

A RETURN TO THE CRAFT OF HEALING WITH PATIENT-CENTERED, TEAM-BASED CARE

Integrative Primary Care Case Study

Patient-centered, team-based care enables physicians to develop the relationships—with patients and with team members—that are essential to health and healing.

Integrative primary care is the coordinated delivery of evidence-based conventional medical care, complementary medicine, and lifestyle medicine within a primary care practice.

FEATURED PRIMARY CARE PROVIDER



William L. Miller, MD

Dr. Miller is chair emeritus of the Department of Family Medicine at Lehigh Valley Health Network and professor of family medicine at the University South Florida Morsani College of Medicine. He has more than 30 years of clinical experience, including in the first group practice in the Lehigh Valley.

For nearly three decades, Dr. Miller has studied relationship-centered and collaborative (team-based) primary care, and primary care practice development. He was an evaluator on the American Academy of Family Physicians' Future of Family Medicine National Demonstration Project.

THE CHALLENGE:

Increasing Complexity Hampers High-Quality Primary Care

High-quality primary care is the foundation of a strong U.S. health care system.¹ Yet, the increasing complexity of patients and the health care system is undermining the ability of primary care physicians and practices to provide high-quality care.^{2,3}

Increasing Complexity of Primary Care

As more patients with multiple chronic conditions live into their 80s and 90s, the complexity of primary care has increased markedly. At the same time, large health systems are taking control of many health care services, including physician practices.² By 2016, only 47.1 percent of physicians had an ownership stake in their practice, according to a study by the American Medical Association.⁴

These factors make it very difficult for primary care physicians and practices to provide high-quality, relationship-centered care, and require more collaboration (teamwork), says William L. Miller, MD, chair emeritus of the Department of Family Medicine at Lehigh Valley Health Network and professor of family medicine at the University South Florida Morsani College of Medicine.²

“Primary care clinicians are in an awful situation where we know we can’t perform as well as we should.”

— Dr. Miller

THE JOURNEY:

A Relationship-Centered and Collaborative Primary Care Culture

As a medical anthropologist and a physician, Dr. Miller has always been interested in culture and the importance of relationships. When Dr. Miller began practicing family medicine, he realized that physician training and socialization often had a detrimental effect on caring, with physicians learning to detach from their emotional selves.

“Relationships with patients are core to the healing process and to the craft of primary care. Detachment makes it difficult for us to bring empathy to the patient experience because we’ve lost touch with ourselves,” he says.

“Relationships with patients are core to the healing process and to the craft of primary care.”

—Dr. Miller

Family Medicine Residents Focus on Relationships and Collaboration

Dr. Miller and his colleagues designed a family medicine residency training program at Lehigh Valley Health Network to overcome the new challenges within primary care. Focused on what they called the Tools of the Turtle Craft, the program places equal emphasis on core knowledge, relationship skills, and self-awareness. It helps residents understand the patient as a whole person within a family and community, and the patient's experience with disease and illness.

The Lehigh Valley Family Medicine residency training program focuses on enhancing the patient-practitioner relationship, incorporating prevention and health promotion, and being realistic about what can be achieved. Patient-practitioner relationships are based on shared goals, decisions, and diagnosis. While Dr. Miller's work focuses on traditional primary care, his model and insights are also at the center of integrative primary care.

About William L. Miller, MD

Dr. Miller is chair emeritus of the Department of Family Medicine at Lehigh Valley Health Network and professor of family medicine at the University South Florida Morsani College of Medicine. He has more than 30 years of clinical experience, including in the first group practice in Lehigh Valley.

For nearly three decades, Dr. Miller has studied relationship-centered and collaborative (team-based) primary care and primary care practice development. He was an evaluator on the American Academy of Family Physicians' Future of Family Medicine National Demonstration Project.

THE SOLUTION:

Patient-Centered, Team-Based Care Seeks to Transform Primary Care

Dr. Miller isn't alone in trying to restore relationships with patients and build collaboration in primary care. Many efforts to transform primary care, including the patient-centered medical home, call for both patient-centered and team-based care.^{5,6} The Agency for Healthcare Research and Quality (AHRQ) includes team-based care (as part of comprehensive care) and patient-centered care as two of the core functions of primary care.⁵

Definitions

Patient-Centered Primary Care:

“Care that is relationship-based with an orientation toward the whole person, and that includes partnering with patients and their families to understand and respect each patient’s unique needs, culture, values, and preferences. Care that is patient-centered also supports patients in learning to manage, organize, and participate in their own care at the level the patient chooses.”

— Agency for Healthcare Research and Quality⁵

Team-Based Care:

“...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.”

— National Academy of Medicine^{7,8,9}

The AHRQ offers a blueprint for ideal patient-centered, team-based care in its white paper *Creating Patient-centered Team-based Primary Care*.⁵ Based on a literature review and input from experts, the blueprint calls for:

- A coherent and identifiable provider team that works together to care for patients.
- Team members who build relationships with patients and with each other. They:
 - » Actively seek and respond to patients' preferences and values
 - » Work with and support patients in achieving their health goals
 - » Work to respect and trust other members of the team and to communicate effectively⁵

Team Members ²⁵

Members of the team vary across practices and within a practice, depending on the size of the practice and the patient's needs at that time. Team members can include:

Clinical staff:

- Care managers
- Dietitians
- Nurses
- Nurse practitioners
- Occupational therapists
- Pharmacists
- Physical therapists
- Physician assistants
- Physicians
- Social workers

Other staff who**perform some clinical functions:**

- Care coordinators
- Health coaches
- Peer counselors
- Scribes

Non-clinical staff:

- Administrators
- Billing clerks
- Patient navigators
- Receptionists

Complementary**medicine providers:**

- Acupuncturists
- Chiropractors
- Massage therapists
- Naturopaths
- Therapeutic yoga instructors

The optimal team size is six to eight people.

The Role of Patient-Centered, Team-Based Care in Integrative Primary Care

Patient-centered, team-based care provides two qualities of high-value integrative primary care:

- **Integrative health care:** The coordinated delivery of conventional medicine combined with evidence-based complementary and lifestyle medicine designed to enhance health, healing, and well-being.
- **Patient engagement in care decisions:** Working together, providers and patients optimize health and well-being. The provider identifies the patients' values and goals for healing and offers evidence-based conventional, complementary, and lifestyle medicine and support to help patients meet their goals.

High-Value Health Care for Payers

High-value integrative primary care enables providers to respond to incentives that reward high-value health care from Medicare and other payers.

 **34%**
LOWER SPENDING

High-value practices compared to average value practices.¹¹

Qualities of Integrative Primary Care

1. Expanded access to care
2. Integrative health care
3. Standing orders and protocols
4. Upshifted staff roles
5. Careful selection of specialists, including specialists in complementary medicine
6. Decision support for evidence-based medicine
7. Patient engagement in care decisions
8. Comprehensive primary care

The Evidence Behind Patient-Centered, Team-Based Care

There are many established and potential benefits of patient-centered, team-based care.

Benefits of Patient-Centered, Team-Based Care

Benefits of patient-centered care:^{12 13 14 15}

- Improved physician-patient communication and relationships
- Higher patient satisfaction
- Better recall of information and treatment adherence
- Better recovery
- Improved health outcomes

Potential benefits of team-based care:

- Expanded access to care (more hours of coverage and shorter wait times)¹⁶
- More effective and efficient delivery of essential services providing high-quality primary care, such as:
 - » Patient education
 - » Behavioral health
 - » Self-management support
 - » Care coordination
 - » Increased job satisfaction^{17 18 19 20 21 22}
- An environment in which all medical and nonmedical professionals are encouraged to perform work that is matched to their abilities²³

The evidence behind patient-centered and team-based care highlighted under implementation strategies are based upon:

- AHRQ's *Creating Patient-centered Team-based Primary Care*
- Dr. Miller's and others' work
- Primary Care Team Guide from the MacColl Center for Health Care Innovation at Kaiser Permanente, Washington Health Research Institute

The implementation strategies offered in AHRQ's *Creating Patient-centered Team-based Primary Care* may lack evidence from clinical trials or other studies; however, they are based upon a literature review and input from experts.⁵

Dr. Miller's relationship-centered approach to primary care and insights on collaborative learning environments are backed by:

- Nearly 30 years of research on primary care practice development
- Evaluation work on the American Academy of Family Physicians' Family Medicine National Demonstration Project
- Creating and teaching in the Lehigh Valley Health Network family medicine residency training program²

Evidence and recommendations from the Primary Care Team Guide are based upon "The Primary Care Team: Learning from Effective Ambulatory Practices." Funded by the Robert Wood Johnson Foundation, this program involved 31 practices and was designed "to identify, study, and engage exemplar primary care practices from across the United States that are using their workforce creatively." Dr. Miller was a consultant on this program. Staff of the MacColl Center for Health Care Innovation at Kaiser Permanente Washington Health Research Institute created the Primary Care Team Guide.¹

THE IMPLEMENTATION:

A Return to Healing Through Patient-Centered, Team-Based Primary Care

Implementing patient-centered and team-based care facilitates the relationships—between patients and primary care physicians and between team members—that are essential to health and healing.^{3,5}

Good relationships among team members "provide the foundation for the development of high-functioning teams and for high-quality patient-centered care."

— Agency for Healthcare Research and Quality⁵

Challenges in Patient-Centered and Team-Based Care

There are, however, challenges in implementing patient-centered and team-based care, particularly team-based care. While some challenges are beyond the control of individual primary care physicians or practices, physicians can take actions to:

- Improve care for patients through more active engagement with them in shared decision-making and with patient advisory councils.
- Increase patient and clinician satisfaction by developing mindfulness and a safer, high- communication environment.

This section provides an overview of key challenges. Solutions are described under implementation strategies.

1. **Patient-centered, team-based care requires “profound” changes.** Changes include the culture and organization of care, relationships among colleagues and with patients, and education and training.⁵ Cultural issues include the threat to physician autonomy posed by team-based care and the difficulty of developing and maintaining relationships.^{2,3}
2. **Patient-centered, team-based care could negatively impact healing relationships.** Teamwork is necessary to provide comprehensive care, yet team-based care could potentially negatively impact the relationships between patients and clinicians that are crucial to health and healing by sharing the care across several team members.⁵

Patients and clinicians are concerned that team-based care might make “relational continuity” difficult. AHRQ defines “relational continuity” as “ongoing, caring relationships in which a patient is known by his or her provider so that past care is linked with current care.” Patients might feel that their clinician no longer knows them and find it disconcerting to have to develop relationships with other team members.

3. **Support from leadership is necessary for patient-centered, team-based care.** Leadership must support the implementation of patient-centered, team-based care by providing time, training, and other resources.^{1,2} Unfortunately, many health systems that own primary care practices often do not provide the necessary support, and most independent practices can’t afford it.²
4. **Health policy hinders patient-centered, team-based care.** Current U.S. health policy focuses more on data and documentation of volume rather than on healing relationships and patient care.²

Implementation Strategies

The strategies featured here focus primarily on actions where primary care physicians and practices can impact the quality of primary care. Physicians practicing in large health systems should work with their practice managers to obtain the leadership support necessary to fully implement patient-centered, team-based care.²

More Implementation Strategies

For more information on how to implement patient-centered, team-based care, see:

- *Creating Patient-centered Team-based Primary Care*
- Primary Care Team Guide

Implementation Strategies for Patient-Centered Care

1. **Build a patient-centered or “relationship-centered” primary care culture.** Consider patients as knowledgeable partners in care and build relationships with them. When delivering care, consider patients’ needs, preferences, and goals.^{5,24} The [HOPE Note](#) provides a tool to find out “what matters” to patients. AHRQ calls this a “culture of relationship.”⁵

“Relationship-centered care will enable primary care physicians to get back to the craft of healing.”

— Dr. Miller

The family medicine residency training program at Lehigh Valley Health Network refers to this as a “relationship-centered, evidence-informed lens.” Using this lens, the patient contributes information about health behaviors, knowledge/beliefs, his/her body, and experience with illness. The primary care physician contributes his/her clinical experience, beliefs and values, and the best available scientific evidence. Together, they use this information to develop personalized health goals and make decisions about care.²⁴

Getting Back to Healing with Mindful Practice^{25 26}

Mindful practice helps physicians provide patient-centered care while also facilitating physician resilience and well-being, and better relationships with team members.

“Mindfulness is the ability to pay attention to what’s going on inside you as well as outside you in a non-judgmental way,” says Ronald M. Epstein, MD, author of [Attending: Medicine, Mindfulness and Humility](#). Dr. Epstein is a family physician, palliative care physician, writer, researcher, and teacher of communication and mindful practice in medicine at the University of Rochester School of Medicine and Dentistry.

Simple ways to be mindful include:

1. **Sit down when seeing a patient.** The patient will feel like the physician is more present, and the physician will feel more present. Sitting makes both patient and physician feel like they have more time.
2. **Spend the first few minutes of a visit facing the patient.** Talking to the patient face-to-face instead of looking at the computer screen enables the physician to process complex information about the whole patient more quickly and completely.

2. **Learn about the community.**^{1 5 27}

Interacting with the community fosters team-based care, according to a study of team-based primary care in the United States, Canada, and Australia conducted by Dr. Miller and colleagues.²⁶ AHRQ suggests assigning staff members to learn about the community and build relationships with key community service agencies and programs.⁵

The Primary Care Team Guide suggests using patient advisory groups, focus groups, and surveys to learn about the community and notes that a social worker or a layperson from the community can work on developing relationships and agreements with key community organizations.¹ This is key to addressing the social determinants of health, which provide up to 40 percent of health and well-being.

3. **Engage patients in setting procedures and policies for the primary care practice.**

Involve patients in planning to help build understanding among patients, primary care physicians, and other team members. Strategies to do this include:

- **Create “a core group of patients to provide ongoing input and contribute to planning processes.”** The group can be an advisory council, or patients can serve as what AHRQ calls “patient partners.” Through regular meetings, the advisory council or patient partners can provide input on anything that affects patient care and experiences.

- **Offer all patients a way to provide input.** Other patients can provide input through a comments box at the front desk or patient surveys.⁵
4. **Hire team members who fit in a patient-centered and team-based primary care culture.**¹⁵
Patient-centered, team-based care requires the right team members. Strategies to ensure that team members fit the culture include:
- **Revise job descriptions to include a patient-centered focus.** A patient-centered focus requires a commitment to patient-centered care and strong skills in building relationships, communication, and listening.⁵ Empathy is a key skill that can be identified when hiring employees and enhanced through training.
 - **Hire team members who understand the people in the community.**¹⁵ “Hiring staff from the community which a practice serves provides an insider’s view of cultural norms, environmental issues, resources, and other important aspects of community life. Their presence tends to relax patients, and they can give important information to the care team about individual patients and their environments,” says the Primary Care Team Guide.¹
 - **Hire team members who want to innovate, are flexible, and believe in team-based care.**¹
5. **Train team members to apply patient-centered, team-based care and engage patients during visits.**⁵
Strategies to do this include:
- **Train team members on:**
 - » Communication, motivational interviewing, and active listening
 - » Viewing patients as resourceful partners in care
 - » Shared decision-making
 - » Listening, emotional labor (managing feelings in accordance with the culture of the practice), and empathy
 - **Develop ways to solicit input on patients’ treatment preferences and goals:**
 - » Use available resources to identify patients’ goals, such as the resources on AHRQ’s [Self-Management Support page](#).
 - » Match each patient with the right team member for conversations about preferences and goals. Patients and team members can be matched by personal skills, status, and/or training.
 - » Use the [HOPE Note](#). Dr. Jonas’s HOPE Note guide gets at what matters to patients and addresses the personal determinants of healing not captured in the conventional SOAP Note interview.
6. **Communicate with patients about and promote patient-centered, team-based care. Seek continual feedback.**¹⁵
After adopting patient-centered, team-based care, communicate with patients about how this is different from the usual primary care visit and what patients should expect. Use patient-centered language to describe the practice’s patient-centered, team-based care approach.

Strategies to communicate include:

- **Train clinicians to talk with individual patients**, focusing on the benefits of team-based care and how patients can have a say in how their team works.
- **Offer group orientation sessions** about patient-centered, team-based care.
- **Create brochures, flyers, letters, videos, and/or website information** about patient-centered, team-based care. Post flyers throughout the offices, including in exam rooms.
- **Develop a team bio sheet to introduce patients to all team members.** The bio sheet should have each team member's photo, name, title, and a brief description of his/her role on the team.
- **Develop a simple script** to explain "that all team members are working together, communicating regularly, and operating under the direction of the patient's primary care provider," says the Primary Care Team Guide.
- **Use "warm handoffs" to introduce a patient to another team member.** A team member who knows the patient introduces him/her to another team member and explains the role of the other team member either personally or by a referral.

Implementation Strategies for Team-Based Care

7. **Shift to a teamwork mindset and culture.**¹²³

Moving to team-based care requires re-thinking the role of the physician and the culture of medicine. Physicians must relinquish some of their autonomy and show respect and humility, says Dr. Miller. They must be both team leaders and team members.

Practice managers and owners should ease the transition to team-based care by providing primary care physicians with:

- Training in communication, leadership, listening skills, and team building.
- Time for communicating and working with other team members outside of patient visits.

8. **Build coherent teams.**¹²⁵

Members of effective teams must communicate often and well and function collaboratively. Primary care physicians must learn to trust their staff and promote a sense of fairness, respect, unity, and collective responsibility among team members.

"Focus on your craft and your relationships with colleagues. Listen to and talk to people around you," says Dr. Miller.

Strategies for building group coherence include:

- **Improve communication through regular meetings, huddles, and other methods.** Review patient care and discuss the practice during regular team meetings and/or short huddles with all team members.

Meetings can “be a way to build relationships between team members and promote a collective, non-hierarchical team identity,” says AHRQ. Adds Dr. Miller, “Physicians need to show up to practice gatherings and show up in a learning mode.” Other ways to communicate include instant messaging and/or calling primary care physicians.

- **Locate team members near each other.** This facilitates communication and relationship- building and allows team members to easily access the expertise of their colleagues.

9. **Redistribute some appropriate work from primary care physicians to other team members.** ^{1 27}

Providing care without direct physician involvement facilitates team-based care, according to a study of team-based primary care in the United States, Canada, and Australia conducted by Dr. Miller and colleagues. ²⁷

Expanding the role of nurses was the most common way to reallocate clinical tasks, with nurses taking responsibility for tasks such as:

- Giving immunizations
- Performing pre-exam assessments
- Chronic disease management through patient assessments and education²⁶

Most of the 31 practices that participated in “The Primary Care Team: Learning From Effective Ambulatory Practices” had medical assistants and licensed practical nurses perform preventive care procedures such as:

- Immunizations
- Ordering cancer screening
- Assessments such as monofilament foot exams¹

How Scribes, Social Workers, and Health Coaches Can Improve Team-Based Care ²

The Lehigh Valley Health Network and other practices studied by Dr. Miller and his colleagues use scribes, social workers, and health coaches to help primary care practices work more effectively.

1. **Scribes** can handle documentation during an office visit, freeing the physician to focus on the patient. “Working with a scribe allows me to be eye-to-eye with the patient in a way that’s not possible when looking at an EHR,” says Dr. Miller. Scribes also allow physicians to see more patients and thereby pay for themselves and improve access.

Medical assistants or aspiring medical students can serve as scribes. Dr. Miller prefers training medical assistants as scribes because of the continuity and team-building aspects. Health coaches can also serve as scribes.

2. **Social workers** can help patients find and access community resources and the social support they need. The social worker

sees the patient after the physician, when necessary, and can help patients with non-medical needs that impact health, such as health insurance, heat, access to food, and housing.

3. **Health coaches** can offer preventive and wellness care to help patients achieve their health goals. The health coach can also see the patient before the physician and take the social and behavioral history, and then come in again after the visit with the physician to provide guidance on self-management issues and behavior change. Dr. Jonas regularly uses health coaches to assist patient implement activities that emerge during the [HOPE Assessment](#). For more information about training for health coaches click [here](#).

“Scribes, social workers, and health coaches are home runs all the way,” says Dr. Miller.

10. **Develop clear roles and responsibilities for each team member and standard orders and work processes.**¹⁵

“Clearly delineate each team member’s responsibilities and create standard work procedures so that each team member understands the roles of others,” says AHRQ. Standard orders and work processes will enable team members to perform common services without involving the primary care physician.

11. **Develop written and verbal information-sharing methods.**⁵

Effective team-based care requires coordination and communication. Strategies for information sharing include:

- Establish record systems that make it easy for team members to record, update, and share patient information.

- Create shared care plans that include the patient's goals, needs, and preferences.
- Use secure text messaging to communicate while the patient is in the office.
- Hold daily team huddles to discuss the daily schedule and the action plan for each patient.

12. Use relevant measures to support ongoing learning and the provision of patient-centered, team-based care.²⁵

"Measure continuity, comprehensiveness, and coordination. Ask questions about these things in patient experience surveys," says Dr. Miller.

AHRQ published an inventory of [measures of team-based primary care](#) and suggests other ways to obtain patients' feedback, including:

- Asking patients for feedback in a short conversation or a brief written questionnaire after the visit
- Walking through the visit process and documenting the care from the patient's perspective

Financial Implications of Patient-Centered, Team-Based Care

It is possible to see a positive return on the investment in team-based care, according to The Primary Care Team Guide.¹ However, payers, not primary care practices, will see the financial benefits. "In theory, relationship-centered and team-based care should reduce the overall cost of care at the population level. There are few ways it will improve the business model of the primary care practice," says Dr. Miller.²

Savings from Patient-Centered Medical Homes

Substantial evidence exists about savings from patient-centered medical homes (PCMHs), whose core functions include patient-centered and team-based care. In 2017, the National Committee for Quality Assurance reported "a growing body of scientific evidence shows that PCMHs are saving money by reducing hospital and emergency department visits, mitigating health disparities, and improving patient outcomes." Most of these financial benefits, however, are seen by Medicare and other payers, not by the practice.²⁸

Potential Financial Benefits of Team-Based Care

The Primary Care Team Guide states that team-based care has the potential to:

- Position primary care practices to capture pay-for-performance and quality improvement bonuses and grants
- Streamline workflow and maximize the use of staff
- Improve efficiency¹

Each of these potential benefits has disadvantages, says Dr. Miller. While primary care practices can capture pay-for-performance and quality improvement bonuses and grants, "the quality of care in other areas of care often goes down. They just meet the goal of the pay-for-performance, and they need to hire people to write grants to get the bonuses."²

It is possible to make modest improvements in the use of staff and workflow, says Dr. Miller. However, the use of staff cannot be maximized. “Maximization assumes known demand. In primary care, we can never know the demands or needs of the moment.”²

Over-emphasis on efficiency can hinder the development of good relationships, which are essential to providing high-quality primary care, says Dr. Miller.²

Impact of the Fee-For-Service Payment Model

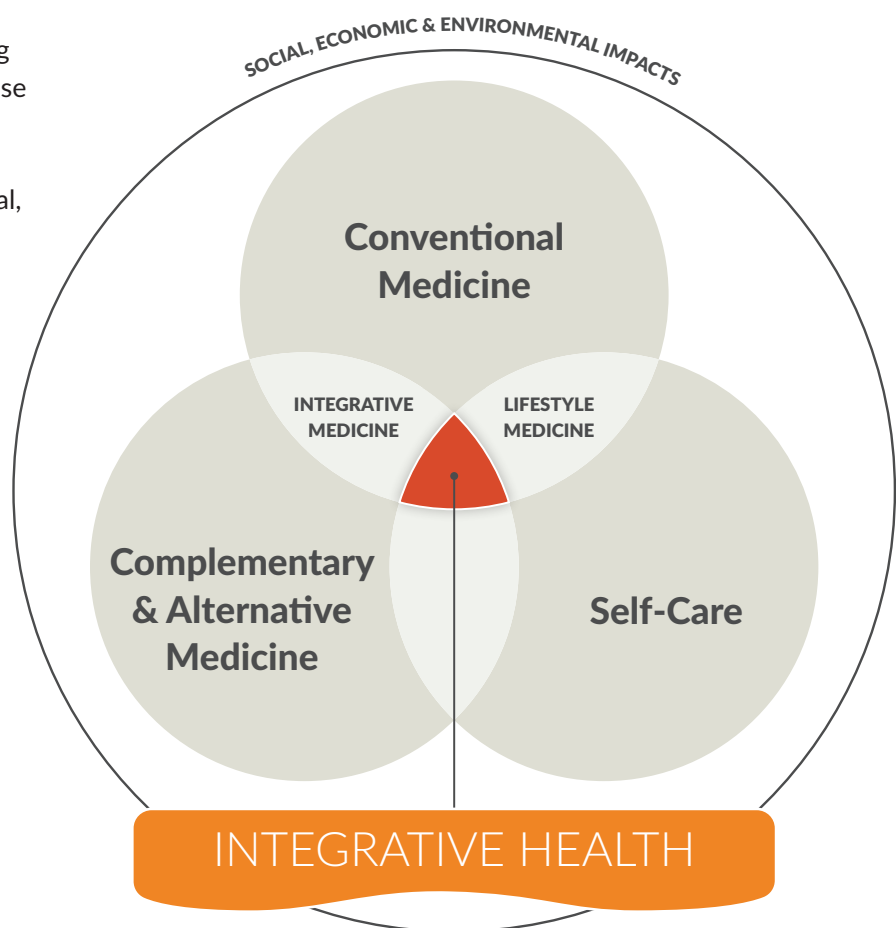
The predominant fee-for-service payment model in the United States hinders team-based care, says Dr. Miller, who prefers calling it “fee-for-documentation.” In a study of team-based primary care in the United States, Canada, and Australia, he and colleagues found that primary care practices that received only fee-for-service payments made little progress toward team-based care. Outside of the United States, reforms to fee-for-service payments facilitated team-based care.²⁶

WHAT IS INTEGRATIVE HEALTH?

Integrative health is the pursuit of personal health and well-being foremost, while addressing disease as needed with the support of a health team dedicated to all proven approaches—conventional, complementary, and self-care.

Optimal health and well-being arises when we attend to all factors that influence healing, including:

- Medical treatment
- Personal behaviors
- Social and emotional dimensions
- Mental and spiritual factors
- Social, economic, and environmental determinants of health



Integrative medicine is the coordinated delivery of evidence-based conventional medical care, complementary medicine, and lifestyle medicine for producing optimal health and well-being.

Integrative primary care is the coordinated delivery of evidence-based conventional medical care, complementary medicine, and lifestyle medicine within a primary care practice.

Lifestyle medicine incorporates healthy, evidence-based self-care and behavioral approaches into conventional medical practice to enhance health and healing.

Integrative health redefines the relationship between the practitioner and patient by focusing on the whole person and the whole community. It is informed by scientific evidence and makes use of all appropriate preventive, therapeutic, and palliative approaches, health care professionals, and disciplines to promote optimal health and well-being. This includes the coordination of conventional medicine, complementary/alternative medicine, and lifestyle/self-care.

Improve Care Quality and Patient Outcomes and Satisfaction

Incorporating integrative medicine into mainstream primary care practices enables physicians and other health care providers to:

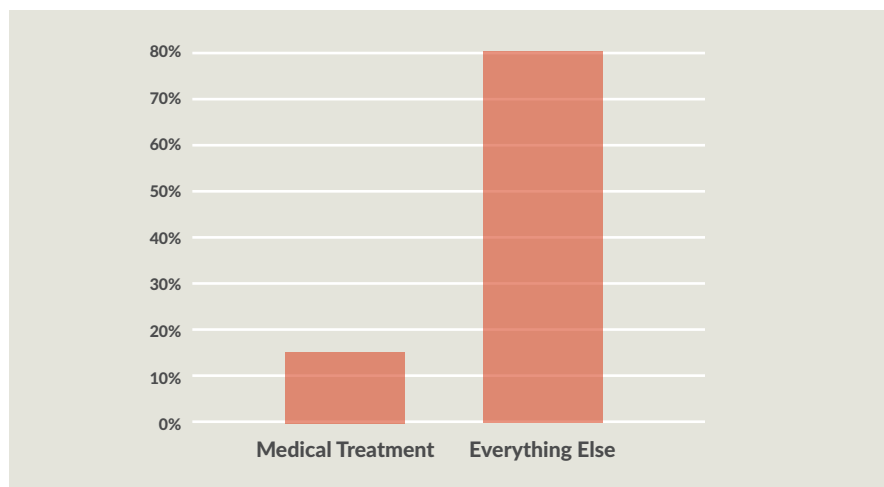
- Deliver higher quality care
- Improve patient outcomes and satisfaction
- Lower costs
- Reduce burnout

Balance Healing and Curing in Chronic Diseases

As currently practiced, modern medicine, which is so powerful in treating acute disease, is missing nearly 80 percent of what contributes to healing for chronic disease. Even optimal medical treatment contributes only 15 to 20 percent to the health of a population.¹⁰

The rest comes from:

- Lifestyle and behavior
- Environment
- Social determinants of health¹⁰



Integrative health balances healing and curing. It goes beyond treating disease to helping patients thrive by tapping into their inherent healing capacity.¹⁰

Guide Patients on their Healing Journey

Integrative health starts with the physician or other primary care provider listening to the patient to understand his/her needs and values. Providers then match the patient's goals with good practices to promote healing and improve health and well-being.

Ways to Guide Patients

- Promote lifestyle, behavioral, and self-care changes
- Promote proven conventional practices and proven complementary practices
- Protect patients from dangerous, disproven, or toxic practices
- Permit practices that may work and have no harmful side effects
- Partner with patients. Be willing to research and discuss the evidence for conventional, complementary, and self-care.

THE RESOURCES

Resources About Patient-Centered, Team-Based Care

Guides

[*Creating Patient-Centered Team-Based Primary Care*](#). White paper. Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, Genevro J Rockville, MD: Agency for Healthcare Research and Quality, AHRQ Pub. No. 16-0002-EF: March 2016. Accessed 5/8/18.

The MacColl Center for Health Care Innovation at Kaiser Permanente Washington Health Research Institute. [*Primary Care Team Guide*](#). 2018. Accessed 5/8/18.

Journal articles

Miller WL and Cohen-Katz J. "Creating collaborative learning environments for transforming primary care practices now." *Families, Systems, & Health*, Vol 28(4), Dec 2010, 334-347. Accessed 3/18/18.

Miller WL, Crabtree BF, Nutting PA, KC Stange, and Jaén CR. "Primary Care Practice Development: A Relationship-Centered Approach," *Annals of Family Medicine*, May 1, 2010 vol. 8 no. Suppl 1 S68-S79.

Tools

Agency for Healthcare Research and Quality [TeamSTEPPS for Primary Care](#)

Agency for Healthcare Research and Quality inventory of [measures of team-based primary care](#)

Cambridge Health Alliance. [Cambridge Health Alliance Team Based Care Toolkit](#).

Resources about Integrative Primary Care

- Jonas, W. [Developing an Integrative Health Model: Who, What, and How](#), 2017.
- Jonas, W. Healing Oriented Practices and Environments (HOPE) Assessment. 2018.
- Jonas, W. [How Healing Works](#). Oakland, CA; Ten Speed Press, 2018.

THE REFERENCES

- 1 MacColl Center for Health Care Innovation at Kaiser Permanente Washington Health Research Institute. [Primary Care Team Guide](#). 2018. Accessed 5/8/18.
- 2 Interview with William L. Miller, MD, April 19, 2018.
- 3 Miller WL and Cohen-Katz J. "[Creating Collaborative Learning Environments for Transforming Primary Care Practices Now](#)." *Families, Fam Syst Health*. 2010 Dec;28(4):334-47. doi: 10.1037/a00220. Accessed 5/8/18.
- 4 Kane C. "[Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent](#)." American Medical Association, May 2017. Accessed 5/8/18.
- 5 Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, Genevro J. [Creating Patient-Centered Team-Based Primary Care](#). AHRQ Pub. No. 16-0002-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2016. Accessed 5/8/18.
- 6 Agency for Healthcare Research and Quality. "[Defining the PCMH](#)." Accessed 5/8/18.
- 7 Naylor MD, Coburn KD, Kurtzman ET, et al. *Inter-professional team-based primary care for chronically ill adults: State of the science*. Unpublished white paper presented at the ABIM Foundation meeting to Advance Team-Based Care for the Chronically Ill in Ambulatory Settings. Philadelphia, PA: March 2010.
- 8 Mitchell P, Wynia R, Golden B, et al. [Core principles and values of effective team-based health care](#). Discussion Paper. Washington, DC: Institute of Medicine; 2012. Accessed 5/23/18.
- 9 Okun, S, Schoenbaum S, Andrews D, et al. [Patients and health care teams forging effective partnerships](#). Discussion Paper. Washington, DC: Institute of Medicine; 2014. Accessed 5/23/18.
- 10 Jonas W. [Developing an Integrative Health Model: Who, What, and How](#), 2017.
- 11 Melora Simon, MPH, Niteesh K. Choudhry, MD, PhD, Jim Frankfort, MD, David Margolius, MD, Julia Murphy, MSc, Luis Paita, PhD, Thomas Wang, PhD and Arnold Milstein, MD, MPH, "[Exploring Attributes of High-Value Primary Care](#)," *The Annals of Family Medicine*, Nov/Dec 2017. Accessed 3/26/18.
- 12 Rickert J. "[Patient-centered care: what it means and how to get there](#)." Health Affairs Blog. Accessed 5/23/18.
- 13 Zolnierek KBH, DiMatteo MR. "Physician communication and patient adherence to treatment: a meta-analysis." *Med Care*. 2009;47(8):826-834.
- 14 Ong LM, De Haes JC, Hoos AM, et al. "Doctor-patient communication: a review of the literature." *Soc Sci Med*. 1995;40(7):903-918.
- 15 Stewart M, Brown JB, Donner A, et al. "The impact of patient-centered care on outcomes." *J Fam Pract*. 2000; 49(9):796-804.
- 16 Campbell SM, Hann M, Hacker J, et al. "Identifying predictors of high quality care in English general practice: observational study." *BMJ*. 2001 October 2001;323(7316):784.

- 17 Shojania KG, Ranji SR, McDonald KM, et al. "Effects of quality improvement strategies for type 2 diabetes on glycemic control: a meta-regression analysis." *JAMA*. 2006;296(4):427-440.
- 18 Walsh JM, McDonald KM, Shojania KG, et al. "Quality improvement strategies for hypertension management: a systematic review." *Med Care*. 2006;44(7):646-657.
- 19 Gilbody S, Bower P, Fletcher J, et al. "Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes." *Arch Intern Med*. 2006;166(21):2314-2321.
- 20 Wagner E. "The role of patient care teams in chronic disease management." *BMJ*. 2000;320(7234):560-572.
- 21 Bodenheimer T. *Building teams in primary care: lessons learned*. Oakland, CA: California Health Care Foundation; 2007.
- 22 Aiken LH. "Achieving an interdisciplinary workforce in health care." *N Engl J Med*. 2003; 348(2):164-166.
- 23 Sevin C, Moore G, Shepherd J, et al. "Transforming care teams to provide the best possible patient-centered, collaborative care." *J Ambulatory Care Manage*. 2009; 32(1):24-31.
- 24 Miller W and Keister D. Tools of Turtle Craft Overview," PowerPoint presentation for Lehigh Valley Health Network family medicine residency program. 2017.
- 25 Epstein RM. "[Mindful practice](#)." Accessed 5/21/18.
- 26 Dawson E. "[Connections: Attending: Medicine, Mindfulness, and Humanity](#)." Interview with Ronald M. Epstein, MD. Accessed 5/21/18.
- 27 Russell GM, Miller WL, Gunn JM, et al. "[Contextual Levers for Team-based Primary Care: Lessons from Reform Interventions in Five Jurisdictions in Three Countries](#)." *Family Practice*, 2018; 35(3): 276–284. Accessed 5/8/18.
- 28 National Committee for Quality Assurance. [Latest Evidence: Benefits of the Patient-Centered Medical Home](#). October 2017. Accessed 5/22/18.

ABOUT THE AUTHOR – DR. WAYNE JONAS

Dr. Jonas is a practicing family physician, an expert in integrative health and health care delivery, and a widely published scientific investigator. Dr. Jonas is the Executive Director of Samueli Integrative Health Programs, an effort supported by Henry and Susan Samueli to increase awareness and access to integrative health. Additionally, Dr. Jonas is a retired lieutenant colonel in the Medical Corps of the United States Army. From 2001-2016, he was president and chief executive officer of Samueli Institute, a nonprofit medical research organization supporting the scientific investigation of healing processes in the areas of stress, pain, and resilience.

Dr. Jonas was the director of the Office of Alternative Medicine at the National Institutes of Health (NIH) from 1995-1999, and prior to that served as the Director of the Medical Research Fellowship at the Walter Reed Army Institute of Research. He is a Fellow of the American Academy of Family Physicians.

His research has appeared in peer-reviewed journals such as the *Journal of the American Medical Association*, *Nature Medicine*, *Journal of Family Practice*, *Annals of Internal Medicine*, and *The Lancet*. Dr. Jonas received the 2015 Pioneer Award from the Integrative Healthcare Symposium, the 2007 America's Top Family Doctors Award, the 2003 Pioneer Award from the American Holistic Medical Association, the 2002 Physician Recognition Award of the American Medical Association, and the 2002 Meritorious Activity Prize from the International Society of Life Information Science in Chiba, Japan.

To access more information on integrative health, including tools and resources for patients and providers, visit DrWayneJonas.com

DrWayneJonas.com

 [@DrWayneJonas](https://twitter.com/DrWayneJonas)

