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The Case for Relationship-Centered Care and How to Achieve It

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Introduction

American health care has entered a period of unprecedented debate regarding our health care delivery system. Adjectives such as affordable, accountable, integrated, and coordinated care routinely used to describe healthcare, but in the midst of reorganizing healthcare, have we lost the critical element of healthcare?—namely, "*care*" itself? This element of true caring within the healthcare debate is often relegated to the realm of patient or consumer satisfaction. The concept of authentic caring in healthcare, as opposed to healthcare as a transaction for acquiring health care services, is best embodied in the paradigm of relationship-centered care. Beach *et al* developed a conceptual framework for defining relationship-centered care that is founded upon four principles: (1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable.[1]

While Beach posits that relationship in healthcare deserve attention because they are morally valuable, we sought to examine whether relationship-centered care can actually help achieve the Triple Aim — lower costs, better health outcomes, and better experience of care. We examine the value of relationships in healthcare within four domains:

- social connectedness or supportive interpersonal relationships outside of healthcare,
- therapeutic relationships between patients and their healthcare team,
- relationships within the healthcare team, and
- relationships between the healthcare team and the community.

Assembling the available research, we developed a framework for primary care practices to assess their ability to foster therapeutic relationships and harness the power of relationships to improve health outcomes.

Social Relationships: Loneliness Kills

While most people would agree that social relationships improve the day-to-day quality of life, do social connections actually provide a health benefit? The answer is a resounding "Yes."

In 1921, a remarkable study began tracking the lives of 1500 Americans from childhood to death. They sought to track what factors in life, such as faith, marriage, pets, and exercise, increased longevity. The most significant finding was that strong social networks mattered most. The quality of social connections was more significant than the quantity.[2] In an interview with National Public Radio, lead researcher, Howard Friedman notes, "We saw that over and above the number of connections and the frequency of interactions that when those connections involved helping other people, reaching out,

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[1] M.C. Beach, T. Inui, et al, "Relationship-centered Care, A Constructive Reframing," *J Gen Intern Med* 21 (2006): S3–8.
[2] Howard Friedman and Leslie Martin, *The Longevity Project* (New York: Hudson Street Press, 2011).

being actively engaged to do things for others, that was an added bonus on top of what we already see as quite beneficial from the social contacts themselves."[3]

While Friedman's study may be the longest-running and most well-known, other researchers have demonstrated the impact of social connectedness on health care outcomes. Women with breast cancer who have larger social networks have been shown to have lower mortality rates than women with smaller social networks.[4] This impact is independent of the physical assistance that women may receive through their social networks. Other research has shown that post-myocardial infraction patients who perceive greater social support from friends had significantly lower mortality risk. The researchers conclude by encouraging clinicians "to assess post-MI psychosocial status to identify high-risk patients."[5]

Of particular importance to Americans, as baby-boomers are now aging into retirement, is the finding that social isolation and loneliness were significantly associated with greater functional decline as people age. A rigorous longitudinal study of 1604 patients over six years assessed social isolation and functional decline on four measures including: difficulty on an increased number of activities of daily living (ADL), difficulty in an increased number of upper extremity tasks, decline in mobility, or increased difficulty in stair climbing. Multivariate analyses adjusted for demographic variables, socioeconomic status, living situation, depression, and various medical conditions. Lonely subjects were more likely to experience decline in all four measure of functionality. Loneliness was associated with an increased risk of death.[6] Another large nationally representative U.S. sample of elderly adults was tracked over six years with the objective of assessing both memory and social integration as measured by marital status, volunteer activity, and frequency of contact with children, parents, and neighbors. Memory among the least socially integrated participants declined at twice the rate as the rate among the most socially integrated, suggesting that social relationships can be an important tool for preventing cognitive decline.

The Biologic Connection

In 2009, the Nobel Prize in Physiology or Medicine was awarded jointly to Elizabeth H. Blackburn, Carol W. Greider, and Jack W. Szostak for the discovery of how telomeres and the enzyme telomerase protect chromosomes. Telomeres are a protective casing, like the tips of shoelaces, at the end of a strand of DNA. Each time a cell divides, it loses a bit of its telomeres and when the telomere becomes too short, the cell dies. Chronic stress and cortisol exposure decrease the amount of the enzyme telomerase that acts as a protectant against telomere shortening. Elissa Epel, Ph.D., the director of the Center for Aging, Metabolism and Emotion at University of California San Francisco, works with Blackburn to study the effect of stress on telomeres. Stress, especially exposures to multiple early life adversities, such as child

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[3] "Talk of the Nation," National Public Radio, March 24, 2011.

[4] C.H. Kroenke, C. Quesenberry, M.L. Kwan, C. Sweeney, A. Castillo, and B.J. Caan, "Social Networks, Social Support, Burden in Relationships, and Mortality after Breast Cancer Diagnosis in the Life After Breast Cancer Epidemiology (LACE) Study," *Breast Cancer Res Treat* 137:1 (January 2013): 261-271.

[5] N. Weiss-Faratci, I. Lurie, Y. Neumark, M. Malowany, G. Cohen, Y. Benyamini, U. Goldbourt, and Y. Gerber, "Perceived Social Support at Different Times after Myocardial Infarction and Long-Term Mortality Risk: a Prospective Cohort Study," *Annals of Epidemiology* 26:6 (June 2016): 424-428.

[6] Carla M. Perissinotto, MD, MHS; Irena Stijacic Cenzer, MA; and Kenneth E. Covinsky, MD, MPH, "Loneliness in Older Persons: A Predictor of Functional Decline and Death" *Archives of Intern Medicine* 172:14 (2012): 1078-1084.

neglect, predict shortened telomeres. The magnitude of stress seems to be related to the impact on telomere length. Stress mitigation is a feature of Epel's research. In an interview on stress and aging for the American Psychological Association, Epel was asked, "Which risk factors for chronic stress do you think are most underappreciated?" and Epel responded:

> Our social environment. How rich is your social fabric? How connected are you to the people in your social circle, starting with your family? A strong social network is probably the biggest buffer from toxic stress, next to exercise. Yet we often lack quality long-term social connections. There is frequent loneliness among high-risk groups like the elderly, who may be more isolated. For those of low income, many are working long and inflexible hours.

As more and more attention is paid to the connection between social factors such as living conditions, poverty, and nutrition and health outcomes—the so-called "social determinants of health—perhaps the most important social determinant of health is social connectedness or relationships, and health systems need to develop strategies to address social connectedness.

Therapeutic Relationships within Healthcare

The caring, empathic clinician has been a long-standing ideal in health care. The attributes of paying attention to patients' psychosocial (as well as physical) needs, the use of psychotherapeutic behaviors to convey a sense of partnership and positive regard, and active facilitation of patients' involvement in decision-making about their care are often collectively referred to as "patient-centered care." The 2001 Institute of Medicine report *Crossing the Quality Chasm* brought patient-centered care into the mainstream of healthcare reform by identifying "patient-centered" as one of the six specific aims for healthcare improvement and equally important as safe, effective, timely, efficient, and equitable care.[7]

However, it is possible that care can be "patient-centered" without necessarily establishing a caring relationship with the patient. Consider for example, a conversation between a clinical pharmacist and a patient with multiple chronic diseases immediately following the patient's discharge from a prolonged hospitalization. Many hospitals and health systems, in an attempt to improve care and drive down the rate of re-hospitalization, have introduced protocols to facilitate transitions of care, such as having a patient meet with a clinical pharmacist for medication reconciliation. The pharmacist may provide valuable clinical instructions to the patient and may provide instructions in a patient-centered way by eliciting questions about concerns such as cost and fear of side-effects that may impact long-term adherence. However, the pharmacist and patient have never met and are unlikely to meet in the future. The pharmacist may provide patient-centered advice but not establish empathy or true concern. Is this necessary and helpful, even patient-centered, health care? Emphatically yes. Does this establish a *caring relationship*? Maybe not.
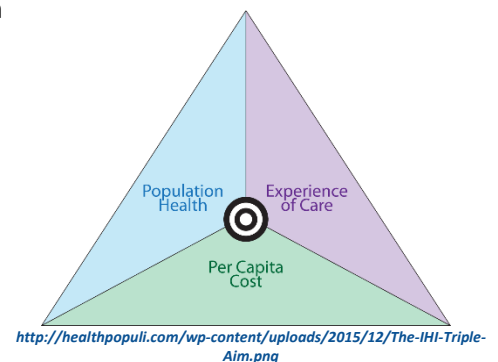
The IOM went on further in their report to formulate a set of ten simple rules, or general principles, to inform efforts to redesign. The first of these rules is: *Care is based on continuous healing relationships.*

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[7] Institute of Medicine (U.S.), *Crossing the Quality Chasm: a New Health System for the 21st Century* (Washington D.C.: National Academy Press, 2001).

However, the IOM emphasizes that a healing relationship cannot be established or maintained unless care is accessible and that such a relationship can be fostered by many kinds of interactions, not just face-to-face visits. (The IOM does not actually define what a healing relationship is).

For the purposes of this discussion, we define the ideal *continuous healing relationship* as: longitudinal series of empathic interactions over time characterized by authentic positive regard, where each participant continuously develops deeper knowledge about the habits, preferences, and behavior of the other through respectful curiosity.

In the past fifteen years since the publication of the IOM Report, healthcare reform has intensively focused on the achievement of the Triple Aim—lower costs, better health outcomes, and better experience of care. Do continuous healing relationships help to achieve the Triple Aim? What threats exist that impair the ability to develop continuous healing relationships? How can we put the focus back on the *caring* part of health care?

http://healthpopuli.com/wp-content/uploads/2015/12/The-IHI-Triple-Aim.png

Continuous Healing Relationships and Health Outcomes

Empathy and Healing

"Bedside manner" is often touted as a value in healthcare. Patients, especially when sick and vulnerable, want to feel comforted. Patient-centered communications styles have been correlated with greater alleviation of concerns, better recovery from discomfort, and better emotional health two months after the initial visit.[8] A review study that evaluated multiple studies on physician-patient communication and empathy concluded that "There is a good correlation between physician empathy and patient satisfaction and a direct positive relationship with strengthening patient enablement. Empathy lowers patients' anxiety and distress."[9]

While definitely improving patient satisfaction and perception of quality, a caring or empathic bedside manner has also been shown to improve health outcomes. [10] Hojat *et al* found a positive relationship between physician empathy and patients' clinical outcomes. [11] Patients with diabetes, who found their physician to be more empathic, had significantly better levels of hemoglobin HbA1C and low-density

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[8] Catherin Hudon, Martin Fortin, Jeannie L. Haggerty, Mireille Lambert, Marie-Eve Poitras, RN, "Measuring Patients' Perceptions of Patient-Centered Care: A Systematic Review of Tools for Family Medicine," *Annals of Family Medicine* 9(2011): 155-164.

[9] F. Derksen, J. Bensing, A. Lagro-Janssen, "Effectiveness of Empathy in General Practice: a Systematic Review," *The British Journal of General Practice* 63:606 (January 2013): e76-84, doi: 10.3399/bjgp13X660814.

[10] S.A. Flocke, W.L. Miller, B.F. Crabtree, "Relationships Between Physician Practice Style, Patient Satisfaction, and Attributes of Primary Care," *Journal of Family Practice* 51:10 (October 2002): 835-840.

[11] John M. Kelley, Gordon Kraft-Todd, Lidia Schapira, Joe Kossowsky, and Helen Riess, "The Influence of the Patient-Clinician Relationship on Healthcare Outcomes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials" *Public Library of Science* 9:4 (2014): e94207.

lipoprotein (LDL) cholesterol.[12] More empathy in the clinician–patient relationship enhances mutual understanding and trust between the clinician and patient, leading to better communication, more accurate diagnoses, and greater adherence to treatment plans. Even for conditions where there is no effective medical treatment, empathy, in of itself, can be a therapeutic treatment. Researchers have shown that the symptoms of the common cold are less severe and resolve more quickly when patients receive empathic care from their physician.[13]

Continuity of Care

Perhaps the most important component of relationship-centered care is a longitudinal relationship with one provider or one consistent team of providers over time. This is referred to as "continuity of care" (COC). A recent study showed that for Medicare beneficiaries with each of three chronic diseases (DM, COPD, and CHF), there was a consistent association between higher levels of care continuity and lower rates of hospital and emergency department visits, lower complication rates, and lower episode costs. As healthcare inflation consistently outpaces general inflation, more and more effort is expended to reduce healthcare costs, so that interventions that can lower costs while maintaining or improving quality are especially important. The researchers showed that a relatively modest 10% increase in the COC measure used in the study was associated with episode-of-care costs for CHF, COPD, and DM patients that were on average 5 percent lower.[14] COC may lower costs in a variety of ways. Greater COC may give healthcare providers a more comprehensive clinical picture of the care received by multiple specialists leading to more efficient and coordinated care. COC may also improve physicians' ability to understand patients' constellation of symptoms, which then leads to lower use of diagnostic testing. COC provides greater opportunities for shared decision-making and motivational interviewing that may lead to improved adherence to treatment. Finally, greater COC may improve trust, which could lead to less use of defensive medical testing.

In an effort to more fully understand the relationship between COC and healthcare outcomes, Saultz explored the concept of COC in primary care and distilled the concept into a hierarchy of three dimensions: informational, longitudinal, and interpersonal continuity.[15] Informational COC refers to the idea that all of a patient's records are organized and available at the point of care. Longitudinal continuity refers to the duration of the relationship between the patient and a clinician or healthcare setting. The last dimension, interpersonal continuity, is the dimension most congruent with the relationship-centered care paradigm. Interpersonal continuity refers to a special type of longitudinal continuity that is characterized by interpersonal trust and responsibility. Saultz performed a critical review of the medical literature regarding the relationships between interpersonal continuity of care and the outcomes and cost of health care. He and his study partners concluded:

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[12] M. Hojat M, D.Z. Louis, F.W. Markham, et al., "Physicians' Empathy and Clinical Outcomes for Diabetic Patients," *Academic Medicine* 86:3 (2011): 359–364.

[13] D. Rakel, B. Barrett, Z. Zhang, et al., "Perception of Empathy in the Therapeutic Encounter: Effects on the Common Cold," *Patient Education and Counseling* 85:3 (2011): 390–397.

[14] Peter S. Hussey, PhD; Eric C. Schneider, MD; Robert S. Rudin, PhD; D. Steven Fox, MD; Julie Lai, MPH; and Craig Evan Pollack, MD, "Continuity and the Costs of Care for Chronic Disease" *JAMA Internal Medicine* 174:5 (2014): 742-748.

[15] John W. Saultz, MD, "Defining and Measuring Interpersonal Continuity of Care," *Annals of Family Medicine* 1 (2003): 134-143.

Forty-one research articles reporting the results of 40 studies were identified that addressed the relationship between interpersonal continuity and care outcome. A total of 81 separate care outcomes were reported in these articles. Fifty-one outcomes were significantly improved and only 2 were significantly worse in association with interpersonal continuity. Twenty-two articles reported the results of 20 studies of the relationship between interpersonal continuity and cost. These studies reported significantly lower cost or utilization for 35 of 41 cost variables in association with interpersonal continuity.[16]

COC and especially interpersonal COC are associated with improved outcomes and lower costs.

Relationships within the Healthcare Team

Team-based Care

Team-based care is a relatively new concept in healthcare. The idea first originated in other high-risk industries such as aviation. Team training in aviation is known as Crew Resource Management training and has led to led to heightened safety-awareness attitudes, improved communication, and safer decision-making behaviors. Crew Resource Management was first adapted into high-acuity medical settings such as surgical procedures, emergency departments, and obstetrics.[17] In the past decade, increasing evidence shows that team-training can positively impact healthcare team processes and patient outcomes, and it has been widely adopted in multiple acute care settings.[18] While the original concept of team training focused on enhancing the team performance of clinicians in specified high-acuity clinical scenarios, newer models of team-based care have focused on expanding the team as well as improving global team performance. Team-based care is especially important for patients with multiple chronic illnesses, the elderly, or the medically fragile. A recent review article analyzing multiple randomized controlled trials assessed the value of multidisciplinary team-based care. The analysis demonstrated that "The tailoring of treatment, underpinned with clear communication strategies can reduce emergency department re-admission rates, mortality and functional decline of older people. Refining health professionals' roles and responsibilities within transition models is an essential component that can improve health outcomes for older people in acute care settings."[19]

Team-based care has also expanded into the outpatient setting. The traditional triad of receptionist, nurse, and physician functioning in the outpatient setting is no longer sufficient to adequately address all of the healthcare and social needs of patients, especially complex patients and vulnerable populations. There is a wealth of evidence that shows that the addition of specific members to the

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[16] John W. Saultz, MD and Jennifer Lochner, MD, "Interpersonal Continuity of Care and Care Outcomes: A Critical Review," *Annals of Family Medicine* 3 (2005): 159-166.

[17] Agency for Healthcare Research and Quality, accessed January 21, 2017, https://archive.ahrq.gov/research/findings/final-reports/medteam/chapter3.html.

[18] S.J. Weaver, R. Lyons, D. Diaz-Granados, M.A. Rosen, E. Salas, J. Oglesby, J.S. Augenstein, D.J. Birnbach, D. Robinson, and H.B. King, "The Anatomy of Health Care Team Training and the State of Practice: a Critical Review," *Academy of Medicine* 85:11 (November 2010): 1746-60.

[19] L.D. Hickman, J.L. Phillips, P.J. Newton, E.J. Halcomb, N. Al Abed, and P.M. Davidson, "Multidisciplinary Team Interventions to Optimise Health Outcomes for Older People in Acute Care Settings: a Systematic Review," *Archives of Gerontology and Geriatrics* 61:3 (2015): 322-329.

primary care team can improve outcomes. Advanced practice nurses can provide a broad range of primary care services and offer practices more flexibility in scheduling. [20] Social workers can assist patients in connecting to community resources and can more thoroughly address social determinants of health. [21] The addition of pharmacists that provide medication therapy management has been shown to improve chronic disease outcomes and reduce costs.[22] The Collaborative Care Model which integrates behavioral health specialists into primary care teams has now been tested in more than 80 randomized controlled trials and has been consistently shown to improve patient outcomes, increase patient and provider satisfaction, and reduce health care costs."[23] Community health workers are generally non-clinical workers who originate from the communities that they serve and provide outreach to individuals and provide culturally competent health education. Studies have shown that community health workers can improve patient and community engagement, improve chronic disease outcomes, and increase the receipt of preventive services. [24] Finally, as rates of obesity and other conditions related to nutrition have soared, nutritionists have become a critical addition to the primary care team. [25]

A high-functioning team with comprehensive clinical skills and expertise, as well as the relational skills to ensure high performance, is a critical element for achieving the Triple Aim.

The Patient-Centered Medical Home and Relationship-Centered Care

Within primary care, the patient-centered medical home (PCMH) model embodies many of the elements of building continuous healing relationships. The medical home is best described as a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. The concept originated in the 1960s as a way to care for children with special needs but was adapted over the past decade to define the type of primary care that everyone should receive in an increasingly complex world of healthcare. In 2007, several primary care organizations disseminated the Joint Principles of the PCMH; the first principle was that "each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care."[26] Since then, multiple organizations such as the NCQA, URAC, and The Joint Commission have developed standards to systematically define and score the attributes of the PCMH model. While

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[20] E. McCleery, V. Christensen, K. Peterson, L. Humphrey, and M. Helfand, "Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses," *VA Evidence-based Synthesis Program Evidence Briefs* (Washington D.C.: Department of Veterans Affairs (US), 2011); *VA Evidence-based Synthesis Program Reports* (September 2014).

[21] C. Boult, A.F. Green, L.B. Boult, J.T. Pacala, C. Snyder, and B. Leff, "Successful Models of Comprehensive Care for Older Adults with Chronic Conditions: Evidence for the Institute of Medicine's "Retooling for an Aging America" Report," *Journal of American Geriatric Society* 57:12 (December 2009): 2328-2337.

[22] M.A. Chisholm-Burns, J. Kim Lee, C.A. Spivey, M. Slack, R.N. Herrier, E. Hall-Lipsy, J. Graff Zivin, I. Abraham, J. Palmer, J.R. Martin, S.S. Kramer, and T. Wunz, "US Pharmacists' Effect as Team Members on Patient Care: Systematic Review and Meta-Analyses," *Medical Care* 48:10 (October 2010): 923-933.

[23] AIMS Center, accessed January 21, 2017, https://aims.uw.edu/resource-library/collaborative-care-people-depression-and-anxiety.

[24] S.L. Johnson and V.L. Gunn, "Community Health Workers as a Component of the Health Care Team," *Pediatric Clinics of North America* 62:5 (October 2015): 1313-1328.

[25] A. Howatson, C.R. Wall, and P. Turner-Benny, "The Contribution of Dietitians to the Primary Health Care Workforce," *Journal of Primary Health Care* 7:4 (December 2015): 324-332.

[26] *American Academy of Family Physicians*, accessed January 22, 2017, http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

multiple evaluations have shown improved health outcomes for primary care environments that have adopted the PCMH model of care,[27] PCMH has come under criticism. PCMH, and specifically the recognitions programs, have been criticized as too prescriptive, hard to achieve, and potentially counter-productive. In an essay published in the *Annals of Family Medicine*, two family doctors, voicing the concerns of many primary care practitioners, stated, "Our practices were recently recognized by the National Committee for Quality Assurance (NCQA) as Level 3 Patient-Centered Medical Homes (PCMHs). After completing the process and weighing the results, we came to an inescapable conclusion: this process wastes time and money and fails to improve patient care. The recognition process encourages low-value documentation in practices of all sizes, unintentionally handicaps small practices compared with their larger counterparts, and highlights how lofty goals alone do not guarantee improved care."[28]

While we still recognize the tremendous value of PCMH, we agree that PCMH does have limitations and may divert valuable time and resources away from efforts to build relationships. Relationship-centered care is complementary to PCMH. Many of the element prescribed by these recognition programs, such as continuity of care and team-based care, reinforce the value of relationship-centered care. However, enhancing relationships beyond what is prescribed in the PCMH models may provide additional improvements in outcomes.

Relationships between the Community and the Healthcare Team

The relationship between communities and healthcare delivery systems has been examined for a long time. Community-oriented primary care, a concept developed over fifty years ago, seeks to combine public health strategies and primary care delivery, despite the fact that most health care systems have developed without collaboration between these two complementary healthcare components. Community Health Needs Assessments may be performed by hospitals and other healthcare providers and contribute to population health management, but an assessment of community health needs does not guarantee that an authentic relationship with the community will be established as a result. More recently, the concept of pro-active population management for a panel of patients has been reinvigorated through the PCMH movement. As the impact of social determinants of health on healthcare costs and outcomes is more understood, health care systems are developing strategies to refer patients to community-based resources such as food banks, housing assistance, and employment training.

The relationship-centered care paradigm acknowledges that patients are profoundly influenced by their communities and that the healthcare team has a responsibility to develop a relationship with the community as well as with individual patients. Beach *et al.* describe the value of the relationship between communities and healthcare delivery systems thusly:

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[27] "Outcomes and Evaluation," *Patient Centered Primary Care Collaborative*, accessed January 20, 2017, https://pcpcc.org/outcomes-evaluation

[28] Lynn Ho, M.D. and Jean Antonucci, M.D., "The Dissenter's Viewpoint: There Has to Be a Better Way to Measure a Medical Home," *Annals of Family Medicine* 13:3 (2015): 269-272.

> Because the root causes or determinants of health are multiple (biologic, environmental, social, psychological, behavioral, economic, and medical care-related), the clinician and clinical team will need to ''reach into'' many sectors, form meaningful relationships with others, and sustain these ''therapeutic partnerships'' if effective care for illness is to be possible. Relationship-centered care emphasizes the importance of practitioners' relationships with communities of patients such that the practitioner understands the local community dynamics, appreciates the importance of the community in contributing to the health and wellbeing of its members, and participates in community dialogue and development.

As healthcare becomes more corporatized and consolidated, the connection between the delivery system and communities becomes more fragile. Relationship-centered care includes a recognition that extends beyond the clinician-patient relationship to the practice/delivery system-community relationship, and it views the collective healthcare delivery system as an integral component of community development.

Potential Barriers to Building Continuous Healing Relationships

The wealth of evidence shows that continuous healing relationships across all four domains can increase satisfaction with care, improve health outcomes, and lower costs. Why then are they so hard to achieve? There are multiple barriers to developing continuous healing relationships in modern healthcare. In the discussion below, we explore a few of the primary barriers.

- *Technology, specialization and medical complexity*
- *Payment models*
- *The competing goals of access and continuity*
- *Practice consolidation*
- *Team-based care*
- *Narrow healthcare networks*

Technology, Specialization, and Medical Complexity

Fifty years ago, technology, specialization, and medical complexity were the spurs of the development of the patient-centered paradigm of care, and they still represent the largest threat to creating continuous health relationships in healthcare. Certainly, advances in medical science and healthcare delivery continue to the benefit of humankind, but as medical science expands therapeutic options, the number of practitioners involved in care also expands. In 2007, Pham *et al.* published a powerful paper in the *New England Journal of Medicine*. They discovered that the typical Medicare patient sees seven different doctors in one year, including five different specialists, working in four different practices. For vulnerable patients with multiple chronic conditions, care is even more fragmented and involves more doctors. Forty percent of the patients in the study had seven or more chronic conditions, and they saw

on average 11 doctors in seven practices; the upper quartile of this group saw 16 or more different doctors in nine or more different practices.[29]

Payment Models

Payment methods do influence provider behavior.[30] In the 1990s, concerns about "cherry-picking" and "lemon-dropping," whether real or not, led to widespread suspicion about HMOs and the gatekeeper model. On the other hand, traditional fee-for-service payment models encourage overuse and create the perception that providers may recommend minimally effective therapeutic interventions for financial benefit. When fee-for-service payment models also impact the clinician-patient relationship by driving the hamster wheel of volume and not allowing clinicians to expend time developing a personal relationship with either patients or other team members.

While newer models of value-based payment such as the Accountable Care Organization offer more patient safeguards by including quality outcomes as performance measures, optimal payment systems that improve care, control costs, and do not negatively impact the trusting relationship between patients and providers have not been widely adopted.[31] Pay-for-performance has been touted as a way to buy value in healthcare, but "Measuring quality in terms of task-based care can diminish the value of clinicians' essential role of deciphering medical complexity and building relationships."[32] Performance and outcome metrics are increasingly important to defining accountability for outcomes. However, as one recent essay notes, "Good performance [as measured by current metrics] is not necessarily good care, and pressure to improve performance can come at the sacrifice of good care."[33] Payments tied to an episode of care may create financial relationships where there is limited clinical integration and even fewer personal relationships between providers

If we decide that continuous healing relationships are valuable, then serious consideration must be given to measuring the value of relationships and deriving appropriate payment models.

The Competing Goals of Access and Continuity

According to a 2015 policy study conducted by the Robert Graham Center, one in five Americans reports no usual source of health care, and the number of Americans reporting that they have a personal relationship with a usual source of care has declined steadily over the past 15 years. The study also noted that the percentage of people reporting an individual clinician as their usual source of care was countered by a nearly equivalent rise in those reporting a facility as the usual source of care.[34] This may

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[29] H.H. Pham, D. Schrag, A.S. O'Malley, B. Wu, and P.B. Bach, "Care Patterns in Medicare and their Implications for Pay for Performance," *New England Journal of Medicine* 356:11 (March 2007): 1130-1139.

[30] T. Gosden, F. Forland, I.S. Kristiansen, et al., "Capitation, Salary, Fee-for-Service and Mixed Systems of Payment: Effects on the Behaviour of Primary Care Physicians," *Cochrane Database of Systemic Review* 3 (2000): CD002215.

[31] Susan Dorr Goold, MD, MHSA, MA and Mack Lipkin, Jr., MD, "The Doctor–Patient Relationship Challenges, Opportunities, and Strategies," *Journal of General Intern Medicine* 14:Suppl 1 (January 1999): S26–S33.

[32] C.R. Dale, M. Myint, and A.L. Compton-Phillips, "Counting Better — The Limits and Future of Quality-Based Compensation," *New England Journal of Medicine* 375 (2016): 609-611.

[33] Rachel M. Werner, MD, PhD and David A. Asch, MD, MBA, "Clinical Concerns About Clinical Performance Measurement," *Annals of Family Medicine* 5:2 (March 2007): 159–163.

[34] "Fewer Americans Report a Personal Physician as Their Usual Source of Health Care," *Robert Graham Center*, http://www.graham-center.org/rgc/publications-reports/publications/one-pagers/personal-physician-2015.html

be due to more team-based care, but the impact of not having a personal relationship with a clinician could be impactful. The rise of consumerism, demand for convenience, and telehealth accessibility have likely contributed to the decline in the number of people reporting a personal relationship with a clinician as a usual source of care.

Consumer choice can be a powerful factor in improving healthcare delivery, but consumers may choose convenience over the development of continuous healing relationships, especially if they perceive that the healthcare system itself does not value or promote them. Consider the rapid expansion of retail clinics, which are now a commonplace, with 10.5 million visits occurring annually at more than 1,800 retail clinics.[35] This trend may be exacerbated in younger consumers. A recent NPR report quoted a millennial: "I personally don't care what doctor I see as long as they're competent, they have access to my medical records, and I can see them as soon as I need to." [36] More comprehensive evidence of consumers' desire for convenience is shown in a 2014 survey by the Consumer Advisory Board.[37] Consumers ranked four access and convenience attributes over being treated by the same provider each time they visit the clinic. Telemedicine also offers a tremendous opportunity to increase access and convenience, and it can expand access to healthcare virtually anytime, anywhere; but when patients use a telemedicine service offered through their health insurer or employer, they usually do not have an ongoing relationship with a clinician. One executive in a large health insurance company recently described their 24/7 telehealth services as a "blind date."[38]

Practice Consolidation

Accelerating practice consolidation has the potential to impact clinician-patient relationships. A 2015 General Accountability Office (GAO) report on Medicare noted that the number of vertically consolidated hospitals and physicians increased from 2007 through 2013. Specifically, the number of vertically consolidated physicians nearly doubled from about 96,000 to 182,000. This growth occurred across all regions and hospital sizes but was more rapid in recent years.[39] The American Medical Association reported in its 2012 Practice Benchmark Survey that a slight majority (53 percent) of physicians owned their practices, down from 61 percent in 2007/2008; 42 percent of physicians were employees, and 5 percent were independent contractors.[40] This trend is reflected in the physician search assignments Merritt Hawkins conducts. In 2014, more than 90 percent of 3,158 searches

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[35] Deborah Bachrach, Jonah Frohlich, Allison Garcimonde, and Keith Nevitt, "Building a Culture of Health: The Value Proposition of Retail Clinics," *Manatt and the Robert Wood Johnson Foundation*, https://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/Retail_Clinic_RWJF.pdf

[36] Christina Farr, "Are Millennials Ready to Ditch their Regular Doctor?" *KQED*, August 12, 2015, *https://*ww2.kqed.org/futureofyou/2015/08/12/convenience-or-loyalty-what-do-millennials-value-more-when-it-comes-to-their-health/

[37] Primary Care Consumer Choice Survey, *Research Brief*, June 25, 2014, https://www.advisory.com/research/market-innovation-center/expert-insights/2014/get-the-primary-care-consumer-choice-survey-results

[38] Reed Abelson, "American Well Will Allow Telemedicine Patients to Pick their Doctor," *New York Times*, May 16, 2016, http://www.nytimes.com/2016/05/17/business/american-well-will-allow-telemedicine-patients-to-pick-their-doctor.html?_r=0

[39] Report to Congressional Requesters on Medicare, "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," *GAO* 16:189 (December 2015), http://www.gao.gov/assets/680/674347.pdf

[40] Travis Singleton and Phillip Miller, "The Physician Employment Trend: What You Need to Know," *Family Practice Management* 22:4 (2015): 11-15.

featured employment of the physician, whether by a hospital, medical group, or any other entity. Fewer than 10 percent featured a true independent setting, down from more than 45 percent in 2004.

Team-based Care

As described previously, team-based primary care can improve outcomes.[41] However, a problem with large teams is that patients may not identify one or two team members who know them well. Expanding the primary care team to include additional members to address more thoroughly the array of patient needs, such as nutritionists, behavioral health specialists, and pharmacists, can also interfere with patient preferences for continuity of care with a single clinician. [42] Premier communication and the development of "teamlets"—a stable pairing of a clinician and clinical assistant(s) who work together every day and share responsibility for the health of their panel—can ameliorate the potentially negative effects of an expanded team.[43] However, as practices add additional resources to focus on specific patient needs, the team must work to ensure that the fundamental relationship with the patient is not lost.

In addition to the potential negative consequences of an expanded team on the clinician-patient relationship, an expanded team creates multiple new interpersonal dynamics within the clinical environment. Simple math demonstrates that when there are two people on a team, there is one communication channel. A four-person team has six communication channels, and a twelve-person team has 66 communication channels. Effective teams require dealing with the challenges of all these personalities and human relationships.[44] Most health care professionals have received very little formal team training and must be coached so that the team develops highly functional inter-professional relationships.[45]

Narrow Healthcare Networks

The use of narrow provider networks in health insurance plans is a cost containment strategy that has recently regained popularity. Network design features differ among plans, but insurers generally seek to offer lower premiums by limiting the group of providers available to plan enrollees.[46] Increasingly, consumers have the option to choose plans that offer lower premiums but limit provider choice. About 70% of plans sold on the Affordable Care Act Exchanges in 2014 featured a limited network, and their premiums were as much as 17% cheaper than plans with broader networks, according to a study by consulting firm McKinsey & Co.[47] Medicare Advantage and commercial plans are also increasingly using narrow network designs. In the past, insurers often kept prices down by limiting benefits or by denying

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[41] K. Grumbach and T. Bodenheimer. "Can Health Care Teams Improve Primary Care Practice?" *JAMA* 291:10 (2004): 1246-1251.
[42] H.P. Rodriguez, W.H. Rogers, R.E. Marshall, and D.G. Safran, "Multidisciplinary Primary Care Teams: Effects on the Quality of Clinician-Patient Interactions and Organizational Features of Care," *Medical Care* 45:1 (January 2007): 19-27.
[43]Thomas Bodenheimer, MD; Amireh Ghorob, MPH; Rachel Willard-Grace, MPH; and Kevin Grumbach, MD, "The 10 Building Blocks of High-Performing Primary Care," *Annals of Family Medicine* (2014): 166-171.
[44] P. Lencioni, *The Five Dysfunctions of a Team* (San Francisco, Calif: Jossey-Bass, 2002).
[45] B.J. Fried, T.G. Rundal, and S. Topping, "Groups and Teams in Health Services Organizations," in *Health Care Management*, eds. S.M. Shortell and A.D. Kaluzny (Albany, NY: Delmar Thomson Learning, 2000).
[46] "Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice," *Academy Health Research Insights*, http://academyhealth.org/files/HCFO/RIBrief0315.pdf
[47] Bob Herman, "Network Squeeze: Controversies Continue over Narrow Health Plans" *Modern Healthcare*, March 28, 2015, http://www.modernhealthcare.com/article/20150328/MAGAZINE/303289988

coverage to consumers with pre-existing conditions; recent health reforms have disallowed this practice, and health plans must offer roughly comparable benefits. The result is that to compete on price, insurance companies must control the costs of the care their customers use, and limiting the provider network is a reasonable cost containment strategy.[48] However, as consumers seek affordable coverage, they may shift from one narrow-network plan to another, creating discontinuity of care and impairing their ability to develop strong relationships with their healthcare team. In addition, consumers who have to switch health plans when they move to a new job or under other circumstances may find that their existing provider relationships are disrupted because their doctors may not be part of the network of the new health plan.

Opportunities to Foster Relationship-Centered Care

In each of the four domains explored in this discussion, there are multiple ways to enhance the development of continuous healing relationships. Relationship-centered care can be fostered in all care settings, but our recommendations focus mainly on primary care as the foundational element of healthcare. We look forward to exploring expansion of relationships-centered care in other care settings.

- *Promote social connectedness and address social isolation*
- *Improve empathy and patient-centered communication skills*
- *Promote continuity of care*
- *Team-based care training*
- *Implement models of care with peer support*
- *Create community connections*

Promote Social Connectedness and Address Social Isolation

Social determinants of health must be addressed with particular attention to social isolation. Clinicians should routinely explore the extent of patients' social networks and use referrals to supports, motivational interviewing, and brief problem-solving interventions to assist patients in developing and strengthening social connectedness. For example, the UCLA Geriatrics Program in Santa Monica has developed a Companion Care Program, where specially trained volunteers visit elderly hospitalized patients who may have few, if any, visitors. The program counters the stress, isolation and depression of hospitalization by providing one-on-one companionship, assistance, and access to activities.[49] Patients

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[48] David Blumenthal, M.D., "Reflecting on Health Reform—Narrow Networks: Boon or Bane?" *Commonwealth Fund,* February 24, 2014, http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane
[49] "Companion Care Program Strives to Make Hospital Stays Less Lonely for Elderly Patients," *Today's Geriatric Medicine,* accessed January 20, 2017, http://www.todaysgeriatricmedicine.com/news/072916_news.shtml

with chronic loneliness should be offered cognitive behavioral therapy to improve social skills that may be perpetuating isolation.[50]

Improve Empathy and Patient-Centered Communication Skills

While most people who work in healthcare, truly have a desire to help people and enjoy working with people, not all of them know how to be empathic. Empathic skills can be learned and enhanced through formal training programs. Even the most seasoned, empathic professionals can develop burnout and "empathy drain" over time and need to have their skills refreshed. There are multiple approaches for enhancing empathy in the health care environment: audio- or video-taping of encounters with patients, exposure to role models, role playing, shadowing a patient, studying literature and the arts, improving narrative skills, theatrical performances, and formal group processes focusing on the doctor-patient relationship. These training modalities often incorporate an element of reflection, prompting clinicians to step away from the busy clinical schedule and examine their relationships with patients. A meta-analysis of interventions designed to improve patient-centered communication skills showed positive effects on communication processes, patient satisfaction, and health status.[51]

Promote Continuity of Care

Continuity of care improves outcomes and reduces health care costs. Attempts to improve care, such as the introduction of hospitalists, should be carefully balanced against the potential disruption in continuity of care. Primary care environments should strive to measure and promote continuity of care through assigning patients to one clinician or team.[52] Policy-makers and health plans can support continuity of care by balancing the potential benefits of narrow networks with the negative impacts on continuity of care, especially for medically fragile and vulnerable populations. In light of the evidence of enhanced health outcomes and potential cost savings, value-based care payment models should provide enhanced payment for continuity of care.

Team-based Care Training

Team-based care has gained popularity, but in many instances, so-called team-based care reflects the reassignment of duties or the addition of supplementary resources such as a behavioral health specialist and not the development of a truly functional team based on inter-professional relationships. There may be a collection of skilled individuals rendering healthcare services to the same patient, but they may not coalesce into actual high-functioning teams. Effective teams must be nurtured. Not only do teams need the mechanistic framework afforded by clear communication, concise role definition, and organized workflows, teams need an opportunity to develop cohesion and safe space for candid conversations.

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[50] Christopher M. Masi, Hsi-Yuan Chen, Louise C. Hawkley, and John T. Cacioppo, A Meta-Analysis of Interventions to Reduce Loneliness. Pers Soc Psychol Rev. 2011 August ; 15(3):

[51] F. Dwamena, M. Holmes-Rovner, C.M. Gaulden, S. Jorgenson, G. Sadigh, A. Sikorskii, S. Lewin, R.C. Smith, J. Coffey, and A. Olomu, "Interventions for Providers to Promote a Patient-Centered Approach in Clinical Consultations," *Cochrane Database of Systemic Review* 12 (December 2012).

[52] G. Vachon and L. Weiselberg, "Empanelment in an Accountable Care Environment: IMPLEMENTATION GUIDE," accessed January 20, 2017, https://www.healthmanagement.com/knowledge-share/briefs-reports/empanelment-in-an-accountable-care-environment-implementation-guide/

Formal team training can improve team function.[53] Healthcare systems should implement formal team training and maintain venues for addressing team dysfunction on an ongoing basis.

Implement Models of Care with Peer Support

> *"We as women better stick together – that's what it is and it's nice. They're offering more, more care is going on."*
> *Comment made by pregnant woman in Centering Pregnancy group.*

Peer supports are recognized as a promising practice, grounded in relationship-centered care principles. Peer support models can be used to enhance care in a variety of settings. Many health systems are implementing peer support specialists for recovery support in behavioral health with promising results.[54] Group prenatal care is another relationship-based, peer support model that shows promise to reduce pre-term birth in high-risk populations. The most widely known model of group prenatal care in the United States is Centering Pregnancy, which was developed in the 1990s to empower women to choose health-promoting behaviors.[55] Studies on health outcomes to date have been mixed, with a recent meta-analysis showing that group prenatal care participants have similar rates of preterm birth, neonatal intensive care unit admission, and breastfeeding. However, the researchers did note that "Our findings in this study suggest a risk reduction of three preterm births per 100 live births in African-American women. This is a potentially significant finding because rates of preterm birth are nearly twice as high in African American women compared with white women, even after controlling for confounding factors such as socioeconomic status."[56] This suggests that group prenatal care, a model founded on continuous healing relationships, may be particular effective for high-risk women and vulnerable populations. Furthermore, the researchers did not evaluate immediate outcomes such as patient satisfaction (which is reportedly high in many studies) or other long-term outcomes such as patient activation, parenting skills, or self-efficacy, which may be positively impacted by the relationship-centered care promoted in the group prenatal care model.

Create Community Connections
Chronic Disease Self-Management Programs (CDSMP) are an example of programs that offer peer support and create a connection to the community. Management of chronic disease is a significant challenge for both patients and providers. Clinicians are routinely frustrated by the failure of health

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[53] E. Salas, D. Diaz-Granados, C. Klein, C.S. Burke, K.C. Stagl, G.F. Goodwin, and S.M. Halpin, "Does Team Training Improve Team Performance? A Meta-Analysis," *Human Factors* 50:6 (December 2008): 903-933.

[54] Cook, J. A., et al., "Developing the evidence base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two statewide initiatives," Psychiatric Rehabilitation Journal 34 no. 2 (2010): 113–120.

[55] *Centering Healthcare Institute*, accessed January 19, 2017, https://www.centeringhealthcare.org/what-we-do

[56] Ebony B. Carter, MD, MPH; Lorene A. Temming, MD; Jennifer Akin, BA; Susan Fowler, MLIS;
George A. Macones, MD, MSCI; Graham A. Colditz, MD, DrPH; and Methodius G. Tuuli, MD, MPH,
 "Group Prenatal Care Compared With Traditional Prenatal Care A Systematic Review and Meta-Analysis," *Obstetrics and Gynecology* (2016): 1–11.

education to lead to patient adherence. First developed by Stanford in the 1990s, CDSMPs generally consist of six weekly sessions given in community settings such as senior centers, churches, libraries and hospitals and facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves. CDSMPs have been proven to be highly effective. A national study from a large cohort of non-institutionalized patients with chronic disease, showed that CDSMP participants demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, with a resulting cost-to-savings ratio of approximately 1:4. Many of these results persist for as long as three years.[57] The Stanford researchers specifically note, "It is the process in which the program is taught that makes it effective. Classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives."[58]

Conclusion and Development of the Building Blocks of Relationship-Centered Primary Care

There is a large body of evidence demonstrating that the development of relationship-centered care can not only improve patient satisfaction but also improve health outcomes and lower costs—in essence, achieve the Triple Aim. *Caring* in healthcare is not only an ideal; it is an evidence-based success.

It is appropriate, therefore, to consider how to foster greater application of the principles of relationship-centered care. To help achieve that objective with respect to primary care, which has been the focus of this report, we have developed a tool to assess the extent to which primary care practices have implemented RCC attributes across the four domains of: 1) social connectedness or supportive interpersonal relationships outside of healthcare, 2) therapeutic relationships between patients and their healthcare team, 3) highly-functional relationships within the healthcare team, and 4) relationships between the healthcare team and the community. In a nod to Bodenheimer and the 10 Building Blocks of High-Performing Primary Care,[59] we have labeled our framework as the Building Blocks of Relationship-Centered Primary Care.

We think that these building blocks are complementary to the PCMH work and will assist primary care providers in identifying opportunities to integrate RCC into practice. RCC is applicable to all aspects of our healthcare delivery system, and we look forward to working with others to expand the framework to other care settings to harness the power of continuous health relationships in healthcare.

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[57] M.G. Ory, S. Ahn, L. Jiang, M.L. Smith, P.L. Ritter, N. Whitelaw, and K. Lorig, "Successes of a National Study of the Chronic Disease Self-Management Program: Meeting the Triple Aim of Health Care Reform," *Medical Care* 51:11 (November 2013): 992-998.

[58] "Chronic Disease Self-Management Program (Better Choices, Better health Workshop)," *Stanford Patient Education Research Center,* http://patienteducation.stanford.edu/programs/cdsmp.html

[59] Thomas Bodenheimer, MD; Amireh Ghorob, MPH; Rachel Willard-Grace, MPH; and Kevin Grumbach, MD, "The 10 Building Blocks of High-Performing Primary Care," *Annals of Family Medicine* (2014): 166-171.

Appendix I – Building Blocks of Relationship-Centered Primary Care

Instructions:

1) Assemble a team to perform the Relationship-Centered Primary Care (RCPC). The team should be comprised of at least one staff member from each of the following areas: providers/practitioners, non-clinical staff, clinical staff/care managers/nursing, and leadership if different from the other groups.

2) Assess the Critical Foundational Elements at the beginning of the tool. If these Elements are not present or developing, the likelihood of implementing RCPC is low and the team should proceed with the remainder of the assessment cautiously, understanding that developing of the Critical Foundational Elements must occur prior to the development of the other domains.

3) The team should discuss and assess the various domains of RCPC. Each domain contains several elements with a descriptive statement representing a continuum of attributes for RCPC from the least developed attributes on the left-hand side of the chart to the most developed attributes on the right-had side of the chart.

4) Practices should agree on the attribute that best describes development in that domain. Comments can be recorded in the final column to assist in future planning.

Critical Foundational Elements: Practice Culture, Vitality and Leadership				Comments
Element 1: Practice Culture				
Practice has no recognition of value of Relationship-Centered Primary Care	Practice occasionally expresses value for Relationship-Centered Primary Care elements	Practice has regular informal expression of value of Relationship-Centered Primary Care through verbal communications but no formalized statement	Practice has formal expression of value of various domains of Relationship-Centered Primary Care though mission/vision statements or other documents	
Element 2: Practice vitality and compassion fatigue				
Practice evidences empathy drain and compassion fatigue through negative commentary on patient behavior	Practice does not address issues of empathy drain or compassion fatigue or ineffective interventions	Practice has informal mechanisms for occasionally addressing compassion fatigue or empathy drain	Practice regularly addresses issues of compassion fatigue and empathy drain through formal support, training, and revitalization and finding meaning in the work	
Element 3: Leadership Commitment				
Leadership does not express value for Relationship-Centered Primary Care	Leadership occasionally demonstrates value for Relationship-Centered Primary Care elements	Leadership regularly, though informally, expresses support for Relationship-Centered Primary Care	Leadership evinces strong support for Relationship-Centered Primary Care and actively cultivates value among team	
Element 4: Leadership Style				
Leadership does not employ relationship-based management skills	Leadership occasionally employs relationship-based management skills	Leadership frequently employs relationship-based management skills	Leadership regularly employs relationship-based management skills and fosters/mentors relationship-based management skills throughout the organization	Note: Relationship-based management skills include: 1. Active listening 2. Respect for all team members and their contributions 3. Team problem solving 4. Value of authentic relationships that recognize the personhood of each individual

Domain A: Support Patients in Developing Supportive Interpersonal Relationships (Patient to Patient)				Comments
Element 1: Interpersonal relationships outside of the practice environment				
Family history is limited to medical factors; social history is limited to facts such as drug and alcohol use; few facts are gathered regarding patient's life experience or relationships.	Practice staff routinely assess for social connectedness and develop interpersonal asset mapping	Practice staff affirmatively encourage development of social connectedness	Practice staff actively engage in efforts to promote social connectedness through use of home visits, motivational interviewing, and focused problem solving techniques	
Element 2: Interpersonal relationships within the practice environment				
Practice has no mechanism for identifying any social connections for patients	Practice has policies for assessing emergency contact person and protecting patient privacy	Practice engages key members of patient's social network through encouragement of visit attendance	Practice engages key members of patient's social network through outreach and home visits	
Element 3: Caregiver support				
Practice has does not routinely assess parent or caregiver skills or needs	Practice assesses caregiver and parent needs through history taking	Practice makes referrals to caregiver/parenting support services	Practice provides robust caregiver/parenting support through active relationships with appropriate services or integrated services	
Element 4: Therapeutic peer support				
Practice has no relationship with peer support treatment modalities	Practice makes occasional referrals to peer support modalities	Practice actively assesses patients and makes regular referrals for appropriate patients to peer support modalities such as BH peer support, group prenatal care, and chronic disease self-management support.	Practice offers peer support modalities as an integrated option for care	

Domain B: Foster therapeutic/healing relationships between patients and all members of care team including non-clinical staff, practitioners/providers, and care management staff. (Patient to Provider)				Comments
Element 1: Non-clinical staff: a) Continuity				
Relationships between non-clinical staff and patients are not expected.	Non-clinical staff occasionally and informally may develop relationships with some patients over time	Non-clinical staff are encouraged to develop relationships with patients	Practice recognizes therapeutic value in relationships between non-clinical staff and patients and routinely incorporates staff into "therapeutic team."	
Element 1: Non-clinical staff: b) Assessment				
Practice focuses on task performance of non-clinical staff	Practice has mechanism to collect feedback from patients regarding patient interactions with non-clinical team such as suggestion box or complaint process and provides feedback to individual staff members as needed.	Practice monitors staff through mechanisms such as secret shopper and provides feedback to the team.	Practice uses results of assessment related to development of therapeutic relationships to develop practice policies, training protocols, and	
Element 1: Non-clinical staff: c) Training				
Practice has no formal training on	Practice provides some training on "customer service" elements.	Practice values development of relationships between non-clinical staff and patients and provides some training for non-clinical staff.	Practice values development of relationships between non-clinical staff and patients and provides regular, formal training for non-clinical staff.	

Domain B: (Continued) Foster therapeutic/healing relationships between patients and all members of care team (Patient to Provider)				Comments
Element 2: Practitioners: a) Continuity of care				
Practice does not address continuity of care	Practice has policies in place to promote continuity of care such as phone script for visit scheduling	Practice has empanelment process and regularly measures continuity of care; warm welcome protocol for new patients	Practice routinely measures and actively promotes continuity of care with providers through practice training and incentives	
Element 2: Practitioners b) Assessment				
Practice focuses on task performance of practitioners	Practice has mechanism to collect feedback from patients regarding patient interactions with clinical team such as suggestion box or complaint process	Practice performs regular assessment of clinicians' empathy and interpersonal skills (not just global patient satisfaction) and evaluates data by race/ethnicity, gender, sexual orientation, language group etc.	Practice uses results of assessment related to development of therapeutic relationships to develop practice policies and training protocols	
Element 2: Practitioners: c) Training				
Practice has no formal structure for addressing clinician empathy and interpersonal skills	Practice provides occasional training on empathy and interpersonal skills mostly related to addressing identified skill deficit or patient complaint	Practice provides proactive, regular training on empathy and interpersonal skill development	Practice provides regular training on empathy and interpersonal skills and actively promotes Relationship Centered Primary Care through incentives and culture	
Element 3: Care management staff a) Continuity of Care				
Practice does not address continuity of care for care managers	Practice attempts to promote continuity of care for care management staff through informal mechanisms	Practice regularly assesses continuity of care for care management staff and promotes through formal	Practice routinely measures and actively promotes continuity of care with care managers through practice training and incentives	

		policies such as addressing part-time staff		
Element 3: Care management staff b) Assessment				
Practice focuses on task performance of care managers (or has no care management staff)	Practice has mechanism to collect feedback from patients regarding patient interactions with clinical team such as suggestion box or complaint process	Practice performs regular assessment of care managers' empathy and interpersonal skills (not just global patient satisfaction) and evaluates data by race/ethnicity, gender, sexual orientation, language group etc.	Practice uses results of assessment related to development of therapeutic relationships to develop practice policies and training protocols	
Element 3: Care Management Staff: c) Training				
Practice has no formal structure for training care managers in empathic or interpersonal communication skills	Practice provides occasional training on empathy and interpersonal skills mostly related to addressing identified skill deficit or patient complaint	Practice provides proactive, regular training on empathy and interpersonal skill development	Practice provides regular training on empathy and interpersonal skills and actively promotes Relationship Centered Primary Care through incentives and culture	

Domain C: High-functioning practice teams based on nurturing interpersonal relationships (Provider to Provider)				Comments
Element 1: Team-based care				
Practice has no team-based care	Practices uses informal or ad hoc teams	Practice forms teams based on roles	Practice deliberately formulates high functioning/high communication level teams based on roles and team dynamics	
Element 2: Team training				
Practice has had no formal training in team dynamics	Practice has occasional training in team dynamics	Practice has some scheduled elements of team training such as annual retreat	Practice regularly sponsors team training and assesses effectiveness of training	
Element 3: Team relationships				
Team dysfunction is not routinely addressed	Practice has some structure for addressing team dynamics such as annual review	Team has some mechanism for discussing and resolving team differences	Team routinely assesses team dynamics and has a mechanism for resolving team dysfunction that honors the feedback from all members equally	

Domain D: Practice engages community in multiple opportunities to promote high quality health care and improved health outcomes (practice to community)				Comments
Element 1: Practice staff is derived from community served				
Practice hires staff based solely on previous experience and ability to perform tasks. Does not seek applicants from the community.	Practice occasionally hires members from local community	Practice makes systematic efforts to hire from local community and avoid outsourcing patient-facing services such as call center	Practice actively engages with community to develop training programs and professional ladders	
Element 2: Culturally competent outreach				
Practice does not have any mechanism for community outreach	Practice occasionally participates in community-focused events such as health fairs	Practice regularly engages with the community in events such as health fairs.	Practice has hired culturally competent outreach staff to routinely perform community outreach for targeted health conditions	
Element 3: Relationships with medical neighborhood				
Practice makes referrals as needed to other providers as identified through habit or insurance coverage	Practice participates in some type of organizing system such as clinically integrated networks or health system that provides framework for developing relationships in the medical neighborhood	Practice actively monitors volumes of referrals and PC provider satisfaction with rendering providers	Practice actively assesses referral relationships in terms of PC provider and patient satisfaction and has affirmative outreach to strengthen relationships with providers receiving higher volumes of referrals	
Element 4: Community Leadership				
Practice has no relationship with the community	Practice participates occasionally in community health improvement projects	Practice participates regularly in community health improvement projects	Practice has an active leadership role in community development and improvement of health outcomes for community members not affiliated with practice	