When Patients' Self-Rated Health Surprises: Primary Care Provider Reactions to Patients with Bad/Very Bad Self-Rated Health

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Purpose: To determine primary care providers' (PCP) reactions to patients who rate their health as bad or very bad at clinic visits.

Background and Prior Work

Prior surveys of PCPs suggest physicians perceive health fundamentally different than patients due to different normalizing factors:

a) "Different perceptions of normal."
b) "Physicians can shape perception of health, normalize circumstances that remove hope/selfesteem, and support resources that shape responses."
c) "I would get an indication of if they want to improve or are satisfied with the way they are."
d) "I'm a physician so I perceive health matters differently than patients."

Prior surveys of PCPs on whether or not SRH can be a quality metric:

a) "I would speculate that SR health correlates to more objective health measures somewhat well and is an important quality metric to guage our 'customer service' abilities."

b) "Too subjective, can't reliably measure."

In general, how would you say your health is today?

Self-rated health (SRH)—a person's subjective evaluation of his general health—is a more valid and powerful predictor of morbidity and mortality than any other combination of objective and self-reported measures. (Picard, Juster, Sabiston, 2013)

Methods

* **Descriptive statistical analyses** of primary database created weekly with patients SRH.
* **Thematic qualitative analysis** of PCP reaction to learning of patients' specific SRH or bad or very bad obtained in email or secure text.
* Midwestern family medicine residency clinic May 2020 to Sept 2020.

Results

Table Two: Thematic Analysis of Qualitative Data on PCP Reaction when SRH for patients is bad or very bad.

Attributional Themes "this happened because"	
Chronic pain	pain leads to poor SRH
Health literacy	not understanding health so says health is bad
Stress/Life chaos	so much else going on in life that health is bad
Specialists	coordination of care essential
Psychosocial	perception of loneliness and difficulties
Treatment barriers	lack of insurance or follow up access
Transient	it will be over soon just acute illness
Descriptive Themes "this happened"	
Social context	like DHS involvement and substance use
Treatment hurdles	treatment not top priority
Emotion	anger, frustration, sadness
Acute	upset with quality of life change
Motivational	way to get PCP to pay attention to life badness
Symptom severity	often in crisis moments, multimorbidity
Surprise	puzzled that patient would respond that way
Justification	reasons that encompass a combo of the above

#RAF: Medicare risk adjustment factor. A risk score assigned on health conditions tied to probably cost of patient's healthcare needs.

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference Lower	95% Confidence Interval of the Difference Upper
RAF Score	Equal variances assumed	1.097	.297	-2.117	147	.036	-.252602	.119301	-.488369	-.016835
	Equal variances not assumed			-1.892	13.807	.080	-.252602	.133488	-.539281	.034078

Figure One: T-test for risk score by SRH bad vs very bad

Table One: Descriptive Statistics characterizing sample of patients with bad or very bad health

N =150	Mean(SD)	
Age	46.22(18.25)	
RAF#	0.545(0.416)	
	N (%)	*verybad*
Female	95(63%)	
Non-white	36(26.86%)	
Report_Violence_concern	8(5.33%)*	*1(7.69%)
Report_Unmetneeds	19(15%)*	*4(31%)
Report_HC_Cost_concern	28(20%)*	*4(31%)

*Social determinants of health markers in those with very bad health

Conclusions

Qualitatively, physicians question the validity for some patients, or attribute poor ratings to the subjective/mental health domain thereby relegating SRH to lesser status.

Quantitatively, patients with very bad SRH have a higher risk score than those with bad SRH.

Next Steps

1) Patient care huddle. Pre-identifying concerning patients for more aggressive in-visit interventions.

2) Clinician teaching. Using SRH for the efficient health indicator it is.

3) Patient input. Patient reaction to the question in the context of a clinical encounter.

4) Impact on quality. Relationship between PCPCM and self-rated health in a clinical setting.

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Early theorization of self-rated health

YOUTUBE PITCH TRANSCRIPT

This poster explores how primary care providers in a Midwestern family medicine residency, respond to learning that their patient's have rated their health at a visit in the past five months as bad or very bad. Self-rated health is a concept widely used in health psychology, for research, but rarely used in clinical visits outside of research despite being a robust predictor of morbidity and mortality. Self-rated health is the question: "in general, how would you say your health is today?" Responses are very bad, bad, okay, good, and very good.

When I requested that self-rated health be asked of every patient at every visit beginning in May 2020, I wanted to do something with that information. The first step was to elicit resident and faculty responses to the concept. I asked questions such as (1) "How might a PCP rate a patient's health differently than the patient?" and (2) "can self-rated health be a quality metric?" Answers to the first question focused on how physicians perceive health differently than patients. Answers to the second question varied from yes to no.

The second step was to create a database of general health rating, RAF score, age, sex, race, zip code, PCP, concerns for violence in the neighborhood, concerns for meeting basic needs, and concerns for affording healthcare. The RAF score is a measure of risk for serious illness. Table One provides descriptive statistics from our database of patients with bad or very bad health. The average age of patients in this sample is 46. Sixty three percent are female. Twenty seven percent are nonwhite. Thirty one percent of those who rated very bad health indicated unmet needs and concerns with healthcare cost.

The third step was to ask PCPS for their reaction when patients of theirs rated their health as bad or very bad, via email and secure texting. A few responses: "Not surprised, she has quite poor health and no friends. She often cries about wanting to be social and get out, but her physical abilities are a barrier and her mental state is not strong enough to just get out there. I've recommended some things in the past like free classes and social gatherings." And "surprises me but from her point of view new job she can't handle due to lumbar pain that local doc won't fix and had to have surgery…and was unable to manage probably caused her to answer this way. Hopefully won't be this way in 6 months." Two raters went through collated responses of PCP reactions and developed attributional and descriptive themes found in table two. Physicians tended to explain patient perceptions self-rated health using the following themes: Pain, health literacy, multimorbidity, challenging coordination of care, loneliness, psychosocial stressors, acute illness insults, high symptom burden, poor quality of life, emotionally charged situations and crisis moments.

Finally, in figure 1, RAF scores differed significantly between those with bad health and those with very bad health, supporting self-rated health as a robust measure. We speculate that patients perspectives on health are closely tied to their subjective experience, which plays an important role in patient well-being, but may be dismissed more readily in western medical culture.

To use Self Rated Health effectively for care in our clinic, I propose the following next steps. First, Self Rated Health has been incorporated into huddles, and patient encounters. This allows us to consider how to leverage more services when ratings are poor. Second Faculty development. What can you do with the question, "how is your health today?" Third, additional direct interviews with patients should allow us to understand better why patients rate their health from good to very bad. Additional information about patients attributions may help physicians develop more confidence in using this

rating to develop effective care plans. Fourth I want to explore more the relationship between self-rated health and the new primary care quality measure, PCPCM.

Please check out my handout for my contact information. I am always open to continued conversations and feedback as well as interest in building a database and collecting this data within other clinics.

CONTACT INFORMATION

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