

Reimagining Relationship-Based Health Care in a Post-COVID World

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Kimberly N Hutchison, MD, FAASM, DABSM¹,
Jennifer Sweeney, MA², Christine Bechtel, MA²,
and Brian Park, MD, MPH^{3,4}

Abstract

The US health care system has a long history of discouraging the creation and maintenance of meaningful relationships between patients and providers. Fee-for-service payment models, the I-directional, paternalistic approach of care providers, electronic health records, and documentation requirements, all present barriers to the development of meaningful relationships in clinic visits. As patients and providers adopt and experiment with telemedicine and other systems changes to accommodate the impact of Coronavirus disease 2019, there is an opportunity to reimagine visits entirely—both office-based and virtual—and leverage technology to transform a unidirectional model into one that values relationships as critical facilitators of health and well-being for both patients and providers.

Keywords

clinician–patient relationship, patient/relationship centered skills, COVID-19, empathy, patient satisfaction

The Coronavirus disease 2019 (COVID-19) pandemic has necessitated unprecedented changes in health care, such as the rapid adoption of telemedicine. This overnight transition to virtual visits during the pandemic shows that system-wide change can be accomplished.

The US health care system has a long history of discouraging the creation and maintenance of meaningful relationships and continuity, a shortcoming that affects both patients and clinicians (1). As patients and providers adopt and experiment with telemedicine and other systems changes to accommodate the impact of COVID-19, there is an opportunity to reimagine visits entirely—both office-based and virtual—and leverage technology to transform a traditionally transactional model to a relationship-based model of care.

Four Barriers to Relationship-Based Care

There is now an opportunity to build a relational, person-centered health care system, one that maintains clinician well-being by reimagining the core of the health care encounter—the office “visit.” Our system is designed to force trade-offs; for example, relationship building and connection take time, but fee-for-service medicine incentivizes providers to see more patients in less time. We have identified 4 primary reasons why relationship-building between

providers and patients will remain challenged, unless visits are reimagined:

1. The fee-for-service payment system disincentivizes emotional connection by rewarding short patient encounters. Many health care systems limit the length of the appointment to accommodate as many patients per day as possible. Clinicians must meet “productivity requirements” on which salaries are based. This approach to payment values volume over relationship and limits the major commodity that healthy relationships need to flourish: time.
2. Health care has traditionally reserved the role of “expert” for clinicians and labeled patients as either “compliant” or “noncompliant.” This paternalistic approach diminishes the lived experience of the patient as an expert of their own bodies, emotions,

¹ Oregon Health and Science University, Portland, OR, USA

² X4Health and Patient Advocate, Washington DC, USA

³ Family Medicine, Oregon Health & Science University, Portland, OR, USA

⁴ Relational Leadership Institute, Portland, OR, USA

Corresponding Author:

Jennifer Sweeney, X4Health and Patient Advocate, Washington DC, USA.
Email: jsweeney@x4health.com



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and perceptions. Patients have preferences and limitations that impact their success with prescribed treatments. When these preferences are not heard, the individual is devalued and treatment plans are more likely to fail (2).

3. Electronic health records (EHRs) feature too prominently. Clinicians in the outpatient setting report spending approximately 50% of their workday on EHRs (3), often making technology a barrier, rather than a tool to enhance the patient and provider connection. Burnout rates are significantly higher in providers who use EHRs (4).
4. Quality metrics and documentation requirements for reimbursement have taken over the visit note, turning this foundational communication tool into technicalities rather than a thoughtful narrative honoring the clinicians' and patients' shared goals. In addition, checklists and pre-written templates have become standard, forcing patient responses into yes/no paradigms that do not represent the individual experience.

As the health care system transitions toward more widespread use of virtual visits, these barriers to relationship-based care are at risk of intensifying. For example, some telemedicine services automatically cut the visit off after a specified time, regardless of whether the clinician and patient have accomplished their goals. This disincentivizes the nonclinical discussions that strengthen human connection. Further, virtual visits rely heavily on eye contact to establish trust and to build relationships. Maintaining eye contact via a camera is challenging, but it becomes nearly impossible when providers must also document minutiae in an EHR.

Reimagining the Patient–Provider Visit

We imagine shifting the paradigm of the visit from medical problem-solving alone to a focus on generating mutual human connection; from providing health care services to promoting health. This would require patients and providers to open their minds beyond a 1-directional model (providers treating patients) and the system (eg, payers) to adapt new documentation models that prioritize connection between 2 humans with a shared health goal.

Relationships are bidirectional, fulfilling, and facilitate health and well-being. They are central to high-quality care (5). Relationships are the basis for trust, which has been shown to facilitate better health outcomes and make clinicians feel more effective (6). A continuous relationship improves patients' ability to follow recommendations and providers' ability to make treatment recommendations that account for patients' values and preferences. Relationships also create more professional enjoyment and less clinician burnout (7).

Four Essential Relational Components

If we believe bidirectional relationships are central to promoting health, patients and providers would have the opportunity to engage in visits differently. There are 4 ways to make visits more meaningful:

1. **Humanity-focused preparation:** Clinicians would have protected time to review patient health information and personal circumstances in advance. They would create an agenda that includes a human-centered connector, such as “Last time we met, you were going on vacation—how was it?” Patients would also set their agenda in advance and be encouraged to think about health and its drivers, not just specific medical advice. Technology would enable both clinicians and patients to cocreate an agenda ahead of time, prompting both to share their top priorities and display that at the time of visit.
2. **Equality and bidirectional empathy:** Patients and providers would take the time to connect as human beings and extend empathy to each other. Providers have technical clinical knowledge, experience, and are trained problem solvers. Patients have deep lived experience and expertise in their own health, community, profession, and life. The combination of these 2 knowledge sets is powerful. When clinicians create rapport and understanding with patients, patient respect for them and the profession increases. Lessons from the national program *3rd Conversation* indicate that patients have a significant and welcome role to play in facilitating human connection with clinicians as individuals. Doing so invites clinicians to share their full selves, be more present, and experience the joy of human connection. Appropriate guidelines can be created to maintain professionalism and a focus on the best treatment for the individual. When patients feel connected to their providers as people, they are more able to share gratitude and empathy for the clinician as a person, which in turn boosts clinician well-being and engagement.
3. **Strengths-based problem-solving:** Visits would begin with patients' strengths. The medical model traditionally positions the patient experience from a place of deficit, pathology, and problems to be fixed by the provider. This mindset risks obscuring patients' strengths, resiliency, and resources. By acknowledging patients' strengths, the focus of the encounter centers on assets to build upon and solutions that are working. Focusing on past successes can improve self-efficacy, which correlates to positive health outcomes and encourages self-management (8,9). Acknowledging patients' achievements not only builds trust but affirms that they have someone in their corner, which is an important factor supporting strong, continuous relationships (10). Identifying

individual, incremental successes also allows clinicians to emphasize what they believe are the important contributors to successfully following the shared care plan as well as lean on those strengths to problem solve.

4. **Holistic focus:** As we expand our understanding of the mechanisms of the mind, we further understand its impact on our physical body. It's time to "retool our tools" to incorporate mental and emotional well-being and reclaim the health care system's role in healing. The separation of physical health from mental wellness divides 2 highly interdependent components of the human experience. In addition, visits would prioritize the primary drivers of health: social needs and social determinants of health. Social needs include food, housing and job security, and social determinants of health emphasize factors that influence access to those needs, such as systemic racism and sexism. These factors account for the majority of an individual's health outcomes (11), and yet have been relegated to "someone else's" domain outside the health system, further fragmenting the provider-patient relationship and limiting our ability to address the structural issues that created inequities in the first place. Relationship-based health care visits would assess the social context of a patient's life, not only to address causes of health but to better understand the patient's reality. This can be further supported with self-management and skill development programs that boost self-reliance and healthy decision-making.

Four System Changes for Relational Care

Patients and providers can be influential in transforming visits to be more relational, but the system itself plays an important role in allowing this to happen. To evolve to a place in which bidirectional relationships are central to promoting health, the system will need to finance care delivery and payment differently:

1. **Adequate appointment lengths and meeting tools:** Appointments would be longer. Corporations do not thrive on 15-minute meetings; how can they be adequate for intricate human interactions surrounding complex medical conditions? Prior "humanity focused" preparation can also help patients and clinicians use the time they have more effectively. Just as many businesses use templated meeting agendas, establish meeting norms, and implement bidirectional feedback at the end of meetings to be more efficient, these kinds of practices from organizational development could be incorporated into health visits.
2. **Coordinated access to a holistic team:** Patients and providers would have access to an interprofessional support team, including coaches, behavioral health

clinicians, community resource specialists, peer mentors, EHR experts, medical assistants, and more. We expect health professionals to play far too many roles, perhaps as a reflection of the individualistic, self-sufficient, "hero" model of physician identity. On the patient side, it is past time we made navigating both the health care system and community supports far easier. If we want patients to "take charge of their health," and we know that health is driven mainly by factors other than medical knowledge, we must organize a cross-functional team that can bridge the boundaries between our medical care system and our systems of community resources.

3. **Pay for relationships:** Instead of paying for visits, tests, and procedures, we would change the payment paradigm to incentivize time together for patients and members of the care team and support high-quality relationships with peers, specialists, community-based organizations, and public health. In a time of COVID-19, primary care, in particular, must have strong relationships not only with patients and internal care teams but also prioritize new relationships with public health to fight community spread; behavioral health to treat the mental and emotional toll of the pandemic, and community-based organizations who are essential for marshaling the nonmedical resources that form a safety net for those in need during a historic time of unemployment.
4. **Divorce quality measures from payment and develop new measures:** Our quality measures are focused on diseases and body parts, promoting a view of health that is grounded primarily in biology. We lack many meaningful measures of patient-centered outcomes, health equity, mental well-being, population health, and relationships. If the adage "what gets measured, gets improved" holds true, it is no wonder that our medical care system is defined by fragmented, siloed care, and rampant documentation. A relationship-based system would not only measure health, equity, and relationships (bidirectionally) but just as critically, create venues for patients and community members to cocreate quality indicators that represent outcomes important to them, such as trust, sense of connection, and quality of life (12).

Crisis, Hope, and Opportunity

Pandemics and other major shifts in culture and environment are destabilizing. They test us, but they are also opportunities for growth and innovation. The COVID pandemic and the widespread adoption of virtual visits represents either a threat to or an opportunity for the provider-patient relationship.

Providers and patients have both been frustrated with the traditional office visit, but have been too busy, sick, or felt powerless to demand change. Now is a critical moment in

time. Prior outbreaks have resulted in spikes in provider burnout and stress (13,14), and the current financial picture suggests health systems will be asked to do more with less. Burned out clinicians operating in a system that seeks to double patient throughput to survive could permanently drive patients and clinicians apart. But there is also opportunity: History has demonstrated the ability to organize for significant positive change following global crises, such as the launch of national health services across Europe after the flu epidemic of 1918 (15).

Today, we know much more about the importance of relationships as critical facilitators of health and well-being for both patients and providers. Physicians and patients do have a voice, and the “pause” caused by COVID is an opportunity to come together and demand change. The rapid adjustments made during the pandemic suggest that the system is nimbler than we thought. While particularly critical in the United States, we believe that these recommendations can benefit (and are relevant to) health care systems worldwide, as the need for authentic connection to promote health is universal. It is time we rise together and use this opportunity to change the way health care is financed and delivered so that relationships—between peers, patients, and clinicians—can finally thrive in service of our singular common goal: health.

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Author Biographies

Kimberly N Hutchison is an associate professor of neurology and sleep medicine at OHSU in Portland, OR. She spends her time seeing patients and teaching medical students, residents, and fellows. She is also the medical director for an underserved clinic on the island of Saipan in the Marianas. Her interests include global health, wellness (patient and providers), and developing new treatment options for sleep disorders.

Jennifer Sweeney is an expert in patient and family engagement and a co-founder of X4 Health, a purpose-driven organization. Jennifer has devoted her career to facilitating meaningful and productive relationships among health care stakeholders and is the co-founder of 3rd Conversation, a national initiative to reinvent the clinician-patient relationship. Her interests include functional medicine, community organizing, women’s health, and human behavior.

Christine Bechtel is a well-known patient advocate and co-founder of X4 Health, a purpose driven organization using social impact design to solve problems that matter. She is also the co-founder of 3rd Conversation, a national initiative to reinvent the clinician-patient relationship for the modern era and serves as the visionary for Community ROCKit, a community engagement initiative helping communities recover from the widespread impacts of COVID-19.

Brian Park is an assistant professor of Family Medicine at OHSU and Public Health at OHSU-PSU in Portland, OR, and practices at a community health center. He is also the director of the RELATE Lab, which seeks to build the relational capacity of healthcare teams/organizations, as well as across multi-sectoral partnerships. His interests include health equity, community organizing, and leadership development.