PRIMARY CARE

An Interprofessional Perspective

Joanne K. Singleton
Robert V. DiGregorio
Carol Green-Hernandez
Stephen Paul Holzemer
Eve S. Faber
Lucille R. Ferrara
Jason T. Slyer

EDITORS

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The Structure of Primary Care

Joanne K. Singleton, PhD, RN, FNP-BC, FNAP, FNYAM •
Robert V. DiGregorio, PharmD, BCACP • Carol Green-Hernandez, PhD, ARNP, FNP-BC, FNS •
Stephen Paul Holzemer, PhD, RN • Eve S. Faber, MD •
Lucille R. Ferrara, EdD, RN, MBA, FNP-BC, FNAP • Jason T. Slyer, DNP, RN, FNP-BC, CHFN, FNAP

Health care delivery in the United States reflects a history of change in response to science, technology, and the cost of health care. Helping people meet their health needs is the central mission of all health disciplines. How this is accomplished, however, continues to change with the times. Lacking a scientific basis, health care before the 20th century was able to offer little more than caring and attention to personal health in the home setting.

The scientific basis for health care became more formalized after 1900 with the inclusion of sciences in the medical and nursing curricula. Health was defined as the presence or absence of disease, and the development of technology was directed at treating and curing diseases. This necessitated movement of the delivery of care into the hospital setting, where patients were seen as passive recipients of specialized, technologic care that focused on their physical and biological needs.

In the early years of the 20th century, great advances were made in the control of infectious diseases. As a result, specialization and technology became more highly regarded than caring and personal care. Although it was recognized that with these changes something had been lost (Flexner, 1930), health care continued to proceed in that direction. Highly specialized care dominated, yet it lacked oversight of the appropriate use of services, the need for services, or the cost of those services.

This view persisted until the later part of the 20th century, when it was acknowledged that the health care needs of the United States, access to services, and the ability to pay for them in a fee-for-service system of reimbursement had changed. Health care needs of Americans were changed by the profound advances made in the control of infectious diseases and the use of technology. This resulted in people living longer, and with this came the advent of chronic diseases.

In the fee-for-service system, economic incentive was based on the use of services. Ultimately, this led to inappropriate use and overuse of services, resulting in trillion-dollar health care costs in the United States. Despite this enormous expenditure, more than 40 million Americans were without health insurance. Access to health care, in the absence of universal health care coverage, remained an issue of national concern. The cost of health care, access to health care, types of services, and delivery of those services were common topics of conversation both inside and outside the health care arena.

■ HEALTH CARE REDESIGN

The Institute of Medicine (IOM) report, in 2001, *Crossing the Quality Chasm*, acknowledged the difficulty in translating knowledge into practice, as well as safely and appropriately applying technology to support care. At that time, the IOM specifically identified the lack of multidisciplinary infrastructures to support the complex needs of the aging population and the concomitant increase of chronic illnesses. Furthermore, they concluded that the important work of health care was conducted in silos.

Crossing the Quality Chasm called for health care redesign and identified the following 10 rules or principles necessary for that redesign:

■ Care is based on continuous, healing relationships
■ Care is customized according to patient needs and values
■ The patient is the source of control
■ Knowledge is shared and information flows freely
■ Decision making is evidence based
■ Safety is a system priority
■ Transparency is necessary
■ Needs are anticipated
■ Waste is continuously decreased
■ Cooperation among clinicians is a process

Health care constituents were asked to commit "to continually reduce the burden of illness, injury and disability and to improve the health of the people of the United States" (IOM, 2001, p. 3). Six aims for health care

improvement were identified by the IOM; they called for care to be safe, effective, patient centered, timely, efficient, and equitable.

■ HEALTH PROFESSIONS EDUCATION: A BRIDGE TO QUALITY

In 2003, the IOM published another critical report that identified core competencies of all health professionals as a bridge across the quality chasm. *Health Professions Education: A Bridge to Quality* identified five competencies central to the education of all health care professionals: provide patient-centered care, apply quality improvement, employ evidence-based practice, utilize informatics, and work in interprofessional teams. The IOM called for accountability of educators in achieving these competencies.

Each proposed solution to the growing issue of delivering safe, quality health care to all Americans posed different challenges, and led in 2010 to the United States' major move toward health reform, the Patient Protection and Affordable Care Act (ACA). In March 2010, the passage of the ACA became a major historical event in U.S. history.

The ACA seeks to improve the current health care delivery system, increase the number of Americans covered, and control costs. The ACA is, and will continue throughout its implementation, to be an ambitious, complex plan, to change health care in the United States.

Highlights of the ACA are many. Notably, the ACA establishes and encourages new models of care, which are an important strategy to address care fragmentation and the current fee-for-service model that drives up the cost of care without accountability of outcomes. These new models of care also recognize that no single practitioner is responsible for a patient's care; therefore, care must be patient centered, coordinated, and team based.

New models of care include:

■ Accountable Care Organizations (ACOs)—ACOs consist of groups of primary care clinicians, hospitals, specialists, and other health professionals, and will be responsible for the primary care and coordination of care for their patients. The goal is to reduce duplication, increase safety, and reduce costs. ACOs enable the sharing in cost savings that they achieve for their included patients. These practice organizations must demonstrate the ability to promote practices based on evidence. Quality outcomes and cost will also be reviewed.

■ Medical Homes/Patient-Centered Medical Home (PCMH)—The PCMH has goals similar to those of ACOs, namely, cost reduction with improved quality and increased care coordination. Multiple PCMHs may join together to form an ACO. The PCMH is a primary care model that aims to improve access to care, and increase communication (via e-mail, or other technologies through the use of electronic health records or other health information technology) among patients and care providers. Care is organized around a patient's needs, preferences, and values. Access to care will be increased with extended appointment hours, and predetermined quality outcomes will be tied to payment.

■ Nurse Managed Health Clinics (NMHC)—The NMHC is a health delivery model led by advanced practice nurses with the goal of improving access to primary health care and wellness service for vulnerable populations living in underserved health care areas. NMHCs are often associated with colleges, universities, departments of nursing, federally qualified health centers, or other interprofessional providers. NMHCs use health information technology systems to collect data for use in quality improvement activities. Workforce capacity of primary health care providers will be improved through NMHCs, as these sites will be training centers for nurse practitioners and other health care professionals.

■ Integrated Care Models—Models of integrated and collaborative care are intended to be interprofessional. These models draw upon the specialized knowledge of all professionals in the patient's health care team. Notably, by recognizing the importance and universality of medication use in the management of acute and chronic disease states, the ACA recognizes the importance of medication management and medication reconciliation across care models and the inclusion of pharmacists as part of the integrated team.

■ Transitional Care Model—The ACA includes suggested initiatives to improve the quality of patient care, decrease hospital-acquired conditions, reduce hospital readmissions due to preventable complications during transitions in care, and to make overall improvements in the transition of care process to reduce hospital readmissions. These models are also intended to be interprofessional in design.

■ Medication Therapy Management (MTM)—Those enrolled in Medicare Part D must be offered MTM services. Services and strategies include an annual comprehensive medication review furnished by a licensed pharmacist or other qualified provider and follow-up interventions, as warranted by the findings of such a review. In addition, at least on a quarterly basis, the medication use of an individual who is deemed to be at risk, but not enrolled in an MTM program, must be assessed.

■ HEALTH: A DYNAMIC STATE OF BEING

Today's view of health must acknowledge the juxtaposition of multiple factors that may influence and predispose a person to illness(es). These factors include the complex interdependent biological, psychological, social, and spiritual needs of the person. The integrated needs of the

individual places the person within the context of his or her family and community. It also recognizes that health is not simply the presence or absence of disease, but rather is an ongoing process that can be fostered through activities directed at health promotion and disease prevention. Health as a dynamic state of being is active, and thus individuals must engage in the process of health if they are to actualize their health potential. This necessitates a change in perspective from the individual as a passive recipient of care to the individual as an active participant in his or her own health.

To meet these needs, health care delivery in the United States continues to strengthen primary care, in which providers address a wide range of health care needs and facilitate health care delivery. The ACA encourages new models of care delivery recognizing the value of team-based care, with the patient as the center of care, and calls for quality, safety, and accountability in outcomes of care.

■ EDUCATING FOR PATIENT-CENTERED CARE

In February 2011, a meeting was held to advance interprofessional education to support patient-centered care. The meeting was convened by the Health Resources and Services Administration, the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, and the ABIM Foundation in collaboration with the Interprofessional Education Collaborative. The Interprofessional Education Collaborative consists of the following:

- American Association of Colleges of Nursing
- American Association of Colleges of Osteopathic Medicine
- American Association of Colleges of Pharmacy
- American Dental Education Association
- Association of American Medical Colleges
- Association of Schools of Public Health

■ GLOBAL INITIATIVES

The World Health Organization defines *interprofessional collaborative practice* as "[w]hen multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care" (2010).

Interprofessional education, according to the World Health Organization, is "[w]hen students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (2010). The importance and value of teamwork to quality, safety, and outcomes in patient-centered care are known and have been documented over several decades; the ACA, however, is a tipping point for putting into practice the evidence that supports patient-centered, interprofessional team-based care. Educating health professionals

for practice in new models of care is imperative to improving the nation's health. The Interprofessional Core Competencies provide this guidance. Four core competencies for interprofessional education were identified by the Interprofessional Education Collaborative Council expert panel, and include:

- Values and ethics
- Roles and responsibilities for collaborative practice
- Interprofessional communication
- Teamwork and team-based care (2011)

Within these four core competency domains are 38 specific competencies that describe the behaviors we should be able to see when the competencies are being practiced. *Primary care* in this book is recognized as the provision of integrated, accessible health care services by providers who are accountable for addressing a large majority of personal health care needs. These providers develop sustained partnerships with patients and practice within the context of family and community (Taylor, Machta, Meyers, Genevro, & Peikes, 2013). This concept of primary care allows patients and providers to enter relationships where patients, families, and communities have the opportunity to become full participants in health care decision making. Primary care, defined in this way, is provided within a primary health care context, and acknowledges "community" in its broadest sense, thereby recognizing the value of team-based care.

In today's health care environment, economic considerations loom. Professional standards may be challenged through any care approach. Despite these changes, providers must rigorously adhere to practice standards and maintain the integrity of their clinical relationships. The patient must remain the focus of care, regardless of whatever changes are occurring in health care. Providers need to work together to develop creative strategies to sustain and nurture patient-centered care.

Foundational to the therapeutic nature of patient–provider interactions is the relationship that develops between patient and provider. This relationship is believed to be central to improved patient outcomes and patient–provider satisfaction (Tresolini, 1994). Patient-centered care redefines the therapeutic value of patient–provider interactions, recognizing the importance of the health care relationships formed by providers with families and communities. Primary care providers can use this time of change in the delivery of health care as an opportunity to work with each other and their patients to create comprehensive, interprofessional, and patient-centered primary health care networks that improve outcomes and satisfaction for both patients and providers.

This chapter identifies concepts essential for achieving patient-centered primary care. The idea of caring and trust as the foundation of primary care is explored. Building upon this, a framework for providers to facilitate comprehensive assessment and management is presented. This foundation and framework creates a structure for providers and patients to work together as architects in the redesign of health care.

■ THE FOUNDATION OF PATIENT-CENTERED CARE IN PRIMARY CARE: CARING AND TRUST

Effective patient-centered primary care demands increased attention to the interpersonal aspects of health care relationships. Valuing professional caring is central to this kind of relationship. Professional caring is comprised of feelings and behaviors within the relationship. It requires providers to enter and sustain relationships with their patients, as well as with colleagues, as opposed to simply performing tasks or techniques. A caring relationship creates the climate for trust to develop, and for the patient and provider to use their personal resources most effectively toward positive patient outcomes (Donohue-Porter, 2014; Green-Hernandez, 1997).

Both patients and providers bring expertise to the care planning. Ideally, they meet and work together to create acceptable plans of primary care. Providers bring expertise in their discipline of study. Patients bring knowledge of their subjective experience of illness or their health care needs that reflect aspects such as family history, culture, values, and beliefs, as they relate to health care. In situations where the patient is unwilling or unable to enter into a relationship with the provider, various standards of assessment are used to provide safe and prudent primary care. When patients refuse care or do not follow jointly agreed-upon plans of care, the primary care relationship must be reevaluated.

Learning How to Give Caring

Fundamental to providers learning how to give caring is their ability to challenge traditional stereotyping or labeling of the patient as a chief complaint, a diagnosis, a disease, or a passive recipient of care. For a partnership to be formed, the provider must see the patient first as a person. In doing so, the provider appreciates and respects the patient's individuality and subjective response to the presenting health care need(s). It must also be recognized that the patient's subjective response to illness or a health care problem will be influenced by values and beliefs, which may differ from those of the provider.

Seeing the patient as a person requires communication, which is essential to learning how to give caring (Green-Hernandez, 1997). Communication goes beyond the spoken word. It involves one person sending a message and another receiving that message. Through communication, both providers and patients let each other know that they are willing and available to enter into a caring partnership. Providers must be open to receiving a response from patients about their willingness and level of ability to participate in their own care. With this understanding, the provider and the patient will be able to define what the patient's health care needs are, and how they will be met. This partnership will be defined and redefined over time (Garofalo & Murphy, 2014).

An ongoing concern of providers is the brevity of health care encounters. How realistic is it, in a 10- to 15-minute visit, to communicate to a patient one's willingness and availability to enter into a caring partnership? Regardless of the length of the visit, providers still retain control over how they interact with patients. Simple approaches to interactions with patients, such as those in Table 1.1, communicate caring and therapeutic intent. These are some of the many approaches that will communicate to patients that they are the focus of the encounter. This caring process is a reflection of using the time the provider has with the patient for the patient (Flocke, Gordon, & Pomiecko, 2006; Flocke, Kelly, & Highland, 2009; Green-Hernandez, 1997; Singleton, 2000, 2002).

Re-Visioning Compliance

From the previous discussion, it follows that providers who learn how to be caring have effectively learned how to use themselves therapeutically. To do this, providers must recognize the importance of what they bring to patient-centered care. This requires both self-awareness and learning how to use the different strategies discussed to be reflective practitioners. These practitioners reflect on their practice,

TABLE 1.1	Caring Interactions With Patients

INITIATING THE ENCOUNTER

- Greet the patient by name.
- Offer a handshake or a touch on the arm.
- Establish eye contact, if culturally appropriate.

DURING THE ENCOUNTER

- Sit nearby without invading the patient's personal space.
- Have only the patient's chart on your desk.
- Take only urgent or emergency phone calls.
- Have all the supplies and equipment needed for the visit in the room, to avoid leaving the room once you have begun the encounter.
- Review with the patient the last visit and what has transpired in the interim.
- Do not do things to patients without explaining what you are doing.
- When discussing the patient's care with others, such as the patient's family or a health care colleague, in the presence of the patient, do not exclude the patient from the conversation.
- Your tone of voice, volume, and speed of verbal communication, and nonverbal behaviors, such as eye contact, nervousness, or hyperactive behaviors, can influence communication.
- Ask questions that allow patients to explain their experiences.
- Do not put words in the patient's mouth.
- Remember to address the patient's reason for the visit and concerns.

ENDING THE ENCOUNTER

- Ask the patient if there is anything else he or she would like to discuss.
- Discuss treatment and management, including options.
- Once a plan is agreed upon, discuss and identify how it will be carried out.

using patient encounters to critique themselves in order to be more effective in their use of self. Reflective practice is a skill that requires conscious self-study and development over time.

Learning how to care necessitates changing preexisting perspectives that may be detrimental to the patient–provider relationship. One such critical perspective that must be revisited is that of paternalistic relationships, in which the provider uses power and authority to prescribe care, seeking compliance from the patient. In these scenarios, true communication does not take place. These patients are at risk of being labeled "noncompliant" if they do not carry out the provider's orders. Because of the lack of communication, it is unlikely that any understanding will be gained of why the patient did not follow through with the plan of care. With the exception of situations that involve the immediate safety or protection of the patient, provider, family, or community, the word "noncompliant" expresses an attitude inconsistent with patient-centered care. Providers who value patient-centered care continue to work toward replacing this word with the word and perspective of *participation*, reflecting a changing paradigm from paternalism to caring for, activating, and engaging patients in their own health. Thus, trusting partnerships are developed (Green, Cifuentes, Glasgow, & Stange, 2008; Simons, Flynn, & Flocke, 2007).

■ TRUST

Trust is an attitude that one has in regard to another. Attributes of trust include reliability, confidence, vulnerability, and fragility (Johns, 1996). Trust must be reciprocal and reflexive. Patients should have trust in providers and in themselves to participate in meeting their own health care needs. Patients will trust providers who are reliable and in whom they have confidence. Providers need to trust that patients will participate in decision making related to health care. Providers must also trust their own technical and professional ability to provide and coordinate the care of patients.

Trust is essential in the patient–provider relationship and may be instrumental in influencing patient outcomes. Elements that may facilitate patients' development of trust in their providers include technical proficiency and professional competence.

Technical Proficiency

Technical proficiency results from developing the psychomotor skill repertoire required for practice. There are skills that will be common to all primary care providers and others that may be specific to providers working with different patient populations, or to the focus and scope of services in their primary care practice group. Providers need to identify the skills necessary to their practice. Learning and performing skills help providers to gain a feeling of technical

competence. Necessary skills will change over time, both in how they are performed and in the skills required. Providers must keep abreast of these changes to maintain technical proficiency.

Professional Competence

Professional competence is predicated on developing essential skills, including learning how to give caring, technical proficiency, and effectiveness in coordinating care. Coordinating care of patients may include interprofessional consultation, referral, or comanagement with the interprofessional team. Professional competence is the culmination of achieving and balancing these skills.

Interprofessional Practice

The relationships among provider and colleagues, although different from provider–patient relationships, are central to providing primary care. Relationships among interprofessional colleagues can offer valuable perspectives on assisting patients in meeting their health care needs. Providers must trust the contributions that can be made through consultation with or referral to their interprofessional colleagues. For this trust to develop, providers have to believe that interprofessional practice will improve patient outcomes. They also need to be willing to gain greater understanding of, insight into, and respect for other disciplines, and the contribution they can make to patient outcomes (Singleton & Green-Hernandez, 1998).

Barriers to interprofessional education and practice include negative attitudes and inaccurate perceptions of faculty and providers toward the benefits of interprofessional education and practice. It is interesting to note, and certainly holds hope, that students of the health care disciplines view interprofessional education and clinical practice experiences positively and actively seek to participate in them. Several benefits of interprofessional practice have been identified. These include greater patient satisfaction, better outcomes, and cost efficiency. Without confronting these barriers, the benefits of interprofessional primary care will not be realized (Centers for Disease Control and Prevention [CDC], 2009a, b).

A caring, trusting patient–provider relationship is the foundation for a patient-centered approach to proactive primary care. Through this approach, providers come to truly know their patients. This facilitates accurate and comprehensive assessment of the patient. Patient-centered care incorporates more than traditional, formalized assessment. From its initiation, the patient is recognized as having expert knowledge of his or her health care need(s). Through empowering the patient in a health care system that traditionally disempowers, negotiation of care occurs through active participation with the patient. This relationship mirrors contemporary thought representing the idea of health stewardship (Teisberg et al., 2009). Health stewardship represents a meta-level of responsibility for patient-centered

care, which involves the responsible use of resources for all patients to foster health.

■ THE FRAMEWORK FOR PRIMARY CARE

The framework for primary care presented in this book offers a comprehensive view of assessing and working with patients, with the goal of developing over time an inclusive management plan. Through this framework, proactive primary care is achieved by assessing factors such as family, culture, nutrition, community, health promotion and disease prevention, and violence exposure and vulnerability, while being knowledgeable about the common conditions, primarily of a chronic nature, seen in primary care. As appropriate for each condition, this book discusses:

- Anatomy, physiology, and pathology
- Epidemiology
- Diagnostic criteria
- History and physical examination
- Diagnostic studies
- Clinical practice guidelines to provide evidence for treatment options and expected outcomes; and comprehensive management, including teaching and self-care, community resources, health promotion, and disease prevention
- Referral points and clinical warnings

Maximizing Self-Care

In its most simplistic sense, *self-care* means taking care of oneself. The processes involved—commitment and motivation of individuals in taking care of themselves—are not yet well understood. Motivation, however, is recognized as a complex phenomenon that is internally driven. Although providers may not be able to directly motivate their patients to care for themselves, they can create a climate to encourage motivation. Educating patients is an important strategy providers can use to encourage patients in care-of-self and to achieve positive health outcomes. To effectively use health education as a strategy, patients should be approached based on their learning styles.

Assessing Learning Style for Health Education

Much is written concerning how the primary care provider can best offer health education in a busy office or clinic setting. The realities of managing this process can be especially challenging when there is little time for teaching during the visit, let alone time for assessing learning needs regarding growth and development, health promotion, disease prevention, and illness/disease management. The following section provides a guide for assessing a patient's learning style, while also providing several suggested teaching intervention techniques.

Basic Necessities for Health Education

The patient's and family's understanding is critical to their success in participating in developing and carrying out a plan. The evaluation component of the plan's outcome is tied to this comprehension. Key areas of knowledge to be evaluated include:

- The disease process and course
- Symptoms and symptom management
- Self-care strategies for symptom control
- Who to call if a problem arises
- Medication administration (including roles and limitations of complementary approaches)
- Anticipating adverse effects and how to manage them
- Use of medical equipment
- Possible food–drug interactions
- When and how to seek further care
- Prior experience with the health care team

Learning style is not a one-dimensional concept. It is made up of many elements, including the learner's reading comprehension and verbal understanding levels, developmental level, learning style, and emotional status. Basic personality and learning style also influence the learner's ability to take in and use new information. A further complication to learning ability may be the fact that, when uninvited information is given (information the patient may not wish to hear or is unwilling to hear), its acceptance and integration may not take place (Etz et al., 2008; Flocke, Crabtree, & Stange, 2007).

Reading Levels and Content Understanding

American adults' reading comprehension and the correlation of that ability with health literacy were last surveyed in 2003 by the U.S. Department of Education. This study uncovered content that is directly related to possible health outcomes in primary care. A slight majority of adults (53%) have intermediate-level literacy. That is, they can understand 67% of what is read. A further 12% are proficient in this understanding. Conversely, 22% have only basic comprehension, while 14% of adults are below basic in their literacy (2003). These statistics correlate with respondents' self-reports of overall health. Respondents whose literacy scored at the below basic level reported that their overall health was poor, compared to the good or excellent ratings self-ascribed by Intermediate and Proficient individuals.

Primary care providers (PCPs) need to be aware of these levels in order to provide interventions that meet the patient at his or her level of understanding, including his or her self-assessment of personal health. Key to this provision is the PCP's recognition of the patient's capability of participating in the learning plan. Table 1.2 presents some of the differences between below basic and proficient learners. The reader can use these differences to best identify where patients who are basic as well as those who are intermediate learners best fit, as some may straddle a level lower or

TABLE 1.2	Differences Between Good and Poor Readers—and How You Can Manage the Problems	
SKILLED READERS	**POOR READERS**	**MANAGING THE PROBLEMS**
Interpret meaning	Take words literally	Explain the meaning
Read with fluency	Read slowly, miss meaning	Use common words, examples
Get help for uncommon word	Skip over the word	Use examples, review
Grasp the context	Miss the context	Tell context first, use visuals
Persistent reader	Tire quickly	Short segments, easy layout

higher than their general capability. Suggestions for how to plan accessible patient teaching are also included.

Poor Health Knowledge

The PCP who cares for patients whose literacy skill is challenged may be at risk of delivering care that turns out to be unexpected by the patient. For example, in preparing to do a particular procedure such as incision and drainage of a wound, the PCP first has to get the patient sign a document of consent. Included in that document is an explanation of a local anesthetic to be used and how it is to be delivered. A patient's response to needle delivery of the local anesthetic may be totally unexpected by the PCP, as this part of the procedure was described in the patient consent form. Sudore et al. (2006) found that patient outcomes were directly influenced by their understanding of the consent form signed prior to procedures.

Of even more concern is the risk patients can face in management of their disease if their understanding of health behaviors that led to their problem is not complete or accurate. If not able to read instructions, patients' self-care in medication dosing and frequency may place them at risk of negative health outcomes. Schillinger, Wang, Rodriguez, Bindman, and Machtinger (2006) found this in their examination of the impact patients' literacy skill had on safe anticoagulation therapy.

Also of concern is the knowledge that patients with low literacy skills are less able to read and understand a medication label, which affects their ability to take medication as directed (Davis et al., 2006). Such misunderstanding can extend into the acquisition of health behaviors, as adults with limited literacy skills are also less able to access the health care delivery system for health screening (Bennett, Chen, Soroui, & White, 2009).

The Patient Living With Comorbid Conditions

It is important that the PCP identify each patient's developmental capability for learning. Just as very young adults may have requirements that differ from those of the older people, comorbidity can also influence the learning continuum. Life experience can help to narrow the gap between

Below Basic and, for example, Intermediate or even Proficient learners. The PCP can help to ensure learner success by integrating such experience into the teaching plan. An older patient with a long history of heart disease who has developed a new cancer will bring very different needs to his or her learning, compared to the young adult with just-discovered hyperlipidemia. A single mother caring for physically and intellectually challenged children may need to have some of the issues faced by these youngsters addressed before she can engage in her own new-diabetic teaching.

There are several tools that can be used to support literacy and communication of health information. Two commonly used tools are the Simple Measure of Gobbledygook (SMOG) and Rapid Estimate of Adult Literacy in Medicine (REALM) tools. The CDC offers a comprehensive guide, *Simply Put* (2009), to help distill complicated health information into written materials that patients can relate to and understand. This excellent guide, which included the use of the SMOG tool to assess the readability level of written materials, can be easily retrieved and is available as a PDF download (see the reference list to obtain this guide). Another short-item instrument that can be used for literacy screening is the REALM-R, which can be accessed at www.ahrq.gov/legacy/pharmhealthlit/documents/realm-r.htm.

Meeting Learning Needs

"The teachable moment" means that the provider uses every possible opportunity to convey the message. In primary care, this message focuses on all aspects of health promotion and disease prevention. Teaching–learning can be contagious. A health message may reach a patient because of its relevance to the patient or to the patient's family and friends. Having a selection of pamphlets available to patients in the waiting room helps to ensure that they pass on the "correct" version of this message. Teaching messages can be reinforced in the waiting room through use of colorful health posters and a variety of pamphlets. Non-English versions should be displayed if appropriate to the patient population.

Consider assigning different clinic staff the responsibility of periodically changing posters as well as replenishing and updating the health teaching literature so that frequent

clinic users will be exposed to more than one or two ongoing messages. Ongoing messages may include, for example, posters and literature related to smoking and alcohol use, safer sex, healthy babies, diabetes, cholesterol, and heart disease. Ideally, posters should be changed every few months. These simple acts can add interest to the patient's wait, while reinforcing the messages providers wish to convey. People will peruse material new to them the first time. After that initial exposure, their interest must continue to be piqued if health messages are to be reinforced.

These strategies can also find their way into examining rooms or cubicles. Consider posting materials on wall space and ceilings. A cheerful poster displayed in an unexpected spot can be an especially powerful teaching strategy.

"The teachable moment" presents itself in many ways. For primary care providers, learning to make the most of a teachable moment may be the critical element in creating a climate to encourage patients in health promotion and disease prevention self-care. Teaching occurs at every patient encounter. The primary care provider must also assess the patient's understanding of the information provided through the use of techniques such as teach-back. The teach-back process begins with the provider informing the patient that he or she (the primary care provider) wants to assess if he or she is doing an adequate job of educating the patient and developing a plan of care. The provider asks the patient to teach-back what the patient believes or understands about the topic. Open-ended questions are asked to assess a patient's understanding and identify areas in need of clarification. Further education can then focus around areas about which the patient is uncertain. This interactive process should continue until the provider is confident that the patient has achieved a satisfactory level of comprehension, thus allowing the patient to make informed health care decision and work toward achieving positive health outcomes.

■ SUMMARY

Current changes in health care needs, how health is viewed, and the delivery of services all point to the importance of patients being actively involved in meeting their health care needs. This calls for challenging traditional ways of thinking, changing views, shedding preassigned roles, and rethinking patient–provider roles and relationships. There is a moral imperative for primary care providers to work as partners with patients, helping them meet their health care needs through developing and maintaining patient-centered, proactive primary care within a primary health care framework.

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