Rethinking Health Care Collaboration: Seven Ideas for Working with Patients with Diabetes

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Case 1

Ron

Case 2

Ashley

Difficult Patient or Difficult Relationship?

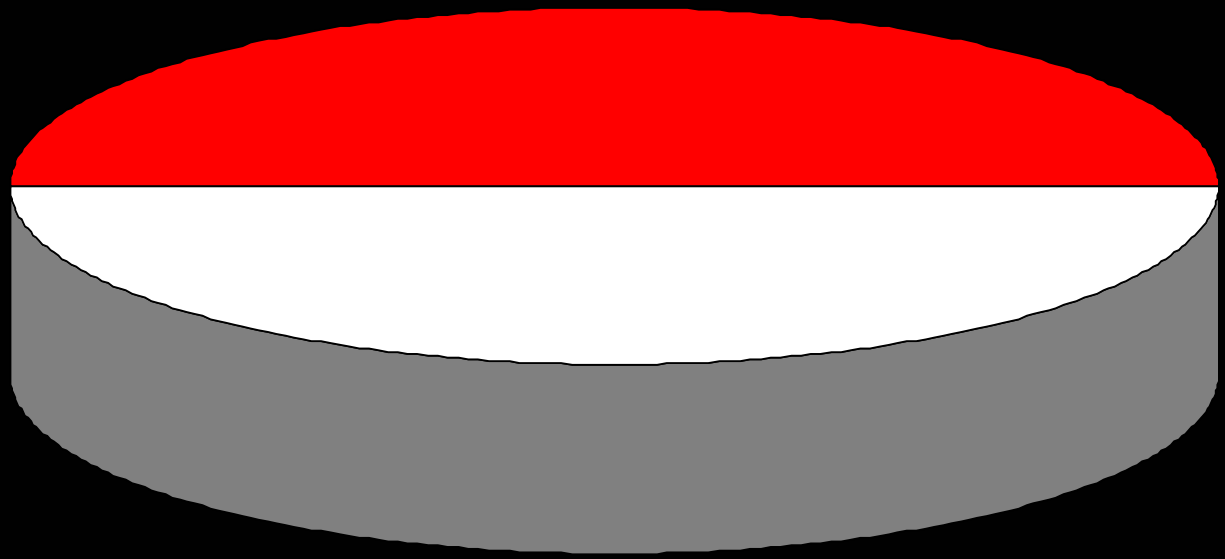
Difficult patients

Difficult patients

Irrational behavior

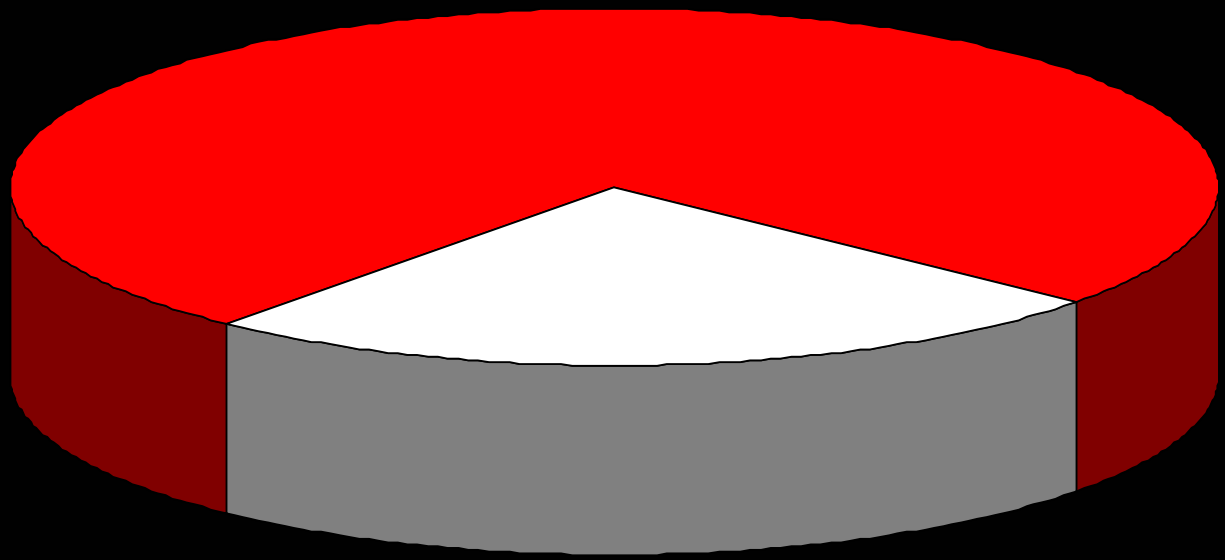
Difficult patients

Irrational behavior



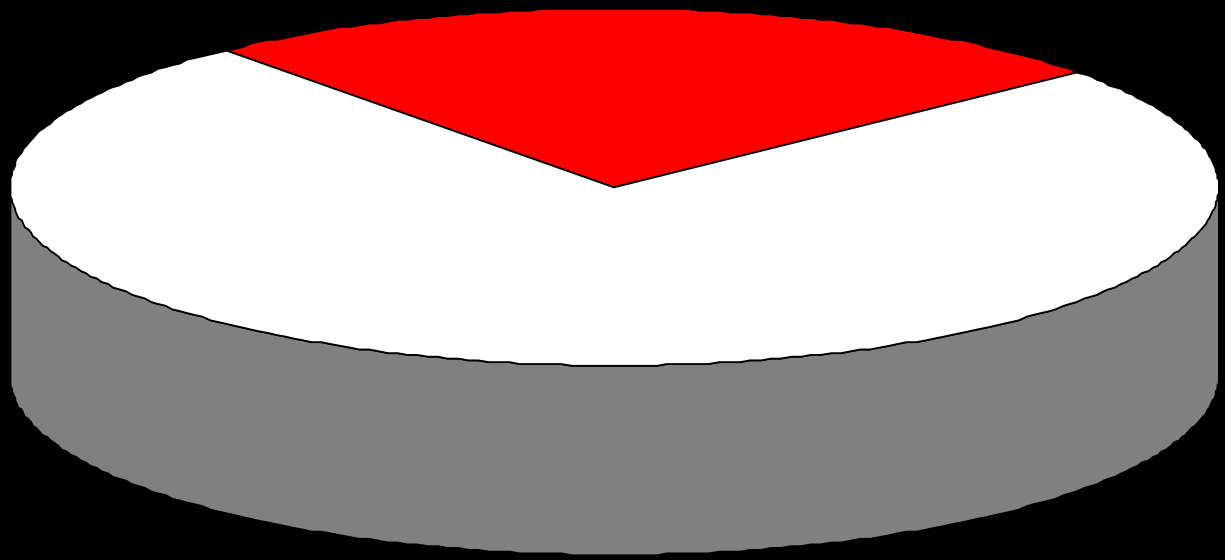
Difficult patients

Irrational behavior



Difficult patients

Irrational behavior



IOM Crossing the Quality Chasm

- Patients are diverse in the ways they prefer to interact with caregivers
- Some seek close personalized relationships with physicians
- Others prefer infrequent contact with physicians

IOM Crossing the Quality Chasm

- The current system of care may be better at attending to patients with chronic illness who schedule regular clinic appointments and actively engage in the patient-provider relationship

What is Attachment Theory?

Support:

- National Institute of Diabetes, Digestive and Kidney Diseases Grant DK60652-01
- Group Health Cooperative/Kaiser Permanente Community Foundation
- Bayer Institute for Health Care Communication
- Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP)

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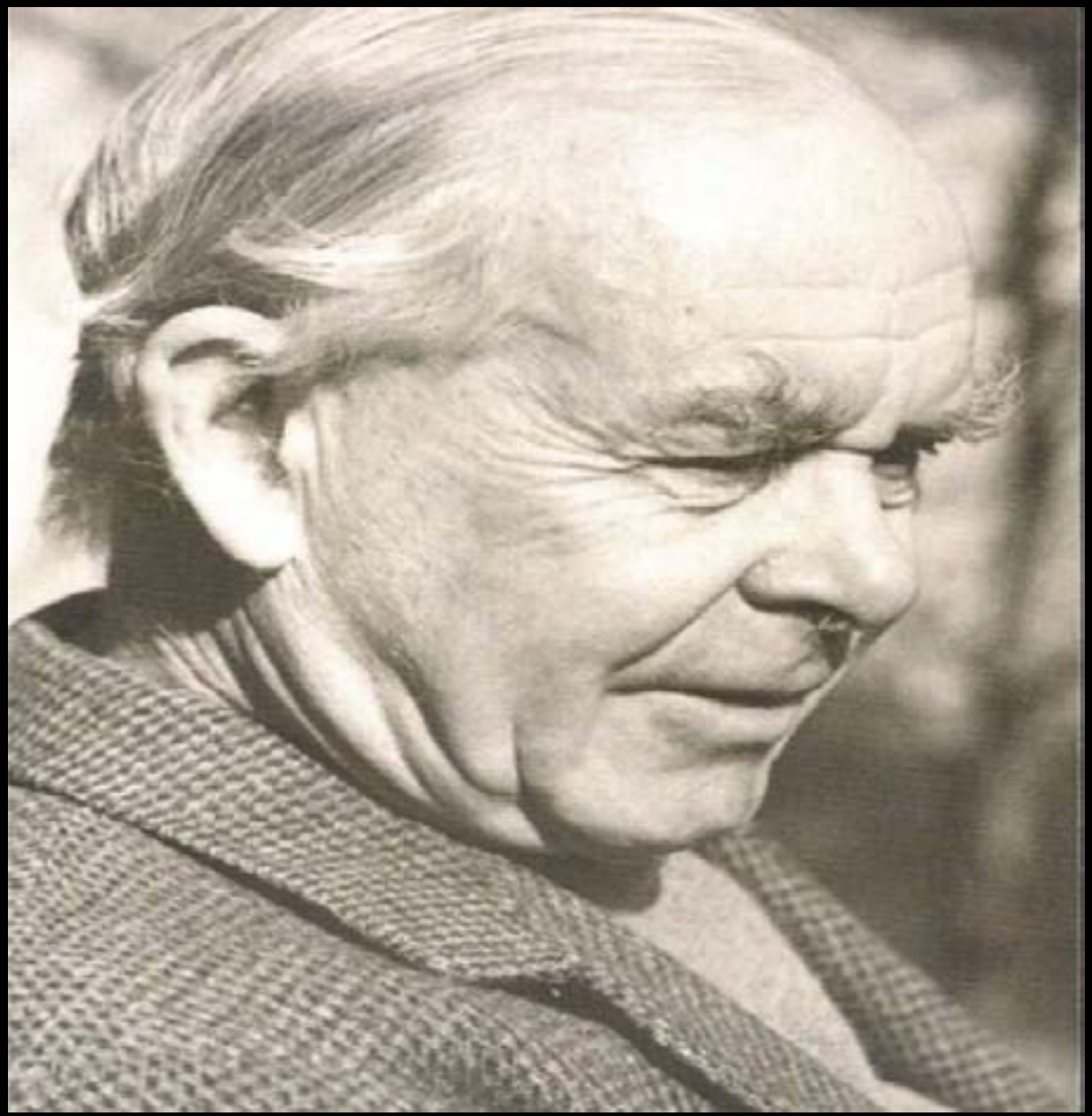
- Bessie Young, MD, MPH
- Leslie, Emma, Sabine



What is Attachment Theory?

- **John Bowlby**
  - from evolutionary standpoint, caregiver is a "*secure base*"

- "**Internal Working Models**"
  - based on prior caregiving experiences
  - determine how an individual *perceives* and *behaves in* interpersonal relationships

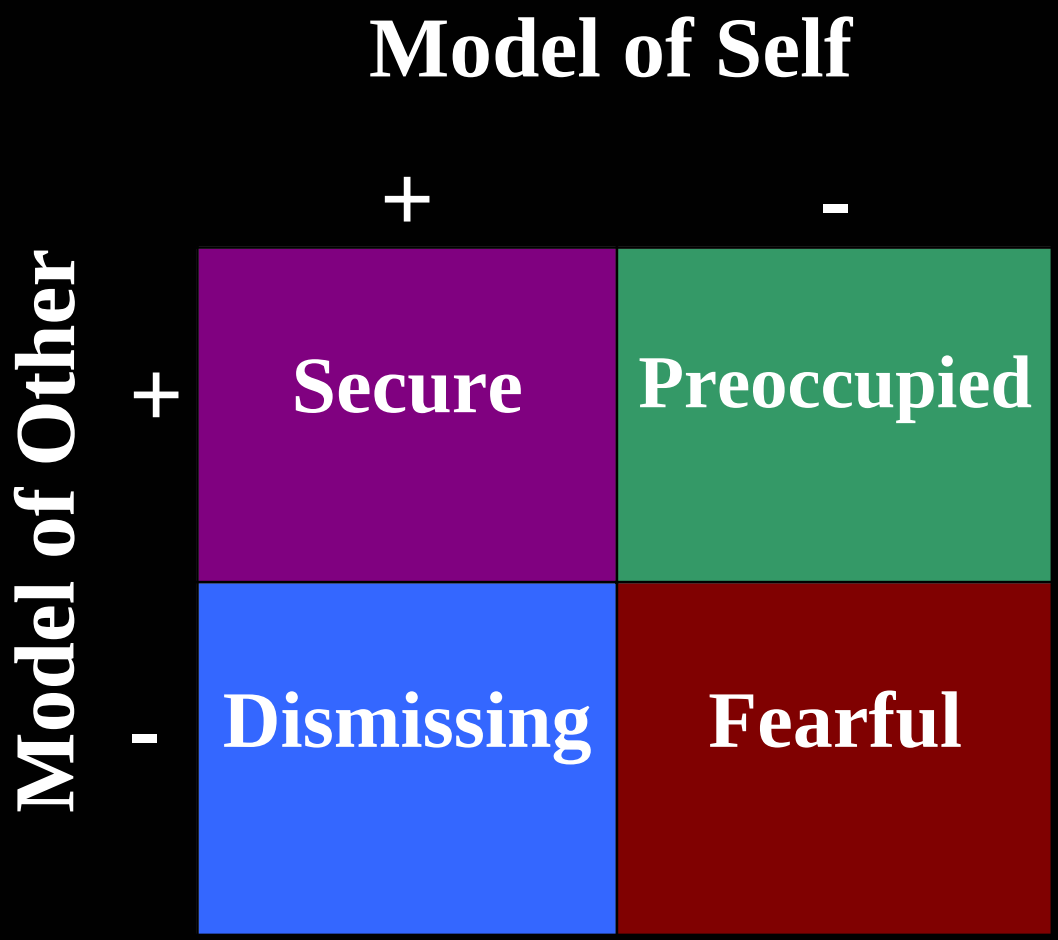
What is Attachment Theory?

- Individuals vary in their ability:
  - to trust others
  - the extent to which they feel worthy of attention

What is Unique About Attachment Theory?

- Taps an individual's cognitive-emotional schema
- May explain "irrational" health behavior better than direct questioning or assessment

Attachment Theory



Secure Attachment Style

- Also known as "*collaborative relationship style*"
- 55-60% general population
- 40-45% clinical population
- Consistently responsive caregiving
- Positive view of self/other
- Actively seek out support
- Are readily comforted
- Clinically: develop collaborative working relationships

Secure Attachment Style

Interactive-Collaborative Relationship Style

Fearful Attachment Style

- Also known as "*cautious relationship style*"
- 10% general, 12-22% clinical populations.
- Consistently unresponsive, harsh caregiving
- Negative view of self/ negative view of other
- **Low level of trust of others**
- **Approach-avoidance behavior**
- **Low self-esteem, high "negative affect"**
- Clinically: Low/chaotic utilization, high symptom reporting

“I worry that I will be hurt if I allow myself to become too close to others”

- I will be hurt
- I will be rejected
- I will be abandoned
- I will be lonely

- I am uncomfortable getting close to others
- I find it difficult to depend on others
- I find it difficult to trust others

- “Go-it-alone” attitude
- Poor collaboration
- Missed appointments
- Poor self-management
- Dissatisfaction
- Poor outcomes

Fearful Attachment Style

Independent-Cautious Relationship Style

Dismissing Attachment Style

- Also known as "*self-reliant relationship style*"
- 25% general, 35% clinical population
- Consistently unresponsive caregiving
- Negative view of other/positive view of self
- **Compulsively self-reliant**
- **Low level of trust of others**
- Clinically: low level of collaboration, lower clinic attendance, poorer adherence to treatment

“I prefer not to depend on others or have others depend on me”

- I will be hurt
- I will be rejected
- I will be abandoned
- I will be lonely

- I am uncomfortable getting close to others
- I find it difficult to depend on others
- I find it difficult to trust others

- I prefer not to depend on others
- It is important for me to be independent
- It is important for me to be self-sufficient

- “Go-it-alone” attitude
- Poor collaboration
- Missed appointments
- Poor self-management
- Dissatisfaction
- Poor outcomes

Dismissing Attachment Style

Independent-Self-Reliant Relationship Style

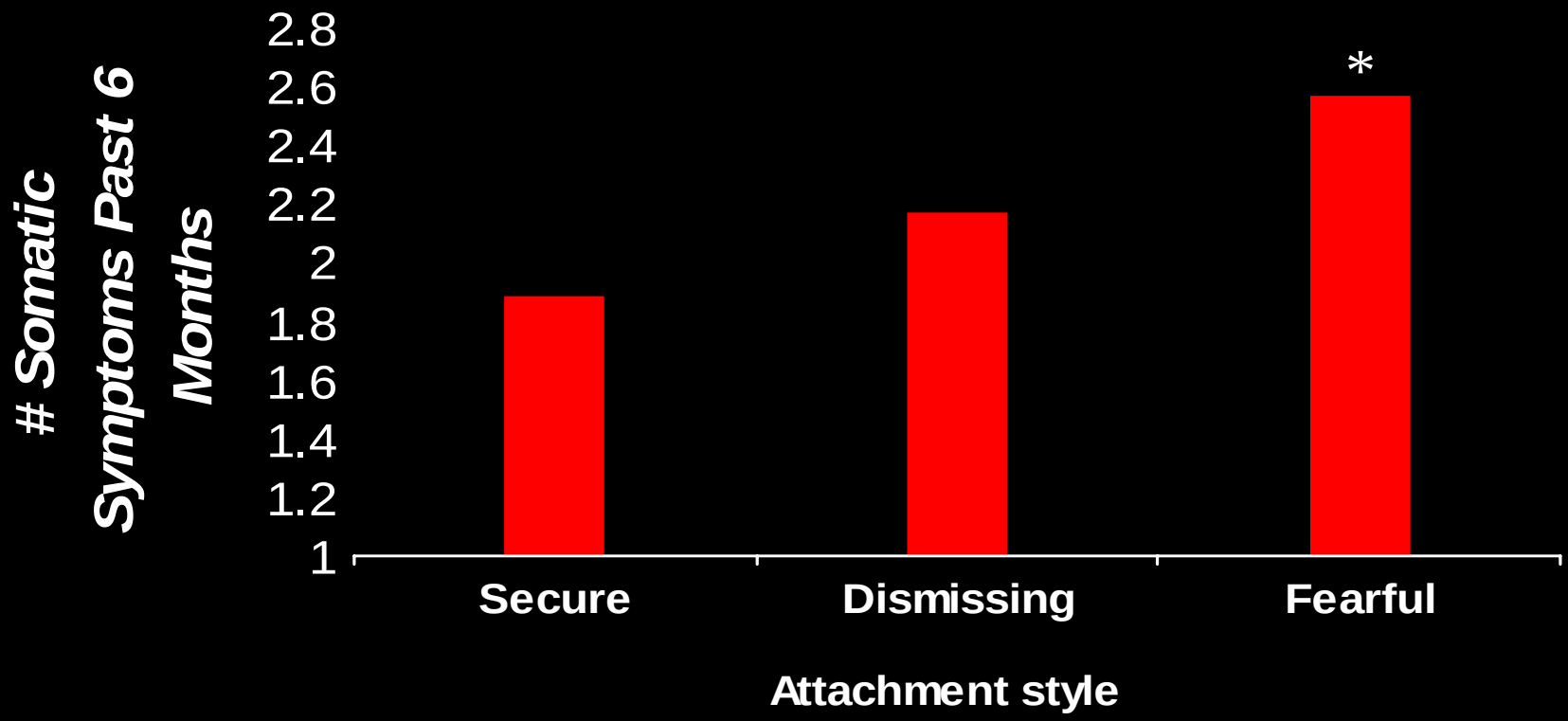
Preoccupied attachment style

- Also known as "*support-seeking relationship style*"
- 10% - 15% of the general population
- Negative view of self/ positive view of other
- Inconsistently responsive caregiving
- **Overly reliant on others**
- **Low self-esteem, high "negative affect"**
- Clinically: High utilization, high symptom reporting

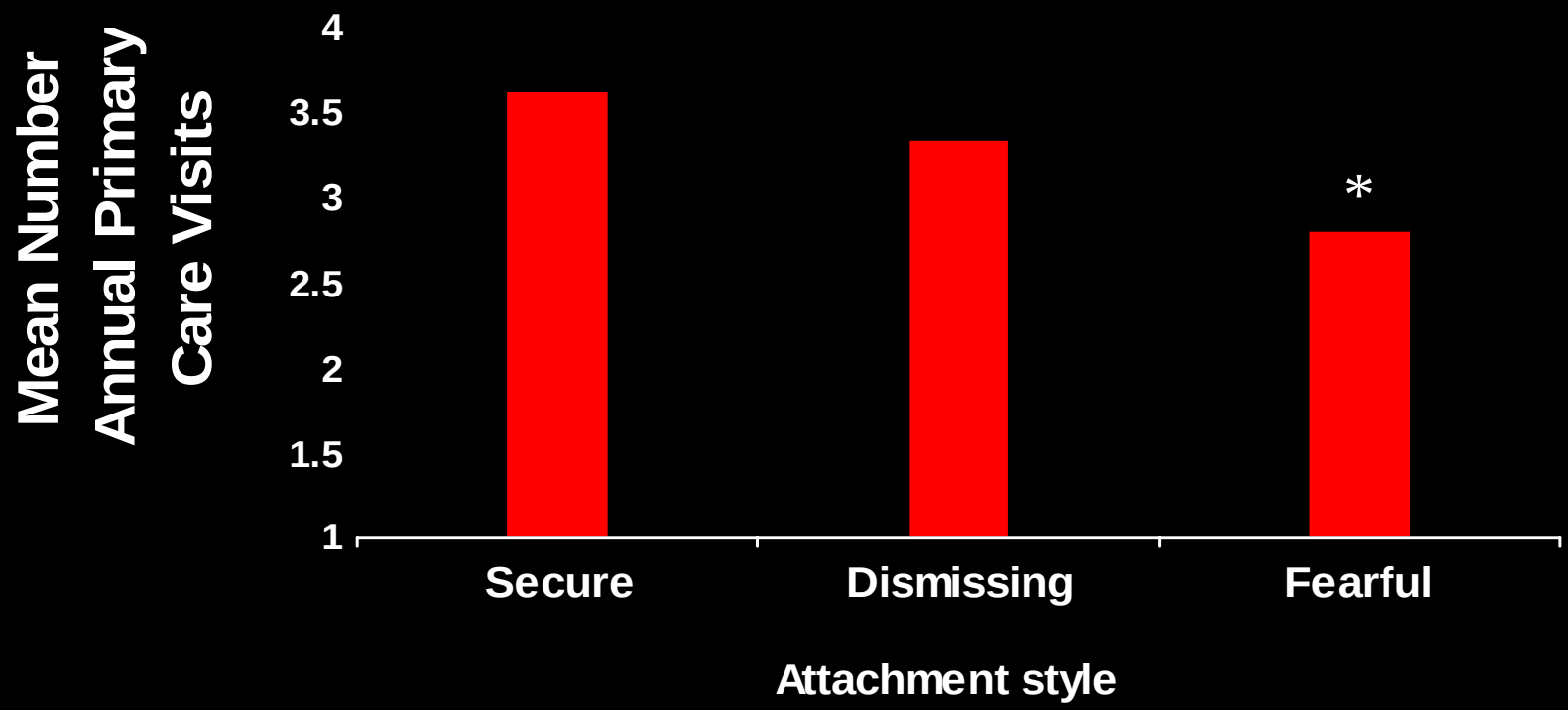
Preoccupied attachment style: Developmental experience

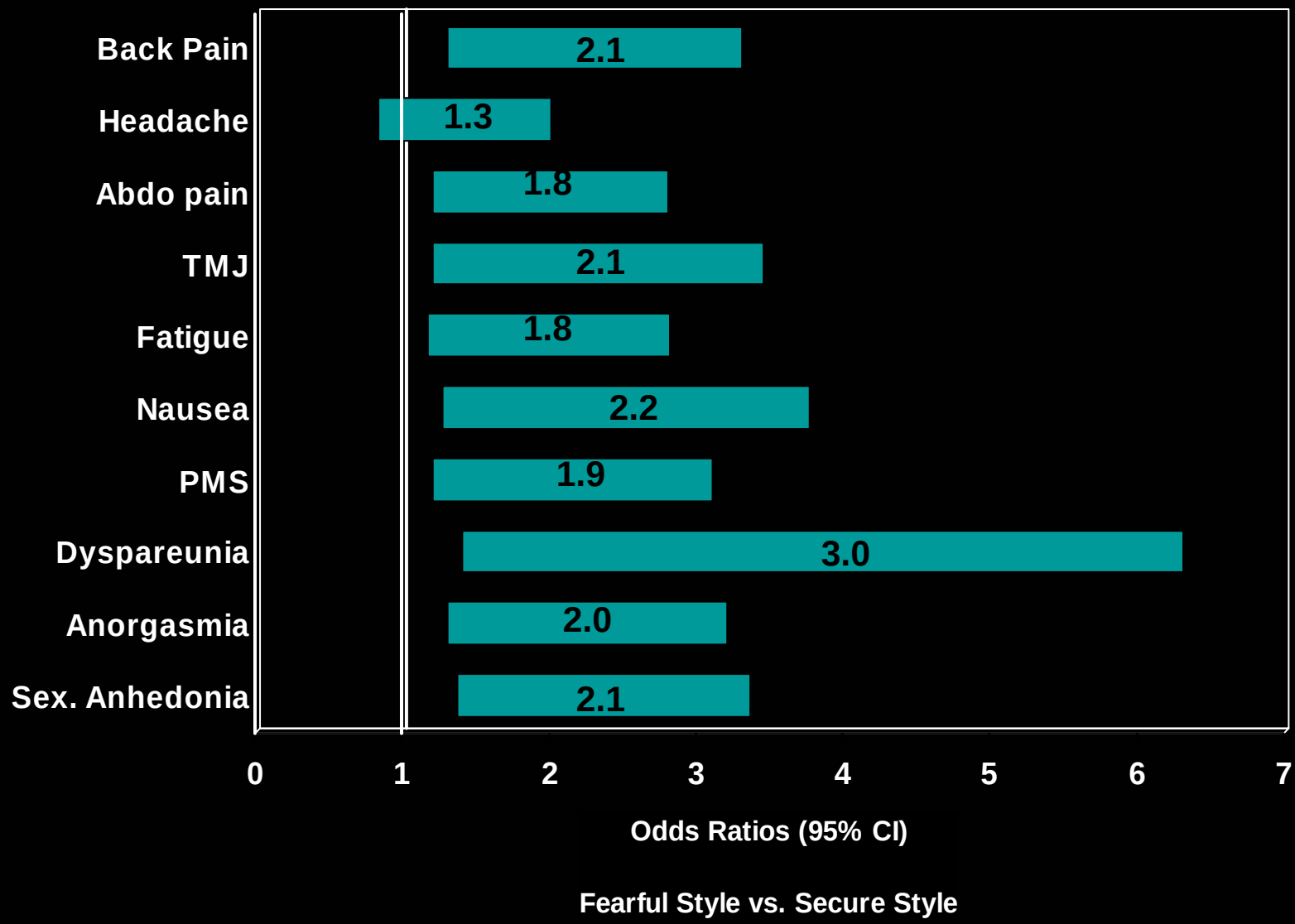
"Slot Machine Caregiving"

Symptom Reporting & Attachment Style



Primary Care Visits & Attachment Style



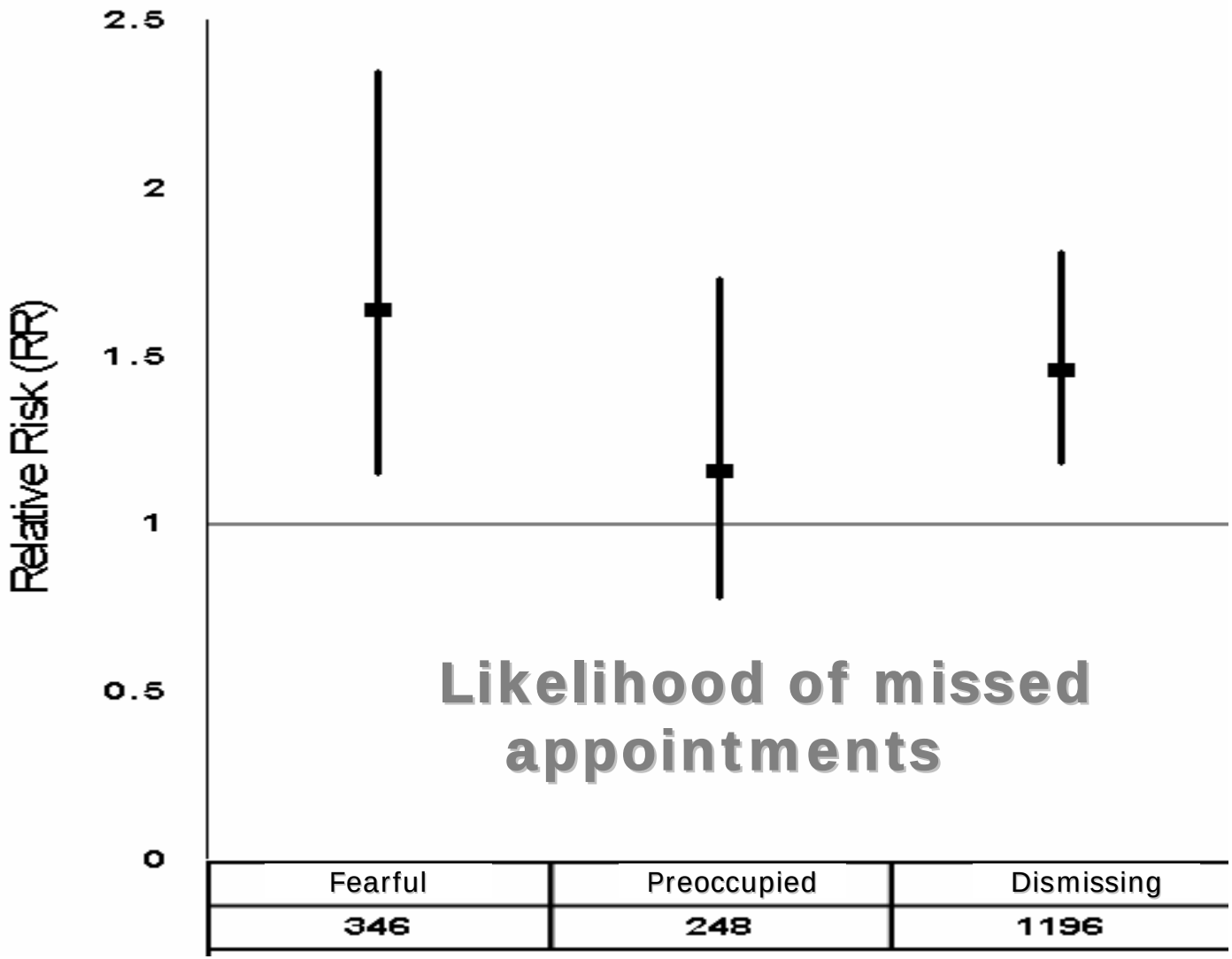

Back Pain
Headache
Abdo pain
TMJ
Fatigue
Nausea
PMS
Dyspareunia
Anorgasmia
Sex. Anhedonia
2.1
1.3
1.8
2.1
1.8
2.2
1.9
3.0
2.0
2.1
0
1
2
3
4
5
6
7
Odds Ratios (95% CI)
Fearful Style vs. Secure Style

Where is the patient?

In a sample of 3,923 primary care patients with type 2 diabetes, those with fearful attachment style had:

- fewer scheduled preventative care visits (OR = .75, 95% CI = .61, .92)
- more scheduled same day appointments ($p<.05$)
- more missed scheduled same day appointments ($P<.01$).

Where is the patient?

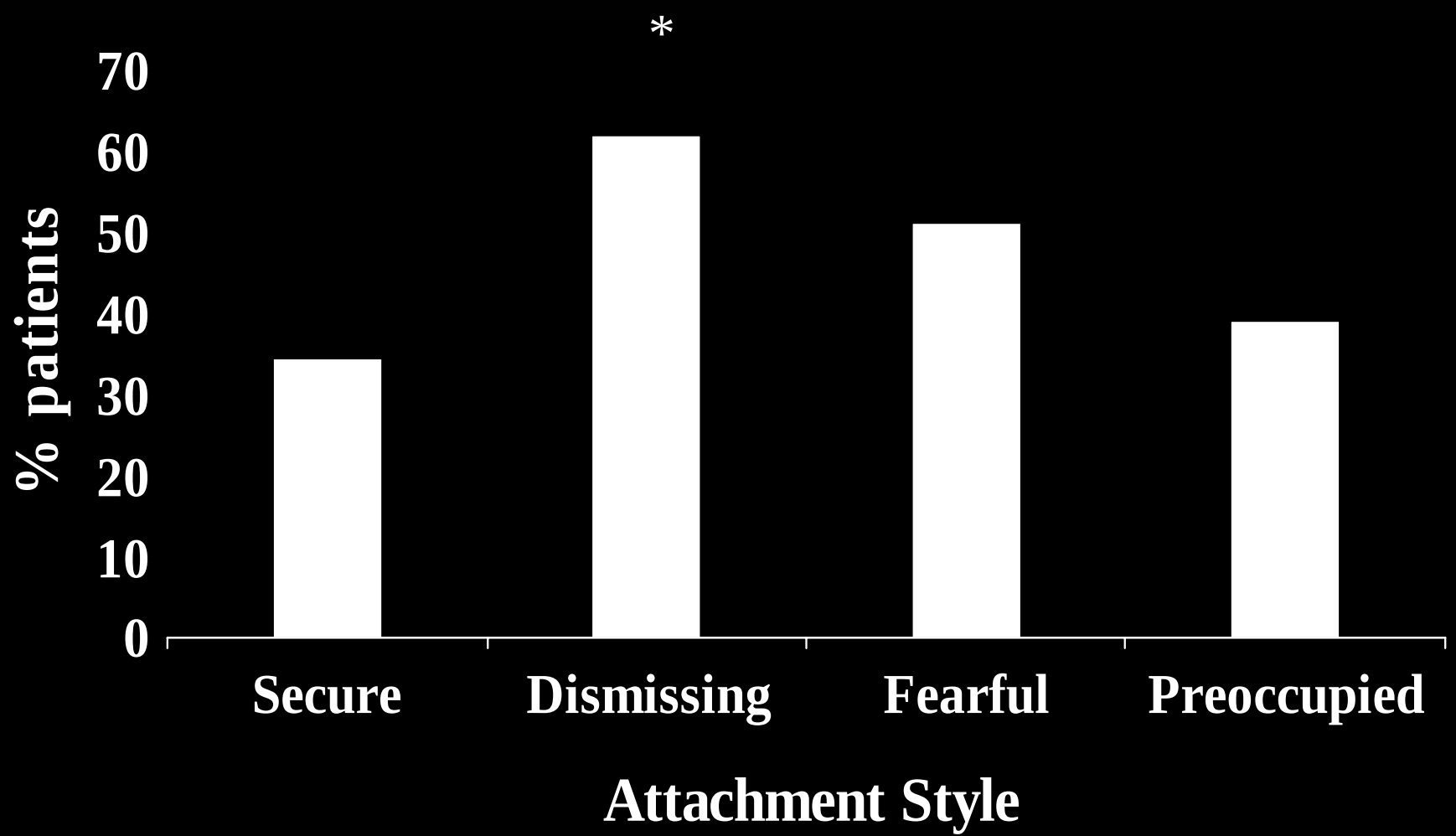


Adherence domain	Dismissing style (N=1463; 35.7%)	
	Odds Ratio†	95% CI
General diet non-adherence	1.41	1.17, 1.69
Exercise non-adherence	1.36	1.13, 1.62
Foot care non-adherence	1.21	1.02, 1.45
Current smoker	1.42	1.08, 1.86
Oral hypoglycemic agents (<80% adherent)	1.23	1.01, 1.51

† Reference group = Secure style (N=1806; 44.1%)

Hb_{A1c} Levels & Attachment Style Category

% Patients with Hb_{A1c} Levels Greater Than or Equal to 8%



Provider Attachment Styles

- Providers, like their patients, have varying degrees of losses, abandonment, and adverse caregiving experiences.
- Providers vary in the degree to which they have reconciled or come to terms with these relationships.

Attachment Styles Among Medical Students

Attachment style	% of class (N=144)
Secure	
Fearful	
Preoccupied	
Dismissing	

Attachment Styles Among Medical Students

Attachment style	% of class (N=144)
Secure	
Fearful	
Preoccupied	
Dismissing	19.4%

Attachment Styles Among Medical Students

Attachment style	% of class (N=144)
Secure	55.6%
Fearful	
Preoccupied	
Dismissing	19.4%

Attachment Styles Among Medical Students

Attachment style	% of class (N=144)
Secure	55.6%
Fearful	13.2%
Preoccupied	
Dismissing	19.4%

Attachment Styles Among Medical Students

Attachment style	% of class (N=144)
Secure	55.6%
Fearful	13.2%
Preoccupied	11.8%
Dismissing	19.4%

Attachment-Focused Diabetes Care

1. Determine the relationship (attachment) style of the patient using the RQ or RSQ

Please rate each of the following relationship styles according to the extent to which you think each description corresponds to your general relationship style.

Style A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

Not at all like me			Somewhat like me			Very much like me
1	2	3	4	5	6	7

Style B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

Not at all like me			Somewhat like me			Very much like me
1	2	3	4	5	6	7

Style C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

Not at all like me			Somewhat like me			Very much like me
1	2	3	4	5	6	7

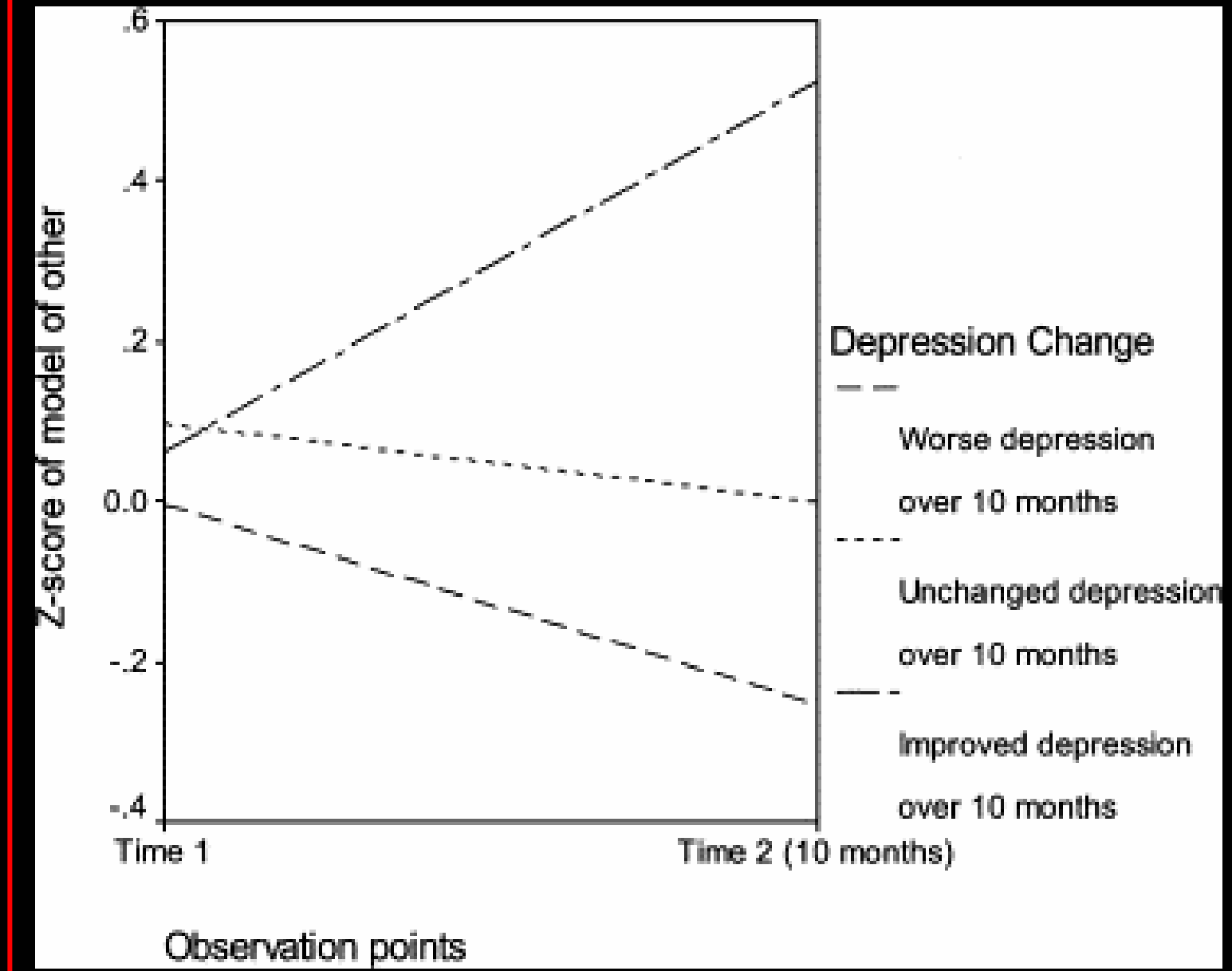
Style D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Not at all like me			Somewhat like me			Very much like me
1	2	3	4	5	6	7

After reading each of the relationship styles described (Styles A through D), please CIRCLE the letter corresponding to the style **that best describes you**:

Style **A** **B** **C** **D** (circle one letter)

2. Determine if concurrent distress, anxiety or depression exist (in patient!) and treat


.6
.4
.2
0.0
-.2
-.4
Z-score of model of other
Time 1
Time 2 (10 months)
Observation points
Depression Change
Worse depression over 10 months
Unchanged depression over 10 months
Improved depression over 10 months

3. Consider “ecological” factors (what does our health care system/clinic “say” to patient)

Institute of Medicine and American Hospital Association/ Picker Institute:

- “Nightmare to navigate”
- Poor access
- Significant waiting times
- Frequent handoffs
- Infrequent follow-up
- Rushed, complex, impersonal
- Reliance on in-person physician visits
- Many inefficiencies and fragmentation in information systems
- Perception that the system blocked access, reduced quality and limited spending for care at the expense of patients

- I will be hurt
- I will be rejected
- I will be abandoned
- I will be lonely

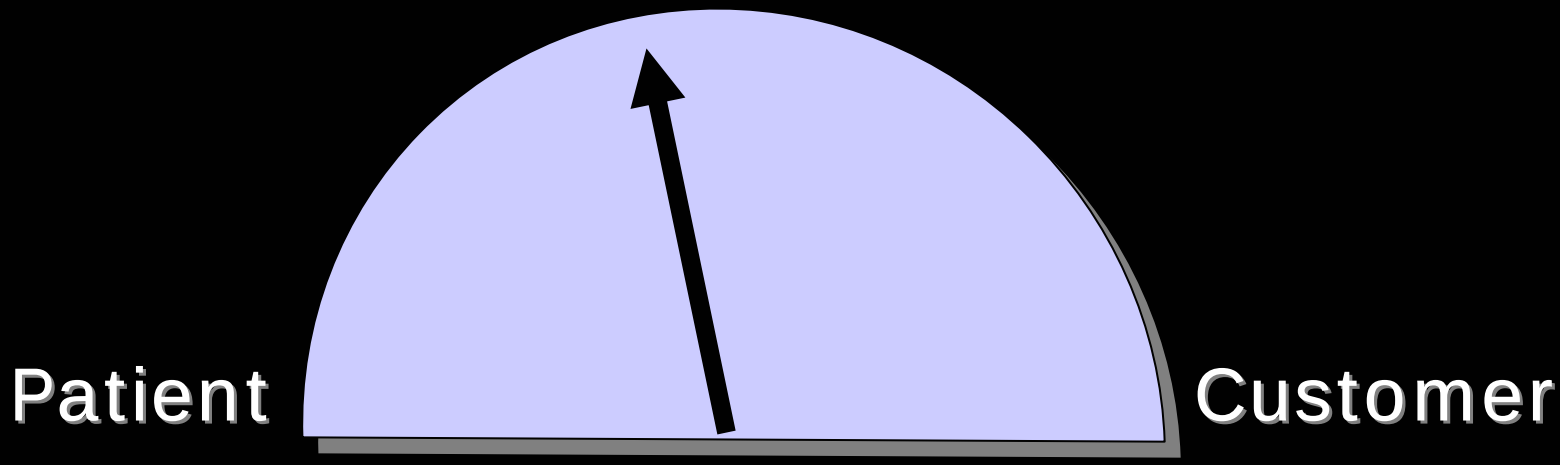
- I am uncomfortable getting close to others
- I find it difficult to depend on others
- I find it difficult to trust others

- I prefer not to depend on others
- It is important for me to be independent
- It is important for me to be self-sufficient

- "Go-it-alone" attitude
- Poor collaboration
- Missed appointments
- Poor self-management
- Dissatisfaction
- Poor outcomes

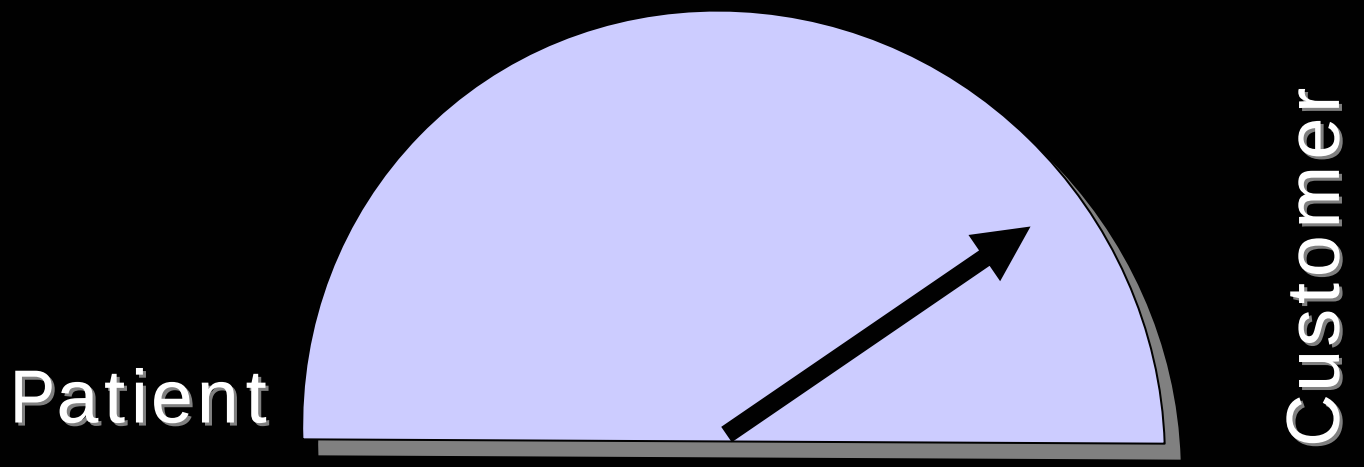
<u>Characteristics of Health Care System:</u> rushed, impersonal, long waiting times, perception that providers block access to care, being seen depends on payment, focus on disease not individual

The Patient-CustoMeter



Mayer and Cates, JAMA, 1999

The Patient-CustoMeter



Mayer and Cates, JAMA, 1999

the ten demandments

rules to live by in the age of the demanding customer

kelly mooney
with laura bergheim

clear communication

customer relevant education and information

continuous access, multiple modes of access

capacity to receive a response in a timely fashion

empowerment of customers, provision of choice

use of automated processes to ensure greater control & speed

product/service expertise

attentive listening to customers

development of an action plan

4. Examine day-to-day and reciprocal healthcare provider behavior (do we co-create difficult patients?)

- I will be hurt
- I will be rejected
- I will be abandoned
- I will be lonely

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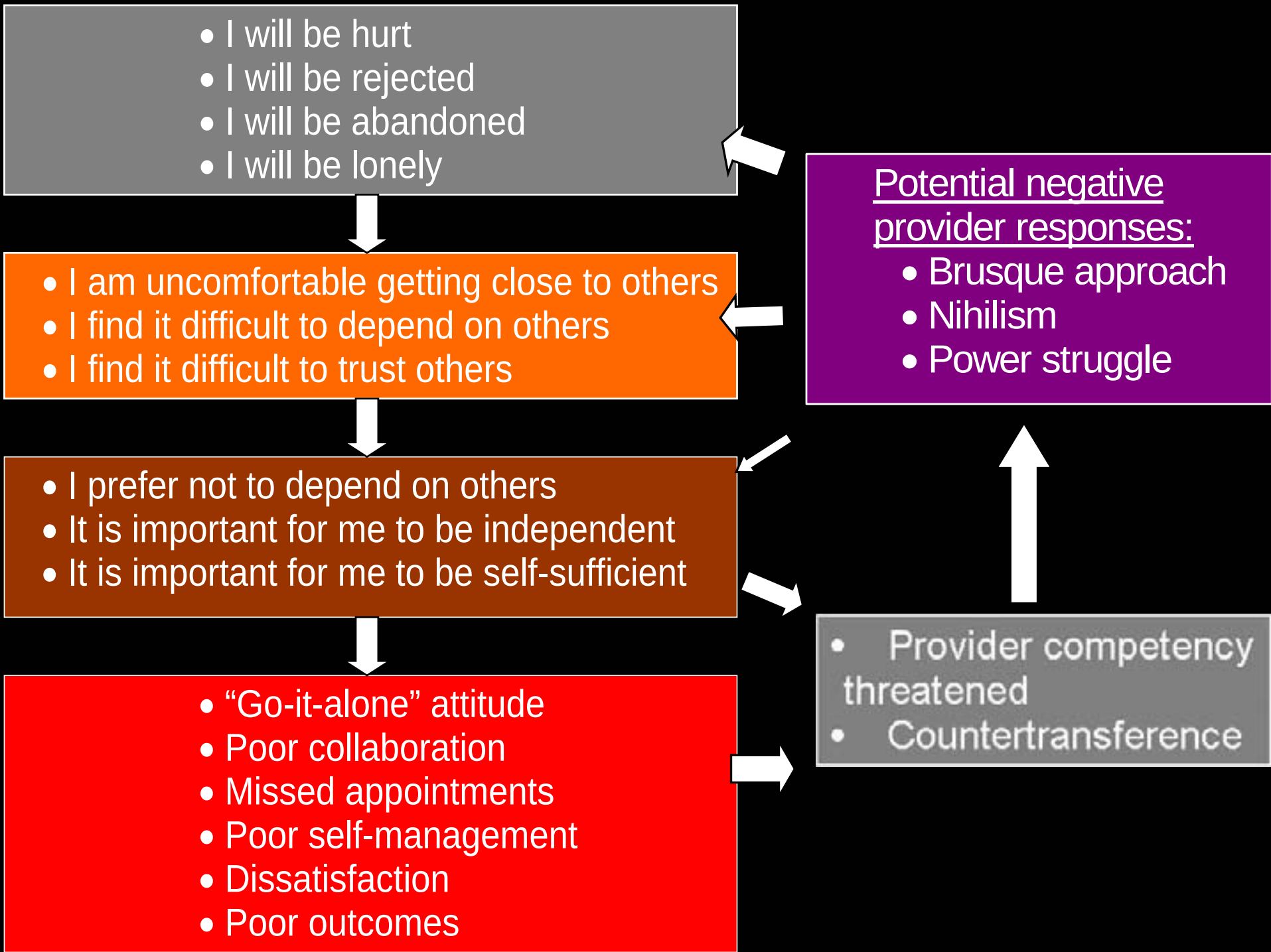
- "Go-it-alone" attitude
- Poor collaboration
- Missed appointments
- Poor self-management
- Dissatisfaction
- Poor outcomes

<u>Characteristics of Providers:</u>
rushed, impersonal, guideline-focused, "wall" between patient and provider, focus on disease outcomes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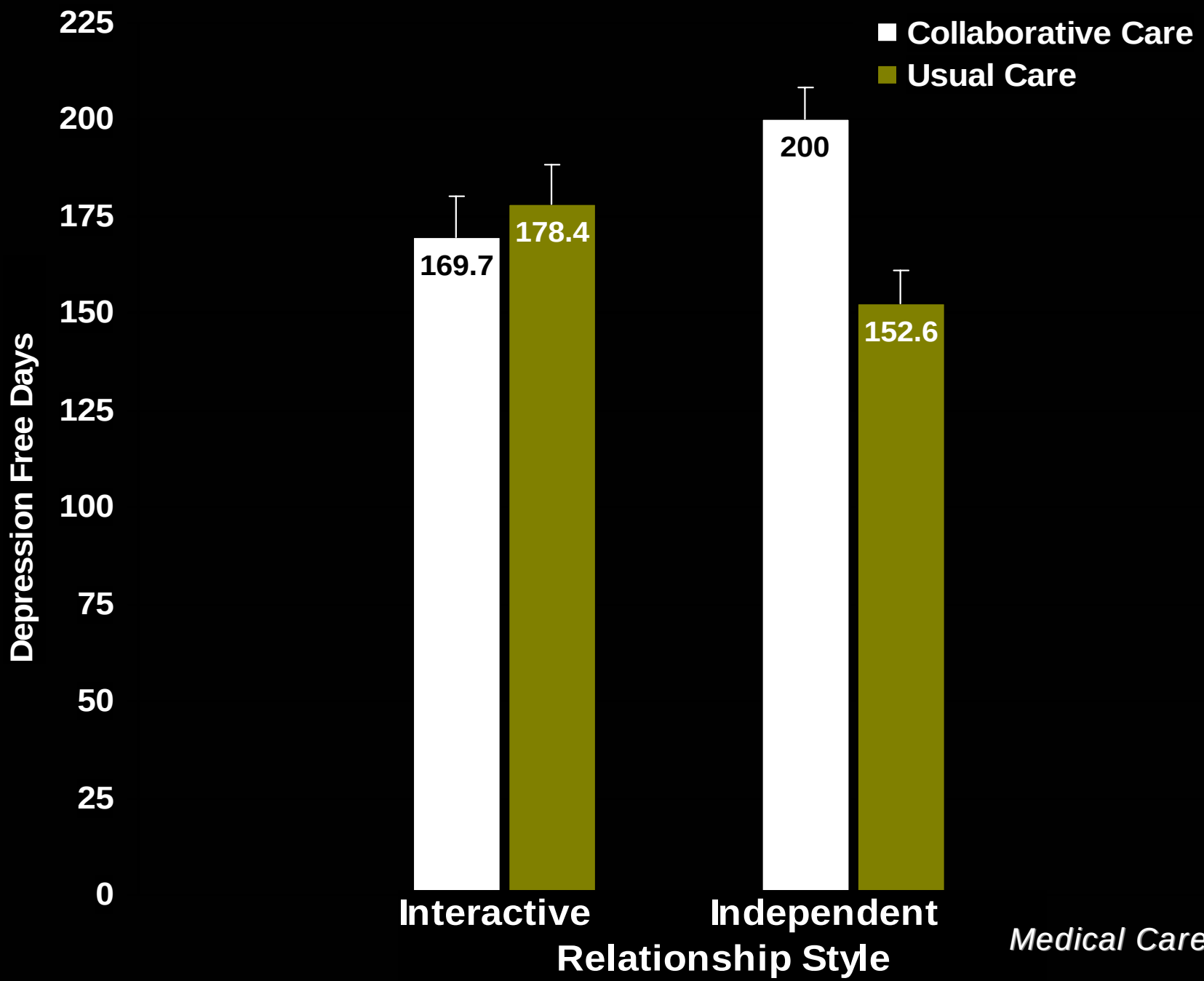
• I find it difficult to depend on others
• I find it difficult to trust others
• I prefer not to depend on others
• It is important for me to be independent
• It is important for me to be self-sufficient
• "Go-it-alone" attitude
• Poor collaboration
• Missed appointments
• Poor self-management
• Dissatisfaction
• Poor outcomes
Potential negative provider responses:
• Brusque approach
• Nihilism
• Power struggle
• Provider competency threatened
• Countertransference

5. Take a collaborative care approach to tailor patient's diabetes health care



Medical Care, 2006

6. Help independent patients maintain autonomy by developing domains of interdependence

AADE7 Self-Care Behaviors

Healthy Eating

Being Active

Monitoring

Taking Medication

Problem Solving

Healthy Coping

Reducing Risks

Diabetes Control

Collaborative Care

Relationships and diabetes self-care

Medication-taking

- insulin-taking and knowledge of dosing
- fears of hypoglycemia and an action plan which may include depending on others
- reminders to take medications
- interactions with health care providers
- picking up medications from pharmacy to prevent lapses

Relationships and diabetes self-care

Key educational areas for insulin management

- How to monitor glucose levels and use the information for decision-making
- Basal/bolus concept of diabetes management
- How to draw up & inject correct insulin dose
- Making anticipatory and compensatory adjustments
- Preventing, recognizing and treating hypoglycemia

Funnell et al., 2004

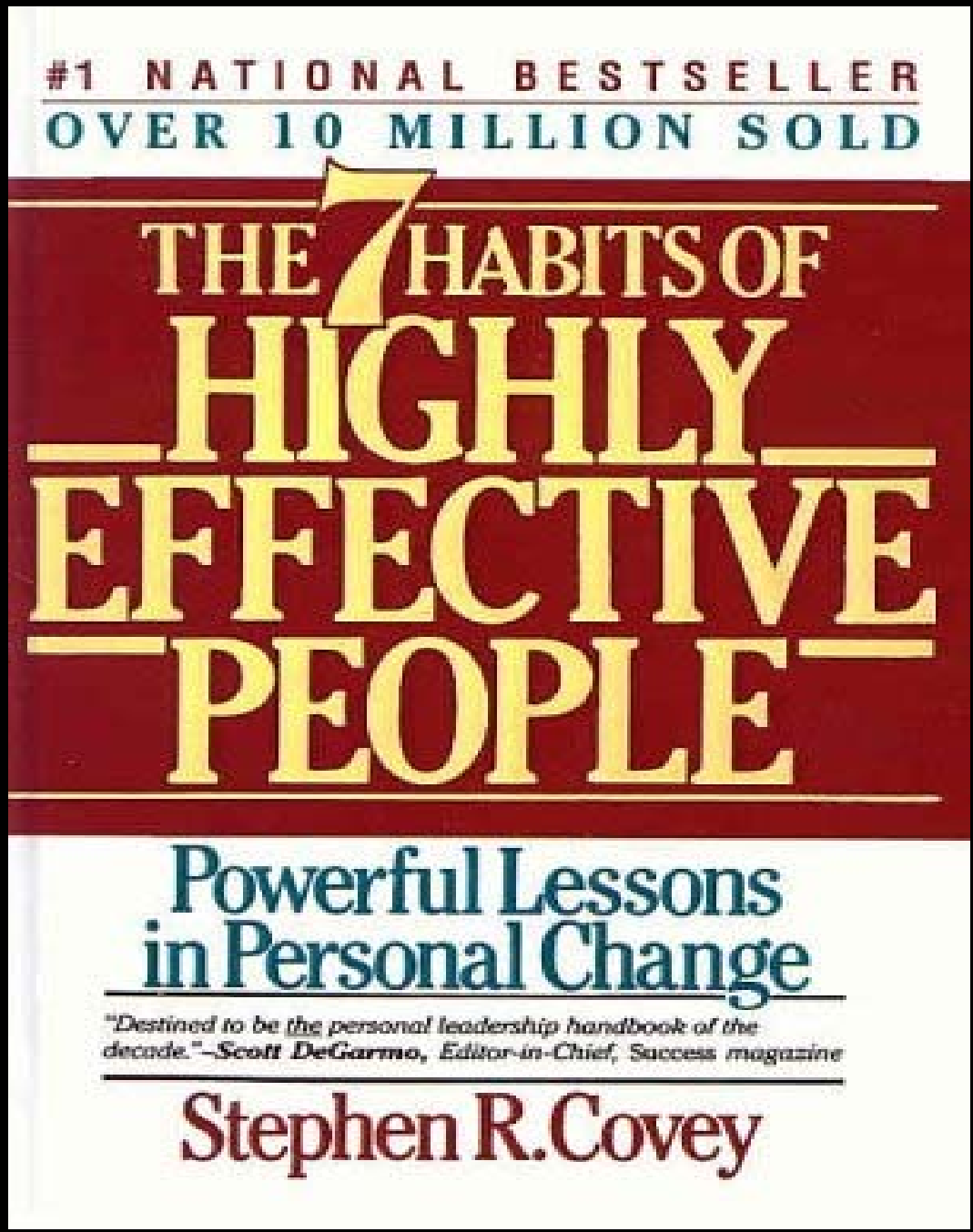
Relationships and diabetes self-care

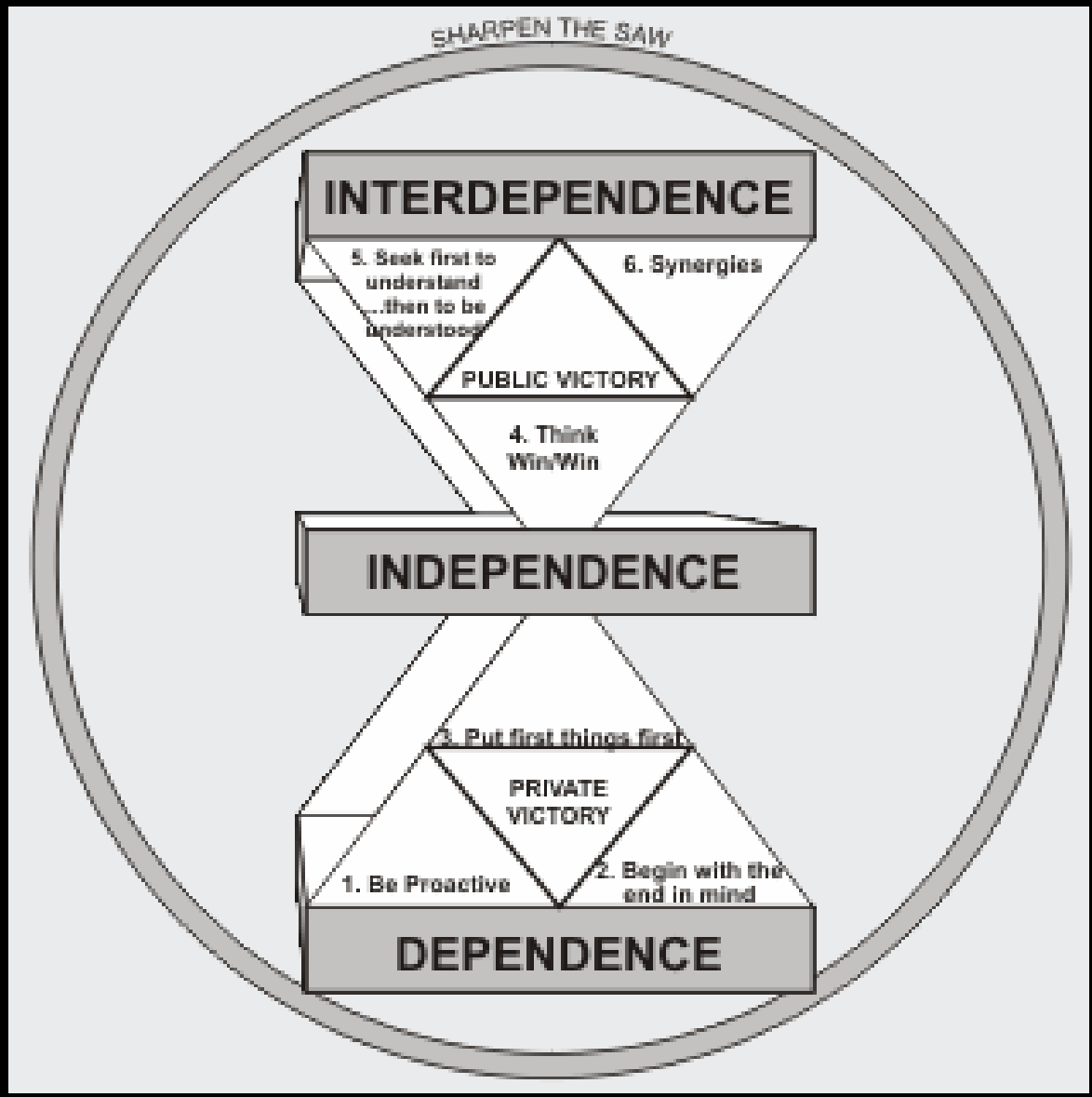
Health care appointments

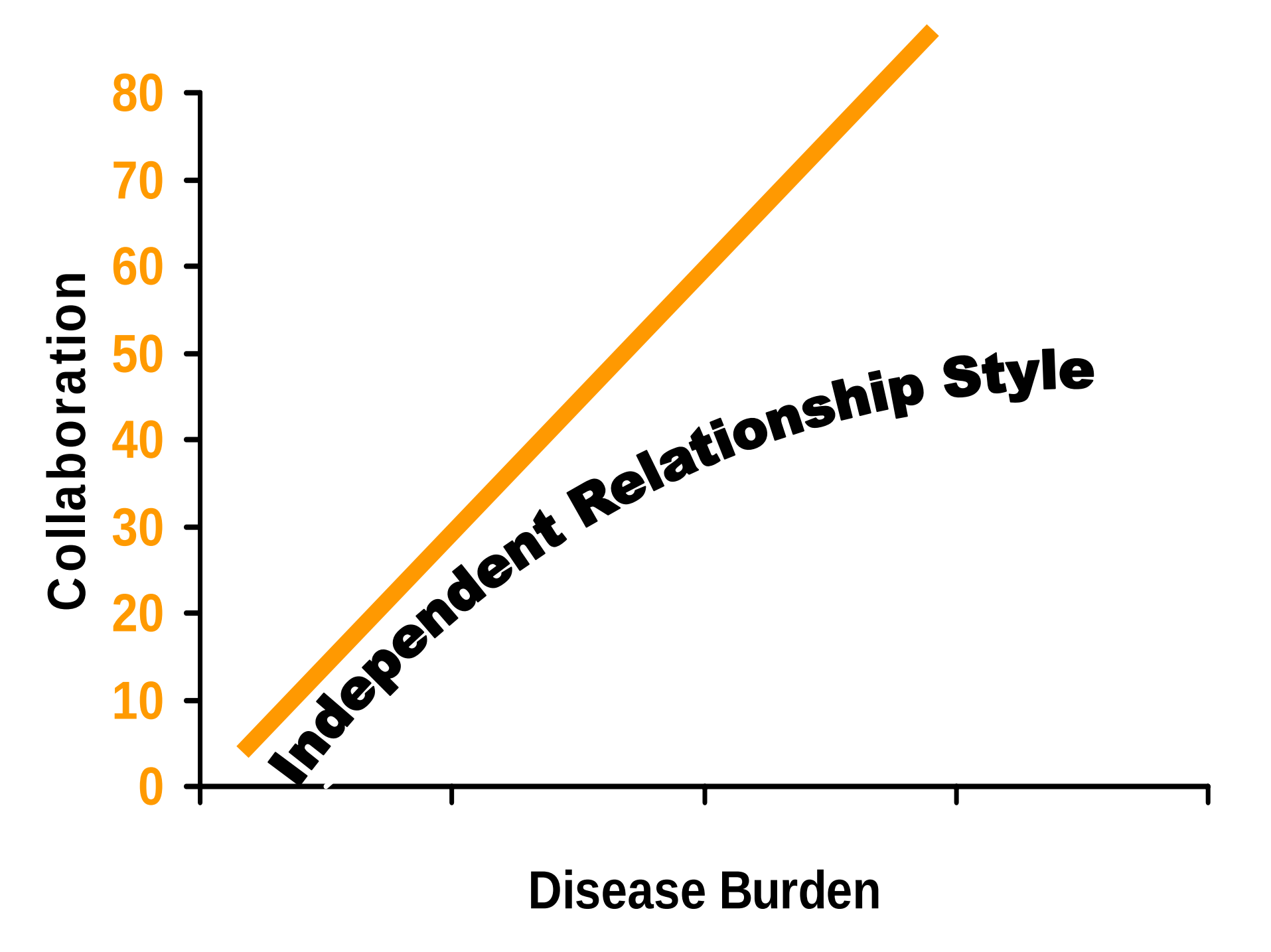
- developing a regular, trusting relationship with providers around diabetes management
- sharing with providers one's results and discussing daily challenges of self-care
- education about diabetes, the disease process & optimal self-management behaviors
- "shared care" or "collaborative care"

Diabetes Self-care Behaviors/Tasks

Relationship-dependent	**“Solo”**
Diet	Glucose monitoring
Exercise	Medication taking
Smoking cessation?	Smoking cessation?
Health visits?	Health visits?


#1 NATIONAL BESTSELLER
OVER 10 MILLION SOLD
THE 7 HABITS OF HIGHLY EFFECTIVE PEOPLE
Powerful Lessons in Personal Change
"Destined to be the personal leadership handbook of the decade."–Scott DeGarmo, Editor-in-Chief, Success magazine
Stephen R. Covey


SHARPEN THE SAW
INTERDEPENDENCE
5. Seek first to understand ...then to be understood
6. Synergies
PUBLIC VICTORY
4. Think Win/Win
INDEPENDENCE
3. Put first things first
PRIVATE VICTORY
1. Be Proactive
2. Begin with the end in mind
DEPENDENCE


80
70
60
50
40
30
20
10
0
Collaboration
Independent Relationship Style
Disease Burden

7. Consider including family members or important others in diabetes health care

Working with Fearful (Cautious) Relationship Style

What works:

- decreasing threat of intimacy
- “clinic” as provider
- use of telephone check-ins/ appointments
- population-based patient tracking, reminders, proactive contact
- develop dependency in isolated domains

Working with Fearful (Cautious) Relationship Style

What works:

- decreasing threat of intimacy
- “clinic” as provider
- use of telephone check-ins/ appointments
- population-based patient tracking, reminders, proactive contact
- develop dependency in isolated domains

What doesn’t work:

- expecting frequent appointments
- excessively exploring feelings about…
- exerting “control” or overemphasizing a poor prognostic course if nonadherent

Working with Dismissing (Self-Reliant) Attachment Style

What works:

- increasing patient autonomy
- motivational approaches
- use of telephone check-ins/ appointments
- population-based patient tracking, reminders, proactive contacts
- develop dependency in isolated domains

Working with Dismissing (Self-Reliant) Attachment Style

What works:

- increasing patient autonomy
- motivational approaches
- use of telephone check-ins/ appointments
- population-based patient tracking, reminders, proactive contacts
- develop dependency in isolated domains

What doesn't work:

- frequent appointments
- excessively exploring feelings about…
- exerting "control" or overemphasizing a poor prognostic course if nonadherent
- unconsciously neglecting to keep these patients in active treatment

Working with Preoccupied (Support-Seeking) Attachment Style

What works:

- *frequent*, *regular* and *brief* appointments
- firm patient-provider boundaries
- exploring feelings about…
- being aware of your countertransference

Working with Preoccupied (Support-Seeking) Attachment Style

What works:

- *frequent*, *regular* and *brief* appointments
- firm patient-provider boundaries
- exploring feelings about…
- being aware of your countertransference

What doesn't work:

- p.r.n. (as needed) appointments and phone calls
- excessive laboratory and radiological testing
- patient seeing multiple providers