Addressing psychosocial needs and physician burnout

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Learning objectives:

- Identify patient behaviors that result in difficult healthcare encounters
- Recognize that practice structure and resource limitations impact physician burnout
- List strategies to improve interaction with patients who have high psychosocial needs

Case synopsis:

Mr. C is a 29 year-old man who suffered from C6 spinal cord injury in a motor vehicle accident one year ago with resulting quadriplegia and chronic suprapubic catheter, presented to the ED with malaise, pelvic discomfort and subjective fever, chills--similar to his prior urinary tract infections. He was subsequently admitted. Mr. C was a frequent visitor to the ED, sometimes weekly, sometimes monthly but he had never gone for more than 4 weeks without an ED visit or hospitalization. In the ED, he was noted to have low BP of 90/60, pulse of 88 and urinalysis with pyuria and bacteria and was given a dose of Cefepime as he had history of resistant bacterial infections. He was underweight with a BMI of 19. He also had a noninfected appearing ulcer at the left olecranon process from pushing against his elbows to turn in bed. Urine drug screen was positive for marijuana. During the course of this hospitalization, his care team found out that he had gone to the hospital to avoid going to jail. He failed to appear in court the month before. He was unhappy with his caregivers at home and preferred to go to a skilled nursing facility (SNF). However, he did not want any of the available SNFs presented to him, and after 2 weeks in the hospital, he decided to return to his mother's home. He was provided home health nursing but he would not let them in if they came too early in the morning or when it was not a convenient time for him. Most of his ED visits were for UTI symptoms (although cultures were often negative), neck/back pain and constipation.

Mr. C had a history of leaving against medical advice due to dissatisfaction with care. He had emotional outbursts from time to time. For example, he became impatient and shouted when the patient attendant took long to clean him up after a bowel movement. Hospital staff also got frustrated that he frequently changed his mind and lied to them to get what he wanted. He relied on 24/7 caregivers to bathe him, empty his Foley catheter bag, change pressure wound dressing, help with bowel movements and prepare meals. He had some motor function of the upper arms but very limited movement of hands and wrists. He lived with his mother but she was not able to care for him due to her own illness and disability. His relatives (aunt, cousin, niece) and girlfriend were paid to provide formal caregiving. He was recently divorced from his wife who accused him of threatening her physically and had filed a temporary restraining order. On good days, he could sit long enough in a car to be transported to the ED or clinic appointments. He had a nephew and an uncle who could carry him from bed to car. Of note, there were about 3 steps up to his mother's home and 7 steps down to the basement where he had a hospital bed with a trapeze bar to help him change position and lift himself up in bed. He would like to have his own handicapped accessible apartment. He had a service coordinator from the health plan to help set up ambulance or van transportation to appointments but patient felt that this process was too onerous so he preferred to call 911 to get paramedics and ambulance transport to the ED. He had history of incarceration and was released from jail 6 months prior to the car accident.

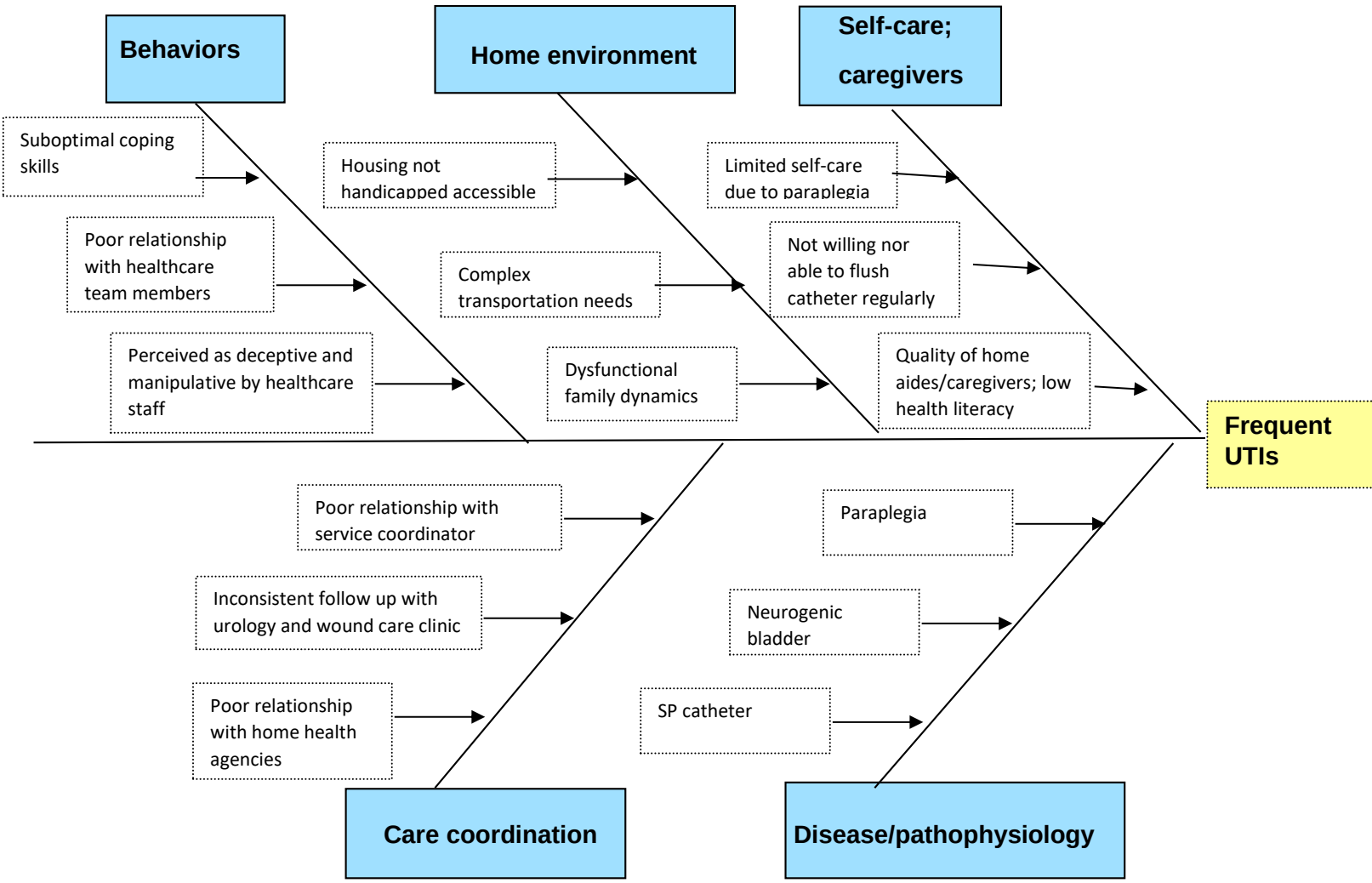
He was eventually referred to a PCP experienced with high-need, high-cost patients. The new PCP developed good rapport with this patient. He was given 24/7 access to the on-call nurse/provider via phone and texting. Home visits were conducted; regular communication with the home nurse was maintained. He wanted to be more mobile with a manual wheelchair so physical medicine and rehabilitation specialist, pain medicine and neurosurgery were consulted. Housing application and various home care supply were facilitated. Appointments were made for him with transportation set up but he often had reasons for refusing to go. His care team felt that they had gone out of their way to help him but he rarely followed their recommendations.

1. **Construct a problem list for this patient**
2. **Conduct root-cause analysis for at least one problem**
3. **Describe positive/protective social determinants of health for this patient**
4. **Describe negative social determinants of health factors**
5. **Propose patient/provider-level solution with attention to facilitators and barriers**
6. **Imagine possible health system or institutional solutions**
7. **Discuss potential community/societal-level solutions**

Facilitator's guide

1. Construct a problem list for this patient
    a. Frequent UTIs
    b. Chronic neuropathic pain
    c. Chronic suprapubic catheter
    d. Chronic constipation
    e. Chronic elbow ulcer
    f. Quadriplegia
    g. Frequent ED visits and hospitalizations

2. Conduct root-cause analysis for one problem



You could also include history of trauma or incarceration under behaviors or behavioral health. He might also have depression from decreased functional capacity, loss of independence and chronic pain.

3. Describe positive/protective social determinants of health for this patient

    Mr. C has benefited from a large extended family. Several members served as his formal caregivers. Even though he was technically homeless, he was welcome at his mom's, uncle's or girlfriend's home at

various times. We don't know exactly whether he completed high school. He was motivated to improve his condition, had a smart phone, read about health conditions and various wheelchair types to improve his mobility. However, he was not always able to discern good or bad sources of information on the internet. He has SSI income and Medicare/Medicaid health insurance. He also qualifies for 24/7 caregiving due to his condition.

4. Describe negative SDH factors

   Mr. C is in need of his own handicapped accessible housing. It is unclear whether his legal issues might be a barrier for subsidized housing application. Men and women with a history of incarceration are also known to be in worse mental and physical health. He is dependent on other people for basic activities of daily living. He lives on a low-income budget. He does not have a consistent mode of transportation to and from medical appointments. Many patients in Mr. C's situation see their value or worth in the income they bring in and fret going to a nursing home for fear of losing monthly income. Usually, a person's monthly income goes to the nursing home then Medicaid pays the nursing home the difference between the patient's monthly income and the amount that the nursing home is allowed under its Medicaid contract.

5. Propose patient/provider-level solution with attention to facilitators and barriers

   Mr. C had long-standing psychosocial difficulties exacerbated by chronic debilitating conditions. Sometimes, his behaviors made interactions unpleasant, contributing to suboptimal outcomes and physician burnout. Medical personnel felt that he was deceptive at times. Mr. C might not be truthful for a variety of reasons—avoidance of negative consequences, desire not to be judged, feeling embarrassed, to avoid humiliation and rejection, to assert his sense of self, to maintain self-esteem, etc. Building trust is a two-way street and providers should consider whether their own behavior may cause patients to be hesitant to open up. Perspective taking is one strategy to reduce implicit bias and to promote empathy for Mr. C's conditions. Ask students to brainstorm communication strategies that could maximize truthfulness in the patient-doctor relationship. Several studies have shown that patients labeled as "difficult patient" are more likely to have multiple physical symptoms, high healthcare utilization, nonadherence to medical advice, self-destructive behaviors, or functional impairment related to mental health diagnoses or substance dependence. Mr. C was often frustrated with clinical encounters because of perceived bias, unmet needs, and complexity navigating the healthcare system. On the other hand, healthcare providers often struggle to care for patients like him. It was easy for his PCP to feel depreciated when he repeatedly dismissed her advice and recommendation. For challenging patients such as an "entitled demander," it is important to set boundaries. Ask students what the PCP could do to set boundaries? (Answer: limit phone calls/texting with patients to business hours only, train patient to access other healthcare providers directly without going through her, acknowledge her emotions with the patient, etc.). It is also important to explore his underlying psychological issues—history of trauma, reaction to fear and loss -- recognize that the patient's hostility may be his way of maintain self-integrity and remind him that his anger should not be misdirected at those trying to help.

6. Imagine possible health system or institutional solutions

   Practice structure and resource limitations can result in difficult encounters and physician burnout. Unmet social needs affect practice by influencing clinic flow, treatment options, and clinicians' emotional wellness. Ask students: who would they like to have on their care team in order to take care of high-need patients? How would they pay for those services? Having a social worker or a community health worker as part of a medical practice help to address social needs would also improve morale and decrease burnout. Partnering with social services agencies would facilitate referrals and better follow-up. Health insurance providers often place practice-based care managers in large primary care practices to improve healthcare navigation and care coordination. Flexibility in clinic scheduling and promoting

home visits will make life easier for both patients and providers. Self-reflection case discussion group (like a Balint group) could support professional development and address both personal and professional stressors. Studies showed that physicians who have a high perception of their clinic's ability to meet patients' social needs were less likely to report burnout.

7. Discuss potential community/societal-level solutions

   The average US healthcare spending in 2015 was 16.8% of GDP compared to 8.8% by OECD countries but the US had worse health outcomes and shorter lives. For social spending, the US spent 16.1% of GDP, slightly below the average for OECD countries that year (17%). There is some evidence to suggest that aggregate spending on social programs is associated with better health. A greater proportion of US social spending comes from private sources and is particularly concentrated on spending for elderly residents. We spend far too little on social welfare which exacerbates problems like poverty and inequality. We underinvest in children, families and education. Given this background, facilitator should ask students to think about policies that we should advocate to bolster safety net programs such as Supplemental Security Income for the elderly or disabled poor, unemployment insurance, SNAP (food stamps), school meals, low-income housing assistance, childcare assistance, etc. Mr. G certainly would certainly benefit from housing assistance. Thinking about your local environment, what are some challenges and facilitators to providing affordable housing?

Additional details and case follow-up:

Mr. C had weekly standing appointments which he kept about 20% of the time so his PCP conducted home visits when he missed appointments. He liked to have the ability to talk to his PCP directly without going through clinic staff and appreciated her responsiveness to his requests. He desired opiates but she was able to convince him to pursue other pain management options. He continued to smoke marijuana for pain and muscle spasm. She got him to see an outpatient urologist to avoid going to the ED to change his Foley catheter. The urologist recommended Botox® injection in the bladder but he only went once and missed other appointments. The PCP also tried to connect him with social services agencies to find suitable housing for him or at least to build a ramp so he could get in and out of the house. The PCP also hooked him up with produce delivery through the local food bank to help him eat healthier with a higher fiber diet to combat chronic constipation. He continued to suffer from frequent symptoms of spinal cord injury-related autonomic dysreflexia which he believed were precipitated by UTI or constipation. He was motivated to try to use a manual wheelchair for better mobility so she referred him to the Center for Assistive Technology. The rehab physicians there recommended more physical therapy to improve upper body strength. He did go to a few PT sessions but stopped when he had transportation difficulty and multiple hospitalizations. His joy in life was to be able to drive around and experience the outdoors. At one point, he moved into his girlfriend's home and stayed away from the hospital for 4 weeks but he ended back in the ED once they had a fight and he could no longer stay with her. After one year serving as his PCP, she started to question her ability to help him meet the care goals of decreasing unnecessary ED visits/hospitalizations, improving mobility and self-care.

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