

# So Much to Do, So Little Time

## *Care for the Socially Disadvantaged and the 15-Minute Visit*

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**T**here is so much to do in primary care, and so little time to do it. During 15-minute visits, physicians are expected to form partnerships with patients and their families, address complex acute and chronic biomedical and psychosocial problems, provide preventive care, coordinate care with specialists, and ensure informed decision making that respects patients' needs and preferences. This is a challenging task during straightforward visits, and it is nearly impossible when caring for socially disadvantaged patients with complex biomedical and psychosocial problems and multiple barriers to care. Consider the following scenario.

Mrs S is a 52-year-old housekeeper with poorly controlled diabetes mellitus, hypertension, and obesity who missed her last 2 visits because of job conflicts. She has not reached her annual insurance deductible and pays for the visit out of pocket. She speaks limited English, and the receptionist translates. Dr M explores her complaints of fatigue, daily headaches, back pain, and conflict with her husband after his job loss. Dr M conducts a thorough medical history and physical examination and concludes that Mrs S's poorly controlled diabetes mellitus, night shifts, work, and depression are contributing to her symptoms. He recommends mental health counseling, but Mrs S declines. Dr M recommends an antidepressant and adds 2 new medications for diabetes and blood pressure and reviews their purposes and adverse effects. Mrs S politely acquiesces, knowing she cannot afford them and doubting their benefit. The receptionist interrupts Dr M to tell him he is behind, and he quickly concludes the visit. Mrs S leaves the office still worried about her health and the costs of care. Because the visit takes 30 minutes, her office fee does not fully cover visit costs. Dr M despairingly notes that

none of Mrs S's preventive or chronic disease quality measures meet local standards. He considers discharging her from his practice for nonadherence to avoid being penalized under pay-for-performance.

As illustrated, constraining care to 15-minute visits for socially disadvantaged patients virtually ensures the perpetuation of health care disparities. Socially disadvantaged patients, often referred to as vulnerable or underserved, are at higher risk for multiple risk factors because of shared social characteristics.<sup>1</sup> They include members of racial and ethnic minority groups and persons with low literacy and low socioeconomic status.<sup>2</sup> These groups, although distinct, overlap considerably, resulting in concentration of risk for patients.<sup>3</sup>

In this article, we illustrate how the 15-minute office visit discriminates against socially disadvantaged patients and propose fundamental reform in primary care structure and payment to address the problem.

### SO LITTLE TIME

The average office visit in the United States lasts for about 16 minutes,<sup>4</sup> not enough time to effectively address multiple complex problems.<sup>5</sup> Typically, 5 minutes are spent on one problem and a minute or 2 on the remainder.<sup>6</sup> Providing all recommended preventive and chronic disease care takes far more time than is available during 2 adult primary care visits per year.<sup>7</sup>

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To provide guideline-concordant care, a physician caring for a usual panel of patients would need to spend 35 hours on preventive health care during a typical week,<sup>8</sup> another 50 hours on patients' chronic care needs,<sup>9</sup> and unknown hours for acute care, in addition to the 8 hours primary care physicians currently spend on patient care outside of office visits.<sup>10</sup> These time constraints severely limit informed decision making<sup>3</sup> and confirmation of patient understanding,<sup>11</sup> and commonly result in omission of discussion of adverse medication effects and costs.<sup>12,13</sup> For socially disadvantaged patients, who more commonly have multiple, complex, biomedical, and psychosocial problems, care is worse.<sup>12,13</sup>

## SO MUCH TO DO

Caring for socially disadvantaged patients poses unique challenges, requiring more time and greater teamwork (**Table 1**).<sup>14</sup> Communication across differences in language, culture, and health literacy takes time.<sup>26,30-53</sup> Socially disadvantaged patients experience worse physical<sup>54-56</sup> and mental health,<sup>22,57,58</sup> including more impairments in vision, hearing, and cognition that slow communication.<sup>15</sup>

Review of the main parts of the office visit illustrates the key challenges of caring for socially disadvantaged patients during 15-minute visits.<sup>28</sup> Initiating the visit involves establishing rapport and identifying the reasons for the visit. Achieving rapport across races, ethnicities, and educational levels can be challenging.<sup>29,59</sup> Eliciting all the reasons for the visit and negotiating an agenda may take longer because socially disadvantaged patients have more concerns,<sup>14,16</sup> symptoms,<sup>15</sup> and illnesses.<sup>60</sup> Patients with low health literacy may not recognize key symptoms as readily.<sup>61,62</sup> Time pressures may undermine physician empathy<sup>63</sup> and patient trust,<sup>64</sup> particularly among marginalized patients.<sup>65</sup>

Gathering information about the illness, including key symptoms and psychosocial context, is more time consuming because socially disadvantaged patients may have more

symptoms, more complex illnesses,<sup>66</sup> and greater psychosocial stress.<sup>67,68</sup> Exploration of patients' perspectives is critical to establishing a partnership and understanding patients' beliefs, but is also more time consuming across sociocultural distance.<sup>69</sup>

Physical examination may also take longer owing to greater illness burden and disabilities that slow the process.<sup>15</sup> Preventive care involving disrobing (eg, Pap smears or breast and rectal examinations) is less likely to happen.<sup>70,71</sup>

Discussion of diagnosis and treatment involves exchange of illness-related information, confirmation of patient understanding,<sup>35</sup> complex decision making, and promotion of behavior change.<sup>5,14</sup> Each of these tasks may take longer because of differences in language,<sup>26,27</sup> health literacy,<sup>24,25</sup> health beliefs, culture,<sup>72</sup> and levels of trust.<sup>65,73</sup> Participatory decision making may seem unfamiliar to historically marginalized patients.<sup>74</sup> In addition, primary care physicians frequently provide time-consuming mental health counseling to socially disadvantaged patients who do not have access to or are suspicious of psychiatrists or psychologists.<sup>75</sup> Addressing barriers to specialty referral and adherence takes time.<sup>38,39</sup>

Closure of the visit—summarizing the diagnosis, treatment plan, and follow-up instructions—takes longer when communication barriers are present. Lengthening visits can help; longer visits are associated with increased empowerment among socially disadvantaged patients.<sup>76</sup>

## EFFECT ON CARE

There has been little systematic study of the effects of 15-minute visits on care for socially disadvantaged patients. However, time-pressured visits contribute to competing demands, clinical inertia, unconscious physician bias, and physician-centered communication.<sup>77-79</sup> Each of these likely contributes to disparities in care. Shorter visits are associated with diminished quality,<sup>80</sup> and discussions of prevention and psychosocial issues suffer.<sup>81</sup> Yet, socially disadvantaged patients re-

ceive shorter, not longer, visits<sup>30,82</sup> and fewer visits per year.<sup>7</sup>

Clinical inertia refers to the failure to implement appropriate clinical action in the context of inadequate chronic disease control.<sup>83,84</sup> Clinical inertia is exacerbated by multiple patient demands and time pressures<sup>85</sup> and by physician suspicion of poor adherence.<sup>86,87</sup> It takes less time to "wait and watch" than to implement a change in treatment plan.

Unconscious physician stereotypes affect care.<sup>31,88,89</sup> Unconscious bias often emerges during periods of stress and time pressure.<sup>79</sup> Physicians, challenged to address the complex needs of patients during a few minutes, more readily simplify these mental tasks by resorting to stereotypical thinking. Busy physicians may attend to data that conform to preconceived notions, such as nonadherence,<sup>31</sup> on the basis of group membership and ignore disconfirming data. In addition, communication with socially disadvantaged patients may result in misinterpretations, even when both parties speak the same language.<sup>90</sup> These misinterpretations are likely to result in lack of agreement about the illness, its treatment, and the patient's role in care.<sup>69</sup> When decision making is rushed, clinical judgment relies increasingly on heuristics, cognitive shortcuts, that often fail to account for individual needs.<sup>91</sup>

Patient-centered communication mitigates some of the effects of social disadvantage on care.<sup>92</sup> However, patient-centered behaviors, such as asking patients about their own beliefs, engaging patients in collaborative decision making, identifying adherence barriers, confirming patients' understanding, and using interpreters, take more time.<sup>26</sup> Perhaps owing to time pressure, physicians engage in less, not more, patient-centered communication with socially disadvantaged patients.<sup>93</sup>

## DISPARITIES IN CARE

The potential consequences of 15-minute visits on socially disadvantaged patients include disparities in patient understanding and satisfaction, low adherence, and suboptimal preventive and chronic disease

**Table 1. Key Tasks and Challenges in Caring for Socially Disadvantaged Patients**

Key Tasks	Challenges
	<b>Exchange of Information</b>
Obtaining history	Higher disease burden, psychological distress, and social problems <sup>14-18</sup>
Eliciting patients' expectations, beliefs, values, and perspectives	Cross-cultural and educational differences between physician and patient (social distance) <sup>19</sup>
Behavioral risk factor counseling	Higher rates of behavioral risk factors (eg, poor diet, physical inactivity, smoking) <sup>14,20,21</sup>
More intensive and/or complex treatment	More symptoms and illnesses <sup>15,17,18,22</sup>
Primary care mental health counseling	More emotional distress and less access to mental health treatment <sup>14,18,23</sup>
	<b>Physical Examination</b>
More time to explain procedures	Lower health literacy <sup>24,25</sup> and language barriers <sup>26,27</sup>
Detailed examination	Greater morbidity <sup>15,28</sup>
More time needed to complete examination	Higher levels of functional disability <sup>15,28</sup>
Special equipment to accommodate disabilities	
	<b>Patient-Centered Communication</b>
Establishing rapport and trust	Social and cultural distance and mistrust <sup>19,29,30</sup>
Negotiating a visit agenda	More concerns to be addressed, lower health literacy <sup>15,16</sup>
Understanding patients' social and family context	Physician bias and misunderstandings more likely; greater need to tailor care to patient's context <sup>31,32</sup>
Understanding patients' beliefs, expectations, and preferences	Social and cultural distance and physician skepticism about patients' health beliefs <sup>19,33,34</sup>
Establishing shared understanding of problem and treatment	Social and cultural distance; prerequisite to patient activation <sup>19</sup>
Confirming patients' understanding	Differences in language, culture, and health literacy <sup>35-37</sup>
Assessing and addressing adherence barriers	Financial, cultural, education, social, and logistical barriers <sup>38,39</sup>
	<b>Nonreimbursed Care</b>
Previsit planning	More complex visits <sup>15,16</sup>
Postvisit planning	Need to confirm patient understanding and address barriers to plan <sup>27,35</sup>
Language translation	Lower rates of English proficiency <sup>36</sup>
Care coordination by physician (referrals, correspondence, etc)	Greater illness burden, more psychosocial problems, and more access barriers <sup>15,16,40</sup>
Assisting high-risk patients in navigating the system	Higher rates of HIV, cancer, diabetes mellitus, and asthma <sup>41,42</sup>
Establishment and maintenance of tracking registry	Worse control of chronic disease <sup>43,44</sup>
Improving access to care	Greater need for patient outreach <sup>41,42</sup>
Patient self-management training	Greater need for outreach to patients in need of care <sup>45-47</sup>
Form completion	Higher rates of disability and involvement with social services, criminal justice system, and drug treatment programs <sup>15,48,49</sup>

Abbreviation: HIV, human immunodeficiency virus.

care.<sup>94-100</sup> Socially disadvantaged patients experience more adverse outcomes (eg, preventable hospitalizations and deaths),<sup>101,102</sup> and physicians caring for them experience higher burnout.<sup>103,104</sup>

These disparities may be avoidable. Findings from randomized trials show that team-based, intensive interventions improve health care quality among socially disadvantaged patients and reduce health care disparities across a range of conditions.<sup>41</sup> Multifaceted, nurse-led programs and culturally sensitive care may also be effective.<sup>42</sup> However, most of these interventions extend beyond the scope of 15-minute physician-directed office visits. Findings, from externally funded research projects, require specific translation into clinical practice, including implementation of new care models supported by new payment systems.

## CURRENT OPTIONS

There are a handful of options within current health care systems (**Table 2**). The most obvious are to schedule patients more frequently or for longer visits. However, health plans have increasingly shifted costs onto patients through higher copayments and reduced coverage,<sup>105</sup> disproportionately affecting socially disadvantaged patients' ability to see physicians more frequently. In addition, many topics are best addressed in a single visit rather than spread out for a long period.<sup>106</sup> Billing coding is based primarily on chart documentation rather than on patients' needs, including language, health literacy, cultural, or adherence barriers. Longer visits are undercoded.<sup>107</sup>

Time for paperwork, such as certification of disability or documentation of eligibility for social services,

follow-up on abnormal test results, and out-of-visit medication management, is not reimbursed.<sup>10</sup> Electronic medical records can improve documentation and increase reimbursement,<sup>108</sup> but fewer practices serving socially disadvantaged patients have implemented them.<sup>109,110</sup>

Group visits offer a potentially viable alternative for some patients.<sup>111</sup> These allow extended time for teaching, discussion, and sharing of experience among patients. However, most health plans do not pay for group visits, and some patients may feel uncomfortable talking in a group about their health or psychosocial concerns.<sup>112</sup>

Ultimately, improving care for socially disadvantaged patients requires more than just longer visits. It requires scrapping a care model predicated exclusively on physician-directed, visit-based care and replacing it with a new model, such as the

**Table 2. Caring for Socially Disadvantaged Patients Under the Current System**

Strategy	Benefits	Limitations
Improve billing coding	Higher reimbursement for longer visits; code for counseling based on time	Costs of communication across languages, cultures, and health literacy levels not covered; more time needed for documentation
Schedule more frequent visits	Spreads care out over more visits, allowing for more focused visits	Greater financial and time costs to the patient
Refer patient for care coordination, navigation, and language translation	Provides key resources not widely available in primary care	Requires separate funding, eg, Ryan White CARE Act for HIV, American Cancer Society for cancer
Pay-for-performance	Focuses on improving performance for selected measures	Fails to consider additional difficulty and costs of improving quality among socially disadvantaged populations; neglects unmeasured but important tasks
Limited capitation	Allows for care to be based on patient needs rather than based on visits	Requires consideration of actual costs of delivering high quality care; not widely available
Patient coaching	Improvement in patient self-efficacy and skills	Requires staff training; not currently reimbursed
Patient registry	Allows identification of patients in need of intervention; extends care beyond the visit	Requires electronic infrastructure and staff training; not directly reimbursed
Previsit team huddles	Allows for previsit team planning	Requires change in routine and few extra minutes before visits
Standing orders	Minimizes potential bias and decompresses visits	Requires identification of patients in need of intervention and physician delegation
Resource list, including low-cost medications and community agencies	Allows easy access to key resources for socially disadvantaged patients	Time required to develop and maintain lists
Physician training in patient-centered medical home, including key communication skills	Provides more efficient and optimal use of visit time; physician better equipped to work with activated patients; improves team function	Not widely offered in either medical undergraduate or graduate training
Recruitment of diverse staff	Improves cultural diversity of team	May require extra recruitment effort

Abbreviation: HIV, human immunodeficiency virus.

## Patient-Centered Medical Home (PCMH).

### PATIENT-CENTERED MEDICAL HOME

The PCMH arose from the need for a single physician or practice to assume responsibility for coordinating the care for children with special health care needs.<sup>113</sup> The purpose of the PCMH is to provide access to primary health care teams built around patients' needs. It depends on appropriate team training and patient activation and is explicitly designed to enhance patient choice, quality, safety, and efficiency. The 7 core principles of the PCMH have been endorsed by the major primary care physician organizations, and there is growing support for it among payers and members of Congress.<sup>114</sup> The first 6 principles represent historic primary care ideals: having a personal primary care physician, team-based care directed by a physician, whole person orientation, coordination of all facets of care, focus on quality and safety, and enhanced access to care.<sup>114</sup> The seventh principle, payment reform, provides means for implementing these principles.<sup>114</sup>

The PCMH represents an idealized model of care for all patients,<sup>115</sup> and many practices and organizations, including the Veterans Affairs Administration Health System,<sup>116</sup> have already begun to implement many of its features.<sup>117</sup> It offers particular promise for improving care for socially disadvantaged patients, as illustrated by the following description of an ideal practice.

A radically restructured primary care team might consist of 1 physician, 1 nurse practitioner (or physician assistant), a patient panel manager, and several registered nurses and medical assistants assigned a defined panel of patients. Tasks are distributed based on capability rather than traditional roles. Exploration of new symptoms and patient concerns likely occurs in-person with the physician, whereas other issues may be addressed through individual or group meetings with nurses and other health care professionals.<sup>118</sup> Professional language interpreters are universally available and funded. Phone visits,<sup>119,120</sup> and secure e-mail when feasible, are used to address some routine concerns and to monitor progress. A secure Web server fa-

cilitates patients' direct access to their medical records, including the ability to update health information,<sup>121</sup> as digital technology diffuses to socially disadvantaged populations.<sup>122</sup> More important, a member of the team, perhaps a nurse, is always available to supplement electronic communications, for example, when patients need to understand test results that are made available online. Providing patients with key information about their health along with the means to understand this information represents a critical step toward patient empowerment.<sup>123</sup>

These innovations reflect a radical redefinition of the roles of the health care team and patient. Patients are trained to provide critical health and health care updates through various modalities. Although many patients communicate electronically with the health care team from home, user-friendly computer kiosks are available in the office for patients who lack reliable Web access; these are also used for in-office demonstrations and training.<sup>124</sup>

Many traditional physician responsibilities are distributed among the health care team to ensure that

the physicians' time is used wisely, for duties such as the assessment of complex problems, discussion of a new diagnosis, meeting with patients and their families, or deliberation about treatment options. A medical assistant updates medical data, reviews preventive care, and helps patients identify concerns before the physician visit.<sup>125</sup> Routine preventive care is provided by the nurse through standing orders, allowing the physician to address more complex or unresolved concerns in greater depth.<sup>125,126</sup> In the vignette, a certified interpreter would translate for Mrs S, and the team would quickly identify and address her sub-optimal health care quality.

Following physician-patient encounters, medical assistants or nurses routinely follow-up by phone or in-person to elicit the patient's understanding of the diagnoses and treatment plans, correct misunderstandings, address barriers to care,<sup>127</sup> and link patients to community resources such as patient navigation.<sup>128,129</sup> In the case of Mrs S, the nurse, or perhaps a team pharmacist, would identify less expensive blood pressure medications and engage the patient with self-management groups or even community-based job training for her husband. Ideally, Mrs S would leave the visit feeling more empowered in self-management.

All abnormal laboratory test results as well as preventive and chronic disease care are tracked using electronic registries.<sup>130</sup> Most important, all members of the care team are expected and funded to meet regularly for patient panel management, eg, to review reports, recall patients, and implement changes in treatment.<sup>131</sup> In the case of Mrs S, the nurse would identify her non-adherence based on review of her electronic medication refill history, and the team would develop a plan for addressing it.<sup>132</sup> Use of a team, particularly a culturally diverse one, to assess these complex issues outside of time-pressured 15-minute visits, minimizes implicit bias and facilitates deliberation of treatment options using decision-support tools and evidence-based guidelines.<sup>131</sup>

## NEW PAYMENT MODELS

This transformation of primary care requires radical payment reform. Such reform must account for the greater health care needs of socially disadvantaged patients.<sup>133</sup> Current fee-for-service payment, predicated on performance of a discrete procedure performed on the patient at a single point in time, is a poor fit for primary care.<sup>115,134</sup> Exclusive fee-for-service payment is particularly detrimental for patients with complex needs who require not only longer visits but also care outside of visits or care by ancillary staff. There is emerging consensus that such payments represent a major obstacle to primary care redesign and quality improvement.<sup>135</sup> It is less widely recognized that current payment models undermine a core dimension of health care quality—equity.

The PCMH principles suggest 4 potential sources of proposed revenue<sup>114</sup>: (1) current visit-based reimbursement, potentially expanded to include non-face-to-face patient visits; (2) payment for nonvisit care, such as care coordination, health information technology, remote clinical monitoring, and population-based management; (3) pay-for-performance, such as bonuses for improved quality; and (4) shared savings from potential reductions in health care costs.

Implementation of the PCMH for socially disadvantaged patients requires payments that recognize the actual costs of high quality care for these patients.<sup>115,133</sup> Currently, such care is underresourced and often lower in quality.<sup>40,136</sup>

Ideally, "payments should recognize case-mix differences in the patient population being treated within the practice."<sup>114(p775)</sup> For example, visit-based reimbursement might be based on the time spent with the patient rather than current complex coding formulas. Monthly payments per enrolled patient should be increased according to the social disadvantage of the patient population.<sup>115</sup> This could be based on individual patient sociodemographic data, requiring notation of patients' race, ethnicity, educational level, and primary language.<sup>137</sup> Alternatively,

proxy information derived from patient addresses geocoded to US Census data can be used.<sup>138</sup> Several European countries use the latter approach to increase payments to practices serving socially disadvantaged patients.<sup>138-141</sup>

Pay-for-performance could be made more equitable by comparing practices serving socially disadvantaged patients with each other and by rewarding improvements in performance, rather than just achievement of benchmarks. The surest way to improve equity in pay-for-performance and to avoid the unintended consequence of worsening disparities<sup>142</sup> is to allocate resources to practices based on patient need. Last, even basic PCMHs reduce Medicaid costs.<sup>143</sup> These cost savings should be shared with practices.

## PHYSICIAN AND STAFF TRAINING

A new model of primary health care should free physicians to attend to the most critical patient needs, for which they are ideally trained, and free them from tasks that could be performed by other members of the team. Although structural and financial changes are necessary, they are not sufficient. The health care workforce must be adequately trained to elicit and provide information effectively and empower, activate, inform, and involve patients in their care.

Physicians need training in new skills,<sup>144,145</sup> and, most important, new roles. Physician training may partially mitigate time pressure. Training in specific communication skills can improve elicitation of patients' concerns<sup>146,147</sup> and organization of the visit,<sup>148</sup> while also reducing visit length. Physician training improves patient-centered communication skills,<sup>149</sup> empathy,<sup>150</sup> and responsiveness to patients' questions.<sup>151</sup> Specific training in cultural competence may improve communication with socially disadvantaged populations.<sup>152</sup>

New communication skills are necessary to facilitate team-based care and to optimize care for socially disadvantaged patients.<sup>153</sup> These skills include team leadership and management; panel man-

**Table 3. Patient-Centered Medical Home Model for Socially Disadvantaged Patients**

<b>Feature</b>	<b>Purpose</b>	<b>Stage of Development</b>	<b>Evidence Based</b>	<b>Funding</b>
Open access	Provides care when patient needs it	Increasingly used by practices, including many safety net practices such as federally qualified health centers <sup>97,154</sup>	Case studies show reductions in no-shows and improvements in preventive care <sup>154,155</sup>	No additional funding required, but adequate staffing necessary to ensure success
Phone, e-mail, or other visits	Tailors communication modality to the needs of the patient; may be particularly helpful for patients with limited mobility, transportation, or job constraints	Phone visits not widely used outside of staff model HMOs; e-mail consultations slowly growing <sup>154</sup>	Shown to improve outcomes for preventive care and depression <sup>120,156,157</sup>	Not widely reimbursed by payers, but support is growing
Sharing physician visit tasks with nurse or medical assistant	Designed to delegate tasks requiring less training, freeing up the physician for more complex tasks; potentially helpful for patients with low health literacy	Currently being piloted in a few practices; limited version, <sup>131</sup> eg, previsit huddles between care team members, becoming more widely used	Nurse-based management shown to decrease disparities, <sup>42</sup> but little data regarding "teamlets" <sup>125</sup>	Not currently funded, although costs could theoretically be offset by increased number of visits
Patient tracking registries	Can easily identify patients in need of an intervention	Widely used by federally qualified health centers <sup>158</sup>	Improvement in quality of care for socially disadvantaged patients <sup>120,159,160</sup>	Not directly funded; many EHRs lack adequate registry functions <sup>108</sup>
Population management	Care based on registry data provided outside of usual visits; particularly helpful among socially disadvantaged patients who are lost to follow-up; potentially could reduce bias	Currently being piloted by staff model HMOs	Case studies show promise <sup>161</sup>	Not currently funded
Intensive individual education	Matches intensity of education to needs; helpful for low health literacy patients	Used in multiple clinical trials, but not widely used in primary care	Shown to decrease disparities in control of hypertension, diabetes mellitus, and HIV, <sup>162-164</sup> but little data from primary care	Not widely funded
Group visits	Provides more intensive training about patient self-management in a group setting	Being piloted in selected practices, including safety net practices across the country	Good evidence for patient self-management <sup>165</sup> ; emerging evidence for group visits <sup>111</sup>	Not widely funded
Portable patient health record	Increases participation of patients in their own care; potentially helpful for disempowered and transitory patients	Currently in development	Unknown	Not currently funded
Patient decision aids	Tailored information to needs of patient; can be designed to address needs of patients with low health literacy or limited English proficiency	A number of decision aids have been studied but have not been widely used in practice	Shown to improve patient knowledge, feeling of being informed, and clarification of values <sup>166</sup>	Not currently funded
Collaborative mental health care	Provides mental health care within primary care, particularly for hard to reach patients	Not widely used outside of staff model HMOs	Shown to improve functional outcomes <sup>167</sup>	Not currently funded
Language translation	Provides communication for patients with limited English proficiency	Primarily used by hospitals and health centers; not widely used in physician offices	Shown to improve patient satisfaction and outcomes <sup>168</sup>	Not currently funded
Patient navigation	Provides assistance in coordination of care through fragmented system; particularly helpful for socially disadvantaged patients	Primarily used for HIV and cancer	Emerging evidence <sup>169-171</sup> ; large studies are in progress	HIV navigation funded through the Ryan White CARE Act; patient navigation funded through private foundations such as American Cancer Society or through research (eg, NCI) or demonstration projects (eg, CMS)

Abbreviations: CMS, Centers for Medicaid and Medicare Services; EHRs, electronic health records; HIV, human immunodeficiency virus; HMO, health maintenance organization; NCI, National Cancer Institute.

agement; communication within health care teams; giving feedback to coworkers; electronic communication with colleagues and with patients; longitudinal care; collaborating with off-site care managers, patient navigators, interpreters, and families; and customizing risk information for low-literacy patients (**Table 3**). In addition, training and guidance by an external practice enhancement assistant may be needed to facilitate practice change.<sup>172</sup>

It is especially important to train physicians and other team members to recognize, promote, and support patient participation in care, particularly among those who are socially disadvantaged. These changes represent a cultural shift from the traditional hierarchies within patient-physician relationships and among members of the health care team. These changes will not come easily and are best initiated early in training.

#### PATIENT TRAINING AND RESOURCES

Socially disadvantaged patients can be empowered to take more active roles in their care.<sup>123,173</sup> Individualized patient coaching, use of prompt lists containing commonly asked questions, and computer programs increase patient participation during visits (eg, question asking)<sup>174</sup> and potentially improve adherence,<sup>175</sup> symptom control,<sup>176</sup> and chronic disease outcomes.<sup>123,177</sup> Decision aids assist with informed decision making; they should be expanded to provide information while also encouraging patients to participate in discussions with their physicians about their care. Furthermore, although increased patient participation may improve care, it may also create tension in the patient-physician relationship<sup>178</sup> unless physicians specifically endorse patient involvement.<sup>151</sup> Although untested, patient activation combined with physician training in organizing the visit has the potential to improve care while also limiting visit time.<sup>148</sup> Patient training can be effectively integrated, at multiple points in care by different team members, using various communication modalities. Improvements in technology will facilitate tailoring of training to the cultural,

language, and health literacy needs of the patient.

#### PHYSICIAN LEADERSHIP

Practice redesign requires strong physician leadership to implement new systems of care, reallocate existing tasks, and actively support new models of patient participation in care. Such reforms represent a fundamental cultural shift in the practice of primary care and cannot succeed without strong physician commitment to reform. Changes in payment models, implementation of health information technology, and training in collaborative care models represent necessary, but not sufficient, conditions for new care models. Success will ultimately depend on the willingness of physicians to champion practice redesign and quality, delegate traditional tasks to team members, and create genuine partnerships with historically disadvantaged patients.<sup>179</sup>

#### CONCLUSIONS

The mismatch between patients' needs and the time and resources available to address those needs is greatest for socially disadvantaged patients, thereby exacerbating disparities in access to, process of, and outcomes of health care. A couple of 15-minute visits per year is too little time to provide patient-centered, evidence-based, safe, high quality care for the average patient and particularly for socially disadvantaged patients. Therefore, elimination of health care disparities requires reform of primary care delivery so that care extends beyond 15-minute face-to-face visits. Work that has been the exclusive domain of physicians should include multidisciplinary teams caring for patients through multiple modalities. Such radical reform requires major changes in the structure of payment for primary care. In particular, health care resources must be allocated according to the health care needs of patients so that practices serving socially disadvantaged patients receive more, not fewer, resources. Only in this way can primary care "ensure that decisions respect the patients' wants, needs, and preferences and that patients have the education and sup-

port to make decisions and participate in care."<sup>180(p7)</sup> However critical, payment reform alone is not enough and transformation of primary care will not come easily. Physician leadership and commitment, change in practice culture, new training programs for health care professionals and patients, and focused research are required to optimize care models for socially disadvantaged patients.

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