THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
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BEST ADVICE

Patient-Centred Care in a Patient's Medical Home

OCTOBER 2014

BEST ADVICE – PATIENT-CENTRED CARE IN A PATIENT'S MEDICAL HOME

Patient-centredness is widely acknowledged as a core value in family medicine.[1] Patient-centred care is also the first pillar of the CFPC's Patient's Medical Home (PMH).[2]

Definitions of *patient-centred care* vary but there is general agreement that it broadens the conventional medical approach to include the patient as an active participant in his or her care and to promote the physician-patient partnership.[3] Dr Ian McWhinney has described patient-centred care as the provider "enter[ing] the patient's world, to see the illness through the patient's eyes . . . [It] is closely congruent with and responsive to patients' wants, needs and preferences."[4] The line "Nothing about me without me"[5] succinctly captures the essence of patient-centred care.

Epstein et al.[6] identify three core values of patient-centredness:

- *Considering* patients' needs, wants, perspectives, and individual experiences
- *Offering* opportunities to patients to provide input and participate in their care
- *Enhancing* partnership and understanding in the patient-physician relationship

Little et al. have found that by viewing patient-centred care as physicians and patients working in a partnership, we are able to improve health care and challenge deeply ingrained practices and behaviours.[7]

Patient-centred care is a mixture of personal, professional, and organizational relationships. Efforts to promote patient-centred care should take into account the needs of patients (and their families), and the functionality of interprofessional health teams. Helping patients to be active in consultations will change physician-directed dialogues into discussions that engage patients as active participants. Training physicians to enhance their awareness of the patient's perspective and concerns transforms the medical role from one that is authoritative to one that seeks to achieve therapeutic partnership, empathetic responsiveness, and collaboration.[8]

Patients' self-determination can be influenced by the professionals who care for them.[9] To become partners in their own care, patients need to be empowered. Family physicians can encourage patients' empowerment by treating them with respect, taking time to listen to them, and making them feel valued.[10]

OBJECTIVE

The objective of this paper is to provide guidance to family physicians on implementing patient-centred care in family practice settings.

While this paper is presented for consideration by all in family practice, patient-centredness is a particularly natural fit for those whose practices align with the CFPC's Patient's Medical Home model (www.patientsmedicalhome.ca).

IMPORTANCE OF PATIENT-CENTREDNESS

Patient-centred care involves actively engaging patients when helping them make health care decisions. Achieving patient-centredness requires the establishment of ongoing, trusting relationships between the patient and his or her family physician and nurse, as well as with other health professionals who may become involved in the patient's care.[2]

Family physicians play an important role in helping patients understand the outcomes and implications that decisions pertaining to their health can have. They are trained medical doctors who are able to fully explore the patient's story, undertake relevant aspects of physical examination, formulate a selection of possible diagnoses, and recommend appropriate tests for every problem presented to them.[11] Their medical education and training enable them to provide ongoing care to their patients, or to arrange referral for them as needed. Family physicians discuss the options of major surgery; open the dialogue about the importance of medications; and help patients understand the need for screening, diagnostic tests, or immunizations.[12]

Patient-centredness can contribute to better care, as measured by a number of important indicators. When health care providers, administrators, patients, and families work in partnership, they enhance the quality of the patients' care. Physician-patient collaboration has been linked to many positive health outcomes, including shorter recovery periods,[13] improved health status,[14,15] and improved clinical health outcomes for patients with chronic conditions, including adult type 2 diabetes and depression.[16] These positive outcomes can be attributed to involving patients and their families as partners in providing care.[5]

When physicians and patients achieve a shared understanding—and when patients are able to participate actively in all aspects of their care, such as choices about treatment and self-management—it results in better adherence to medications and improved chronic disease control.[17] Research by Little et al.[7] found that most patients strongly preferred a patient-centred approach. From the patients' perspective, there were three important domains of patient-centredness: communication, partnership, and health promotion.

Patient satisfaction is also positively associated with patient-centred care. Mallinger et al. found that patient satisfaction is improved when physicians incorporate patient-centred behaviours into their care.[18] Studies have also demonstrated that patient-centred care can improve disease management,[19] increase patient engagement,[20] reduce anxiety,[17] and increase provider satisfaction.[21,22]

Patient-centredness requires a balance in the therapeutic relationship such that physicians actively exchange ideas, discuss different treatment options, and share power and influence with their patients while serving the patient's best interests. Options they discuss should be a product of collaboration between the patient and the physician, with the patient able to autonomously make choices that are informed by both the medical facts and the physician's experience.

Patient-centred strategies implemented into a practice should ultimately serve the patients' best interests and meet community needs. For example, although home visits can be beneficial to many patients, it may not be a feasible strategy that all family physicians can implement. Factors such as a busy office practice, hospital care, emergency department shifts, teaching, administrative work, difficult weather, and for some, large geographic distances or traffic, may lead to some challenges to physicians who want to provide their patients with home visits.[23]

Patient-centred care is the heart of family practice. CFPC strongly supports it as the most efficient approach to patient-provider interaction, and has made it the first pillar of the Patient's Medical Home.

With the many differences among primary care practices, such as size of practice and organizational characteristics, physicians may face barriers when trying to achieve the patient-centredness ideal. From the provider's perspective, it can be challenging to engage with patients in a meaningful way in the brief time allotted for a standard office visit. Depending on the practice structure, this change in productivity can affect the provider or practice in different ways, including spending less time with other patients, longer office hours, or not enough time to complete administrative responsibilities.

However, there is evidence that patient-centred interviewing can improve patient care *without* taking more time. There is evidence of the impact of patient-centred care on a range of positive outcomes. Examples include improved hemoglobin A_{1c} levels, blood pressure control, better control of pain, and faster symptom resolution.[24]

Lein and Wills found that the use of patient-centred interviewing strategies makes patient care processes more effective and enhances outcomes, while still maintaining the efficiency of patient management.[25]

Brock et al.'s research determined that a patient-centred communication technique, "collaborative upfront agenda setting,"* helped patients to air their concerns earlier in the visit so that they could be addressed, and did *not* increase visit length.[26]

**Collaborative upfront agenda* is defined in one of three ways: 1) physician requests a list of concerns or initiates an additional elicitation, and the patient indicates that they have completed listing their concerns; 2) physician asks for a list of concerns or initiates an additional elicitation, and demonstrates negotiation or prioritization; or 3) physician makes multiple additional elicitations or asks for a list of concerns multiple times.[26]

With these barriers in mind, providing care that is centred on the needs and preferences of the patient should be a priority for all family physicians. While both physicians and patients may initially find the change in the doctor's role from authority figure to a partner in care awkward, the benefits it will bring to health outcomes and patient and provider satisfaction make the transition worthwhile.

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Please see Appendix 1 to compare the characteristics of patient-centred practices with those of traditional practices.

GUIDING PRINCIPLES OF PATIENT-CENTREDNESS

Within the Patient's Medical Home, these *principles* guide the practice of patient-centredness:

1. Care and caregivers in a Patient's Medical Home must be person-focused and provide services that are responsive to patients' feelings, preferences, and expectations.
2. Patients, their families, and their personal caregivers should be listened to and respected as active participants in their care decisions and their ongoing care.
3. Patients should have access to their medical records as agreed upon by each person and his or her family physician and team.
4. Self-managed care should be encouraged and supported as part of the care plans for each patient.
5. Strategies that encourage user-friendly access to information and care for patients beyond traditional office visits (eg, email communication) should be incorporated into the Patient's Medical Home.
6. Patient participation and feedback (eg, patient advisory councils) should be included as part of the ongoing planning and evaluation of services provided in the Patient's Medical Home.

The PMH Self-Assessment Tool is an effective way to measure the patient-centredness of a practice.

Visit patientsmedicalhome.ca/self-assess/ for more information on CFPC's PMH Self-Assessment Tool.

STRATEGIES FOR IMPLEMENTING PATIENT-CENTRED CARE

Below are *strategies* that family physicians can use to incorporate patient-centredness into their practices.

1. PATIENT ENGAGEMENT IN CARE

Physicians can support patient-centred care by engaging their patients whenever decisions regarding their health care are required,[27] for example, when they need to choose among different medical options and understand the potential consequences of each.

Inform your patients and engage them as partners in their care by providing:

- Information about their health conditions, as well as about treatment options, and their benefits and risks
- Clearly defined roles and responsibilities for patients, caretakers, and clinicians
- Reminders that they are due for routine preventive care or alerts when they need follow-up (eg, in the case of abnormal test results or required medication dosage changes)
- Access to their own medical records and opportunity to add or clarify information in the record
- Assistance with self-care
- Assistance with behavioural change
- Patient education
- Guidance and counseling to parents on child health and development issues

2. SHARED DECISION-MAKING

By involving patients in decisions about their care, physicians can help patients understand the importance of their values and preferences in deciding on the best possible course of action. When patients know they have options for the best treatment, screening test, or diagnostic procedure, most of them will want to participate with their clinicians in making the choice.[27]

Understanding the patient's goal in treatment can also increase the probability of adherence.[12] Shared decision making enables the provider to identify barriers to adherence and to incorporate solutions specific to the patient. The patient may be concerned about issues related to symptom management, side effects, cost,

quality of life, and complexity of treatment.[28] Providing options allows the patient to address concerns and to choose a treatment that aligns with his or her ability to adhere to treatment.

3. SELF-CARE

Patients' Medical Homes should facilitate and support patient self-management.* Support for self-care has been shown to be most effective when the support is consistently available from all team members of a practice.[2] Family physicians, nurses, and other team members should always consider recommendations for care from the patient's perspective. They should work collaboratively with patients and their personal caregivers to develop realistic action plans and to teach problem-solving skills within a patient's capability.

Self-care is particularly important for those with chronic diseases. Evidence has shown that it may be helpful for a practice to host group visits for patients with chronic diseases. The goal of self-managed care should be to build confidence in patients and their personal caregivers to help patients deal more effectively with their illnesses and to improve their health outcomes.[2,29]

4. CONTINUOUS QUALITY IMPROVEMENT AND PATIENT FEEDBACK

A patient-focused practice continually strives to improve patient satisfaction and the quality of care. It encourages patients' feedback, including their rating of access to appointments and the adequacy of the time allowed, through surveys and other tools. To strengthen a patient-centred approach, practices should consider evaluating the effectiveness of its services on an ongoing basis as part of its commitment to continuous quality improvement (CQI).[2] As well, they should monitor the health outcomes and satisfaction of their patients, to identify and address any deficiencies within the practice and to improve overall effectiveness.

Please see Appendix 2 for examples of patient feedback tools.

5. TEAMS

The CFPC acknowledges the importance of collaboration within primary care health teams where every health professional practises to the full extent of his or her knowledge and expertise.

In a collaborative setting, patients can receive care delivered by different health professionals working together in strong system-supported teams. Addressing patient needs is about having access to the right provider at the right time in the right place. The implementation of team-based care allows health professionals, such as peer physicians, nurse practitioners, and physician assistants, to complement the care provided by family physicians, while still working within their own scope of practice.

* *Self-management support* is defined as the systematic provision of education and supportive interventions that a health care team would use to increase a patient's skills and confidence when managing their health problems. Support can include regular follow-ups discussing progress and problems, goal setting, and problem-solving support.[29]

As patients and families will interact with different sets of health care providers on various visits, it is important for the family physician to serve as a central connection to the team for the patient, ensuring appropriate service provision and information sharing. Health care teams will work together to establish shared goals that reflect patient and family priorities and that can be clearly articulated, understood, and supported by all members.[30] Teams that are more cohesive in their approach to care appear to be associated with continuity of care,[31] higher patient satisfaction,[32] and increased provider satisfaction.[33]

6. TECHNOLOGY, INCLUDING ELECTRONIC MEDICAL RECORDS (EMRs) AND EMAIL

The use of technology is an integral component of primary care practices. A range of technology options should be available to patients in patient-centred medical homes.

Health technology should be used to reinforce continuity of care, patient engagement, and improved communication among physicians, staff, and patients. Patient-oriented record systems should give the clinician easy access to information about the patient's family and other contextual data, provide space to document the patient's treatment preferences, and ensure ease of use for the clinician when completing documentation for administrative and billing purposes.[17]

Technology should promote patients' active participation in clinical encounters by helping them engage in conversation with their family physician.[17] Ongoing, planned interaction with patients by email, telephone, or other electronic communications can facilitate management of patients' care, and in particular, care for those with chronic diseases such as diabetes, hypertension, arthritis, and mental illness.[34]

EMRs should also be utilized in a patient-centric fashion that encourages patients' involvement. For example, a reminder for an appointment or vaccine in the EMR could be sent to a patient or the patient's family using an automated preferred mode of communication, such as a phone call or email.

Other benefits of EMR use include reduction of adverse drugs events and increased patient compliance,[35] more efficient workflow and patient recalls,[36] and increased security of data and enhanced patient confidentiality.[37]

See the CFPC's You've Got Mail! What Family Physicians Should Know Before Hitting "Send"[38] for information on emailing your patients.

Please see Appendix 3 for two examples of electronic tools that engage patients in their health care.

7. INCREASED ACCESS TO CARE

Practices should implement a system that ensures appropriate, timely access to appointments for all patients. Timely access has been rated by patients as one of the most important elements of primary care.[39] Family practices have been implementing various appointment booking models to achieve timely access to appointments. For example, one of the strategies currently being implemented is same-day/advanced access scheduling. Practices can also implement systems that allow:

- Ability of patients to select the day and time of their appointment themselves
- Email and telephone visits when they are an appropriate substitute for in-person care
- Off-hours service that makes primary care readily accessible on nights, weekends, and holidays[40]

See the CFPC's Timely Access to Appointments in Family Practice: Same-Day/Advanced Access Scheduling[34] for further information.

Utilizing the above strategies will help your practice become more patient-centred, forging strong partnerships between you and your patients that can lead to higher patient satisfaction and better health outcomes.

APPENDIXES

Appendix 1:
Characteristics of traditional health care model vs patient-centred model

	TRADITIONAL HEALTH CARE MODEL	PATIENT-CENTRED MODEL
Patient's role	• Passive • Patient mostly listens as health provider discusses treatment	• Active • Physician encourages patient to actively discuss treatment options and preferences
Decision-maker	• Provider (usually a family physician) dominates as the decision-maker • Provider does not offer options	• Provider collaborates with the patient when making decisions • Provider offers recommended treatment options and discusses pros and cons of each
Focus	• Disease-centred • Provider focuses on treating just the diagnosed medical disease	• Patient-centred • Provider engages with patient to actively exchange ideas and look for solutions on how to better the quality of life for the patient, and not to just simply "treat" the disease
Communication	• Provider does most of the talking • Little time is provided for patient to ask questions	• Provider listens more and talks less • Time is provided to allow patient to ask questions and to discuss the pros and cons of the recommended treatment options
Treatment plans	• A treatment plan is recommended and provided to the patient • The plan focuses on treating the diagnosed ailment	• Several treatment options are discussed by patient and provider • Once the patient and provider have agreed on the treatment, the family physician, along with the health care team, creates a comprehensive treatment plan that considers the individual patient's situation, concerns, and preferences • The plan includes a course of treatment for the diagnosed ailment, as well as other recommendations for a healthier lifestyle—eg, a patient diagnosed with diabetes who is on the verge of being overweight may have a diet and exercise plan recommended
Technology used	• The practice may have an EMR system in place but not be using it to engage patients	• Patient's information is secured in an EMR system that is accessible by the patient's health care team • Tools on the EMR make it simple to track the patient's progress, eg, graphs and charts easily allow a physician to show a patient past and present health results and projected future results
Providers of care	• Patients are seen by their family physicians	• Patients have access to a team of health care providers, which may include family physicians, nurses, physiotherapists, and social workers, who work together to create the best possible action plan for treatment

Appendix 2: Examples of patient feedback tools

The **Canadian Institute for Health Information (CIHI)** developed a set of health care surveys that address three different levels of primary care practice: patient, provider, and organization. The surveys can be used separately or together, and can be linked through anonymous identifiers that will link patients to their providers and providers to their organizations.[41]

The Quality in Family Practice Project, initiated by McMaster University, implements a comprehensive and integrated CQI program that promotes and celebrates excellence in family practice. The Quality project is designed to recommend an interdisciplinary assessment tool for use by family practices.[42]

The **Saskatchewan Health Quality Council** created a Patient Experience Survey Toolkit, which is a practical guide to surveying patients in primary care practices. The toolkit describes a routine survey process and methods for planning and conducting surveys, as well as how to use the results in your practice's CQI. The toolkit provides both a short and a long version of the survey for flexibility.[43]

Appendix 3: Examples of technology-oriented resource tools

In March 2014, **Canada Health Infoway** launched its e-Booking Initiative,[44] which supports eligible physicians or nurse practitioners in offering electronic appointment booking ("e-booking") to their patients. With a majority of Canadians wanting the option to book appointments electronically, e-booking can be a useful tool to increase convenience and control in practices. Early adopters of e-booking in Canada have highlighted benefits such as reductions in no-shows, gains in administrative staff efficiency and satisfaction, and improved patient empowerment and satisfaction.

There have also been initiatives produced at a more micro level. For example, **Sunnybrook Health Sciences Centre**'s e-Health initiative, MyChart™, is an online tool that patients can use to create and manage their personal and clinical health information. MyChart™ considers the rights and needs of patients and caregivers, while maintaining security related to private information.[45]

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