whole practice team is involved, motivated and educated to organize blended care successfully. Vocational and CPD training in PCP needs to build on eHealth capabilities now. We strongly advise the incorporation of eHealth education into vocational training and CPD activities, rather than providing it as a separate single module. How learning goals and activities take shape and how competencies are evaluated clearly requires further practice, evaluation, and study.

References:


**Poster #3**

**Long-term risks of living kidney donation**

**Author(s):**


**Purpose:**

There are limited data on long term outcomes of kidney donation. Well-designed studies with well-matched healthy controls are needed to provide a comprehensive understanding of the long-term risks and complications.

**Population:**

The sample included living kidney donors from University of Minnesota and Mayo Clinic and are compared to healthy individuals who visited providers at Olmsted and surrounding counties form early 1960s to present.

**Methods:**

We matched living donors from University of Minnesota and Mayo Clinic to controls from Rochester Epidemiology Project REP (a well-defined population, with detailed medical records linked between all providers in Olmsted and surrounding counties who have the same geographic region and era as the donors). We selected healthy controls by carefully reviewing medical charts and identifying acceptable donors on index date
(the date the matched donor donated). We assessed them at that date by kidney function (e.g., normal creatinine and no proteinuria), body mass index, smoking history and family history of kidney disease, high blood pressure and diabetes. We recorded outcomes from their electronic and paper medical records and from surveys sent to both donors and controls. Finally, the outcomes are verified from national registries (National Death Index and United States Renal Data System). Leading outcomes to be compared are endstage kidney disease, cardiovascular disease and mortality, estimated glomerular filtration rate (eGFR) trajectory and chronic kidney disease, pregnancy risks, and development of diseases that frequently lead to chronic kidney disease (e.g., hypertension, diabetes, and obesity).

**Conclusion:**
Our study will provide a better definition and quantification of long-term risks of kidney donation, which could help potential donors in making an informed decision and encourage follow up and care of living donors.

**Poster #4**

**Development of a Shared Decision-Making Measurement Tool using Purposeful SDM**

**Author(s):**
Misk Al Zahidy, M.S.*, Victor Montori, BA., Ricardo Torres Loor M.D., Maddie O’Grady BA., Victor M. Montori, M.D., Ian Hargraves, Ph.D.

*Lead Presenter

**Purpose:**

**Background:** Shared decision making (SDM) is a deliberative process in which patients and clinicians talk together to understand the patient’s problematic situation and collaboratively develop a plan of care that makes intellectual, practical, and emotional sense as a response to the situation and the individuality of the person (Hargraves et al., 2019).

**Significance:** Despite its potential benefits, there is a lack of standardized measures to assess the occurrence and impact of SDM in clinical practice (Elwyn & Vermunt, 2020; Gerwing & Gulbrandsen, 2019; Gulbrandsen et al., 2014; Montori et al., 2006).

**Objective:** To address this gap we are working on developing a new measurement tool that focuses on the theory of "Purposeful SDM," which acknowledges that the process of SDM can vary depending on the patient's unique situation (Hargraves et al., 2019).

**Population:**
Clinician and patients with multiple chronic care conditions.

**Methods:**

**Brainstorming Sessions:** Organize brainstorming sessions with field experts to gain detailed insights into Shared Decision Making.

**Literature Review:** Conduct a literature review to comprehensively explore current SDM measures and generate potential items.

**Video Analysis:** Analyze real-world video recordings of patient-clinician encounters to generate items.

**Delphi Consensus:** Implement the Delphi method to come to a consensus on the items that capture SDM behaviors and processes.

**Validation:** Following the development of the SDMo tool, conduct validation processes to ensure its accuracy, relevance, and utility in clinical encounters.

**Results:**
While this project is still ongoing, preliminary outcomes from the initial phases have been promising. To date, we have generated over 1000 items from the three methods, laying a robust foundation for the next stages of the study.

Conclusions including relevance to Care that Fits:
The development of a comprehensive SDM measurement tool holds potential to enhance the ability of patients and clinicians to collaboratively determine the most medically justifiable, feasible, sustainable, and emotionally desirable solutions. This tool will bridge existing deficiencies, fostering a more collaborative and patient-centric care approach.

References:


Poster #5

Interventions to Address Risk-Treatment Paradox in Patients at Risk of Cardiovascular Events: A Systematic Review.

Author(s):
Misk Al Zahidy, M.S.*, Ricardo Torres-Loor, M.D., Esteban Cabezas, M.D., Danny Segura, M.D., Bashar Hasan, M.D., Jennifer L. Ridgeway, Ph.D., Victor M. Montori, M.D.

*Lead Presenter

Purpose:
The risk-treatment paradox describes situations where individuals at lower risk receive more interventions than their higher-risk counterparts, potentially exposing low-risk individuals to unnecessary treatments, side effects, and costs, while leaving those at greater risk undertreated.

The objective of this systematic review is to identify and assess interventions designed to address the risk-treatment paradox in patients at risk for cardiovascular (CV) events.

Population:
Adult patients are at risk of experiencing CV events, including but not limited to coronary artery disease, cerebrovascular accidents, and congestive heart failure.

**Methods:**

**Interventions of Interest:** A range of intervention methods (e.g., educational sessions, academic detailing, and decision support tools).

**Outcome Measurement:**

The primary outcome is intervention efficacy, defined as significant changes or differences in treatment rates, focusing on the enhancement of risk-concordant therapy, personalized medical treatment, and the balance between overtreatment and undertreatment, considering the patients' risk profiles.

**Study Selection:** A comprehensive search strategy and two-phased selection process was devised: Phase I (initial screening based on PICO criteria) and Phase II (full-text review). Conflicts will be addressed through consensus or the involvement of a third reviewer.

**Data Synthesis and Analysis:**

Due to the expected heterogeneity of designs and interventions, our focus is narrative synthesis approach. Our primary objective is to deliver a descriptive summary of the study findings, illuminating commonalities, variances, and inconsistencies amongst them.

**Results:**

The initial systematic review identified 913 papers related to our study objectives. Phase I screening identified 114 papers, which are currently undergoing Phase II detailed full-text review.

**Conclusions including relevance to Care that Fits:**

Addressing this paradox goes beyond mere clinical appropriateness; it's about ensuring that care truly fits the patient's needs. Through our systematic review, we aim to shed light on interventions that can rectify this imbalance, ensuring both clinically sound and patient-centered approaches to CV care.

**References:**


**Poster #6**

Setting the example? A cross-sectional videographic analysis of uncertainty and patient involvement in medical drama series

**Author(s):**
Marleen Kunneman, PhD; Esmée van der Poort, MSc; Amber Zeeman, MSc; Marij Hillen, PhD; Victor Montori, MD, MSc; Liesbeth van Vliet, PhD

Purpose:
To explore how medical drama series portray patient-clinician communication about uncertainty and patient-clinician collaboration when designing care plans.

Population:
Consecutive portrayed adult patients with a serious illness (N=80) and their clinicians (N=31) from the most recent aired seasons of four medical drama series (Grey’s Anatomy, The Good Doctor, New Amsterdam, and The Resident).

Design:
Cross-sectional videographic study, observing and coding patient-clinician encounters as portrayed in medical drama series

Methods:
This is a cross-sectional videographic study, in which we observed and coded patient-clinician encounters from fictional in-patient and out-patient U.S. healthcare facilities, as portrayed in medical drama series. We coded all observed expressions of uncertainty, who initiated the expression, whether uncertainty was explicitly acknowledged or left implied, and to which of 9 possible dimensions of the concept of ‘Making care fit’ each expression was related. Clinicians’ efforts to involve patients in decision making was assessed using the validated OPTION12-scale (0-100 scale, with 100 reflecting maximum behaviors).

Results:
Encounters had a median duration of 64 seconds (IQR 49;91). Uncertainty was expressed 25 times within 19 of 80 encounters (24%). Clinicians initiated most expressions of uncertainty (N=19/25, 76%), and did so implicitly (N=19/25, 76%). Most expressions related to the content of patient-clinician collaboration (e.g., discussing the options available, N=13/25, 52%). Patients were involved to a limited extent in designing their care plans (OPTION12-score mean =21, SD=9.7; score of 50 is considered ‘baseline skills’), with higher involvement in recurrent visits compared to first visits (OR 1.4 (95% CI 1.21;1.69) p<0.001), and no between-series differences or differences with real-life encounters.

Conclusions:
Medical drama series consistently portray limited patient-clinician conversations on uncertainty and portray limited patient involvement. Reflecting the power of scripting, medical drama series achieved similar OPTION12 scores to those compute from complete real-life encounters, while portraying only a brief fictional interaction.

Poster #7
MetroMapping: Development of a methodology to redesign care paths to support Shared Decision Making

Author(s):
Marleen Kunneman & Anne Stiggelbout, Medical Decision Making, Leiden University Medical Center; kunneman@lumc.nl

Ingeborg Griffioen, Panton Design and Department of Design, Organisation and Strategy, Faculty of Industrial Design Engineering, Delft University of Technology; Ingeborg.griffioen@panton.nl

Marijke Melles, Department of Human-Centered Design, Faculty of Industrial Design Engineering, Delft University of Technology; m.melles@tudelft.nl
Purpose:
To support shared decision-making (SDM), initiatives are often focused mainly on communication in the encounter and the use of decision aids. Our previous research (Griffioen et al. 2021) revealed: decision-making as a sequence of (un)planned moments before, during, after the consultation; work for patients and relatives to acquire/understand/recall information; often unclear roles and tasks, and unexpected energy drains (due to, e.g., changes in the trajectory).

We aimed to develop a service design methodology to improve SDM. The entire patient journey is considered a service. All ‘touch points’ (leaflets, devices, etc.) become part of a consistent service, supporting stakeholders’ decision making. We used oncology as a case.

Methods:
We combined methods and insights from design research, which are distinct from health services research methods:

● Co-creation and process-mapping, enabling participants to oversee and improve decision-making, cooperation, and task allocation

● Presentation of complex information along the care trajectory

● Resilience, of individuals and systems, in terms of anticipation, sense-making, trade-offs, and adaptation

Results:
We developed MetroMapping (MM, www.metromapping.org/en/), to redesign care paths in a human-centred, holistic, iterative way, actively engaging patients, significant others, clinicians, and quality-of-care staff throughout the design process. MM addresses five layers: 1) current experiences of patients, significant others, and clinicians, 2) metroline visualizing the entire care trajectory, 3) information needed in every phase, 4) persons involved in care and decision-making, and 5) physical contexts and artefacts. Its quick uptake in the Netherlands demonstrates its attraction to both clinicians, quality of care staff and researchers.

Conclusions:
Important assets of MM are its flexibility for heterogeneous care paths and its intuitive visual language, enabling multidisciplinary collaboration and engagement of patients with various levels of health literacy, to design care plans that fit well. It is currently tested in various care paths in Europe in the HorizonEU project 4D-PICTURE.
Poster #8

Making Care Fit in the Lives of Young Adults with type 1 Diabetes: A study protocol

Author(s):
Anka van Gastel, MSc;1,2 Anne Stiggelbout, PhD;1 Matthijs Graner;3 Victor M. Montori, MD, MSc;4,5 Viet-Thi Tran, MD, PhD;6,7,8 Sean Dinneen, MD;9,10 Jessica Mesman, PhD;11 Joris Swaak;12 Henk-Jan Aanstoot, MD, PhD;13 Eelco De Koning, MD, PhD;2 Marleen Kunneman, PhD1,4.

1Medical Decision Making, Department of Biomedical Data Sciences, Leiden University Medical Center, Leiden, the Netherlands
2Department of Internal Medicine, Leiden University Medical Center, Leiden, The Netherlands
3The ééndiabeter foundation, Amsterdam, the Netherlands
4Knowledge and Evaluation Research Unit, Mayo Clinic, Rochester MN, USA
5Division of Endocrinology, Diabetes & Metabolism, Mayo Clinic College of Medicine, Rochester, MN, USA.
6Department of General Medicine, Paris Diderot University, Paris, France
7METHODS Team, Epidemiology and Statistics Sorbonne Paris Cité Research Centre, Paris, France
8Centre d'Épidémiologie Clinique, HôpitalHôtel-Dieu, Assistance Publique-Hôpitaux de Paris, Paris, France.
9Galway University Hospitals, Galway, Ireland
10Department of Medicine, NUI Galway, Galway, Ireland
11Department of Technology & Society Studies, Maastricht University, Maastricht, the Netherlands
12Panton Medical Design Agency, Deventer, the Netherlands
13Diabeter, National Centre for Pediatric and Adolescent Diabetes, Rotterdam, the Netherlands
Purpose:
Three of every four young adults with type 1 diabetes (T1D) indicate that their investments of time, energy, and efforts in healthcare are unsustainable over time. At the same time, their glucose levels are less regulated compared to other age groups. The aim of this study is to understand how young adults live with T1D (what are their efforts and what is the impact of care on their lives), and to co-create a conversation aid to be used during clinical encounters with their clinicians to discuss and consider these efforts and impact.

Population:
Dutch young adults (18-30 years old) with a diagnosis of Diabetes Mellitus type 1.

Methods:
This multi-method study consists of four projects: 1) a national survey (N=500), 2) Photo-elicitation (N=30) followed by group discussions, 3) video observations and video reflexive ethnography (VRE) (N=40), and 4) an expert meeting (N=30).

Part 1-2 generate a thematic map of issues and behaviors important to young adults when making diabetes care fit in their lives. Part 2-4 generate a context- and age-specific Making Care Fit conversation aid, and a prioritized catalogue of patient and clinician efforts that support or hinder making care fit.

Results:
Data collection will start in September.

Conclusions and Relevance:
Care plans can seem right from a medical perspective, but if care doesn’t fit for each person, we ‘deliver care’ without ‘caring’. This study aims to support young adults with T1D in their lifelong, ongoing, daily endeavors of making diabetes care fit into their lives, and to successfully collaborate with their clinicians in designing care plans that they need, want, and are able to implement well. This study builds on the body of evidence on ‘Making care fit’, a first in its kind to evaluate all its domains in practice and from the patient’s perspective.

Poster #9
The work of shared decision-making: A systematic review

Author(s):

Purpose:
For shared decision making (SDM) to be a truly patient-centered technique to make care fit rather than just another ‘box to check’, we need to shed light on possible adverse effects imposed in daily practice. The aim of this review is to investigate whether studies that assess SDM also assess the work or burden that may be involved in SDM.

Methods:
We performed a citation search of all papers describing the use of SDM measures\(^1\). We included 1) original research, 2) published between 2012-2022, 3) including real-life patients, clinicians, or decisions about health or care, 4) that reported scores of at least one SDM measure, and 5) assessed the work, workload, or burden of the SDM process. All papers were screened for eligibility in duplicate.

Results:
The review is ongoing. Our search yielded 3059 unique papers, of which we included 1350 (44%) after title/abstract screening. We are close to finalizing full-text screening, so far including ~9% of papers. We will
extract data on study and participant characteristics. We will report all qualitative and quantitative methods used to evaluate the work, workload, or burden of SDM. We will categorize quantitative measures according to their focus (temporal, cognitive, emotional, social, logistical/financial, expectations, or other) and perspective (patients, loved ones, clinicians).

**Conclusions and relevance to Care that Fits:**

SDM is a promising method to support patients and clinicians in making care fit. To truly understand SDM’s potential contribution to making care fit, we need to shed more light on, and start to consider, the possible work and burden that SDM imposes on patients, their loved ones, and clinicians.

**References:**


**Poster #10**

**The Experience Model of Communication: Supporting Care that Fits**

**Author(s):**

Chad Connor, Jen Packard

**Purpose:**

This poster introduces the Experience Model of Communication (XMOC) and how the principles and elements work together to support the goals of minimally disruptive medicine (MDM). The authors share examples of how the 4 principles and 9 elements of XMOC support conversations with patients and between healthcare professionals that create trust and transparency crucial to understanding honest patient goals, the burden of illness, and additional burden related to treatment.

**Description:**

XMOC is a model of communication designed by the Experience Training, Education & Coaching (XTEC) team at Mayo Clinic to support excellence in interpersonal communication between employees and patients, as well as between colleagues. The XTEC team champions the adoption of XMOC strategies through a wide array of live workshops, coaching and consultation, and development of digital resources. XMOC borrows from several evidence-based therapeutic communication models and theories including Motivational Interviewing, Appreciative Inquiry, Nonviolent Communication, Theory of Mind, and best practices in health and wellness coaching.

**Summary/Recommendation:**

Empathic, transparent communication is critical to creating authentic, human relationships. Training in communication skills is a critical part of professional development that can positively impact patient care and should be offered to both clinical and nonclinical employees in healthcare environments.

**Conclusions:**

XMOC is a model of communication designed by healthcare communication experts at Mayo Clinic that supports the provision of Care that Fits.

**References:**

[1] [2]


Poster #11

**Patient-clinician collaboration in making care fit: A qualitative analysis of clinical consultations in diabetes care**

**Author(s):**
Martha Kidanemariam, MD, Matthijs Graner, MSc, Willem Jan W. Bos, MD, PhD, Marielle A. Schroijen, MD, PhD, Eelco J.P. de Koning, MD, PhD, Arwen H. Pieterse, PhD, Anne M. Stiggelbout, PhD, Victor M. Montori, MD, Marleen Kunneman, PhD

**Purpose:**
Patient-clinician collaboration to make care fit has been described to include nine relevant ‘dimensions’, based on experts’ opinions and a literature review. The purpose of this study was to provide an indication of the validity of these described dimensions and explore how patients and clinicians collaborate to make care fit in clinical practice.

**Population:**
Adults with diabetes visiting a tertiary academic medical center in the Netherlands for their yearly check-up.

**Methods:**
As part of an ongoing study, we audiotaped and transcribed patient-clinician consultations. We purposively selected consultations based on participants’ heterogeneous demographical, biomedical and biographical characteristics. We analyzed transcripts using reflexive thematic analysis. We combined a deductive and inductive approach, using the pre-described dimensions of making care fit (maximally responsive to 1) patients’ unique situation and 2) priorities, while minimally disruptive 3) patient’s lives, and 4) social networks, using collaboration in terms of 5) content and 6) manner, in 7) ongoing, iterative, and 8) unhurried conversations, that 9) may impact positively on those involved), and adding new (sub-)dimensions when pertinent.

**Results:**
We analyzed 24 clinical consultations. Our data from clinical practice validated the nine previously described dimensions and provided eight new sub-dimensions of making care fit with examples from clinical practice (problematic situation, influence of devices, sense of options, shared agenda setting, lack of collaboration, clinician context, adapting to changing organization of care, and possibility to reconsider). We observed that patients and clinicians collaborate by exploring aspects of patients’ unique situation and their priorities, and by responsively changing, adapting or maintaining care plans.

**Conclusion:**
Our study confirmed, specified and enriched the conceptualization of making care fit through practice examples. It supports clinicians and research with insights in important aspects of patient-clinician collaboration. Ultimately, this would lead to optimal design of care plans that fit well in each patient’s life.

Poster #12

**Title:** Acceptance as a Form of Caregiver Self-Care: A Group Health Coaching Case Report

**Author(s):** Cassie Zell MA, NBC-HWC & Erin Erickson DNP, MPH, MA, FNP-C, WHNP-BC, IFMCP, NBC-HWC

**Background:**
Personal caregiving for children, spouses, and parents living with chronic, progressive illness is a debilitating role, affecting caregivers’ health and wellbeing. Caregivers endure significant stress undertaking daily challenges while trying to comprehend the many uncertainties ahead. Interventions that provide support, increase awareness, and examine difficult emotions have been shown to reduce caregiver burden by increasing quality of life and ability to cope with stressors.
Case Description:
This case highlights a group health coaching experience focused on self-care for six personal caregivers recruited through a caregiver support organization. Sessions were led by two health coach facilitators.

Intervention:
Caregivers participated in weekly 90-minute group coaching sessions for five consecutive weeks. All sessions were held virtually and followed a similar format, including a mind-body practice, activities to deepen self-awareness, and significant time to share, set goals, and connect as a group. The coaches were creative in their approach, adapting to the group’s needs, to engage participants, evoke new insights, and shift their perspectives.

Outcomes:
After the coaching intervention, participants’ ability to find balance and care for themselves trended upward. Participants also uncovered the power of acceptance as a form of caregiver self-care. Participants’ reflections during and after coaching demonstrated their growth and how group coaching was foundational for this transformation to accepting and moving forward with greater self-care.

Conclusions and Relevance to Care that Fits:
This case explores the deeper workings of self-care, extending beyond “typical” self-care practices. When working towards person-centered care opening our own perspectives around enhanced wellbeing is essential. Additionally, creating opportunities for caregivers to connect and deepen their awareness evokes capacity for movement towards wellness. Group health coaching can inspire caregivers to identify their needs, desires, and values, and discover room for acceptance, creating greater capacity to care for themselves and their loved one in a meaningful way.

References


