Achieving patient centred care – empowering and valuing individuals and carers

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Masterclass overview

• Principles of patient-centred and family-focused care

• Co-creation principles and approaches that could be applied to providing patient-centred care

• Value of partnering with patients, their families and carers

• Key communication techniques and tactics for patients, their families and carers to co-create value
What is patient-centred care?

Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions

Patient, families and carers:

• At the centre of care
• Partners in care (co-creators)
• Empowered and actively engaged

“They give me exactly the help I need and want exactly when I need and want it.”
Group activity

Put yourself in a position of a patient

- What is of value to you?
- Is it the medications, the hospital, equipment that is used, expertise of the doctor?
- What differentiates one hospital/service from another? One doctor from another?
Patient experience

https://www.youtube.com/watch?v=--uMNY55nw4
Group activity

What are the key things that you picked from the video?
Eight principles of patient-centred care

8 Dimensions of Patient-Centered Care

- Patients’ Preferences
- Emotional Support
- Physical Comfort
- Information & Education
- Continuity & Transition
- Coordination of Care
- Access to Care
- Family & Friends
Patients valuable role

Patients are often a problem to be solved, not a solution

To date, organisational approaches to involve consumers have been mostly focused on tokenistic consultations, questionnaires, one-off projects or a seat on a committee

Patients, carers and members of the public have a valuable role to play in tackling the problems facing health care
Patients as partners – value co-creators

Health services, agencies, patients and communities need to work together more and differently to address challenges of health care, to improve quality of health care services, enhance health outcomes, and to achieve a more productive and sustainable health system that is responsive to the needs of health consumers.
Patient as co-creators of value

Value co-creation defined as collaborative activities that empower patient, engage patients and enhance their experience

- value is co-created if and when patient is able to personalise their experience
- Patients determine value based on their individual experiences as end-users

Empower and educate patients to be informed ‘partners in care’ to work collaboratively with the health care team, families and carers as co-creators contributing to their own health care

Enable patient contribution in all aspects of the health system and health service activity – as co-participants and co-creators
Models for patient value co-creation in health care

**Partnership model** - explicit knowledge acquired from patients, such as innovative ideas, are combined with existing knowledge to develop new solutions or to improve existing services.

**Open-source model** - consumer and community led activities with a focus on new knowledge co-creation.

**Support group model** - consumer and community led forums for sharing specific knowledge and experiences related to disease and treatment.

**Diffusion model** - knowledge-sharing activities initiated and led by health care organisations, focusing on those services or products offered by the organisation.
Benefits of patient co-creation

- Empowered to self-manage
- Increased efficiencies in health services
- Improved health outcomes
- Increased trust in the health care team
- Reduced health care costs to the patient and the health system
- Increased patient satisfaction and compliance with treatment regimens
- Value can be co-created for the individual, clinical practices, health care organisations and providers, and government
Patient co-creation embedded across health care

**Macrosystem**
- National initiatives, policies, incentives
- Macro-level infrastructure
- Government led changes to health systems

**Mesosystem**
- Support of microsystems
- PHNs to drive consumer health co-creation
- Strengthen interface between microsystems to provide coordinated, accessible, patient-centred care

**Clinical microsystem**
- Helping clinicians to develop skills, knowledge, attitude to support and motivate patients with chronic conditions

**Individual caregiver and patient system**
- Education and family engagement strategies

**Patient centeredness, self-care system**
- Giving people with long-term conditions the skills, confidence and support to self-manage

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Partnering with patients to co-create health

Key communication techniques and tactics for patients, their families and carers to co-create value

- Engaging patients to play an active role in their health
- Building partnership and trust
- Expressing empathy
- Mapping an agenda
- Information sharing
- Coaching patients to self-manage their condition in partnership with care team
- Increasing patient activation
Engaging patients in their care

**Individual level** - while they are receiving care from a member of the care team

**Clinic level** - where patients may be included on committees

**System level** - where patient experiences inform policies and regulations across health organisations
Building partnership

Co-creation is built with

- **Trust** - developing communication habits that build trust

- **Empathy** - expressing curiosity and compassion about the perspective and emotions of others

- **Collaboration** - increased patient empowered and activation through collaborative approaches to teamwork and patient care
Building trust

Trust exists when patients perceive their provider

- Is technically competent
- Shows interest in them by - listening, understanding, providing complete and honest information, and expressing empathy
- Puts the patient’s welfare ahead of other considerations
Expressing empathy

- Closely related to trust
- Demonstrates respect and appreciation for patient’s emotional experience
- Empathetic statements

**Reflection:**

“You seem [frustrated, worried, sad]...”

**Validation:**

“Anyone would feel...”

**Partnership:**

“I’d like to help...”

**Respect:**

“I’m impressed by how you...”
Three enablers

Becoming an active partner

Making change

Maintaining change

Agenda setting
• Identifying issues and problems
• Preparing in advance
• Agreeing a joint agenda

Goal setting
• Small and achievable goals
• Builds confidence and momentum

Goal follow-up
• Proactive – instigated by the system
• Soon – within 14 days
• Encouragement and reinforcement
Patient activation

‘Patients vary in the degree to which they believe that their action is critical to their health’

‘They also vary in the level of confidence they have in their ability to take actions that will make a difference in their health’
Patient activation journey – four levels

**Level 1**
**Starting to take a role**
Patients do not yet grasp that they must play an active role in their own health. They are disposed to being passive recipients of care.

**Level 2**
**Building knowledge and confidence**
Patients lack the basic health-related facts or have not connected these facts into larger understanding of their health or recommended health regimen.

**Level 3**
**Taking action**
Patients have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

**Level 4**
**Maintaining behaviors**
Patients have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

*Increasing Level of Activation*
### Patient Activation Measure (PAM)

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Agree</th>
<th>Agree Strongly</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>When all is said and done, I am the person who is responsible for taking care of my health</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>2.</td>
<td>Taking an active role in my own health care is the most important thing that affects my health</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>3.</td>
<td>I know what each of my prescribed medications do</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
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<tr>
<td>4.</td>
<td>I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
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<tr>
<td>5.</td>
<td>I am confident that I can tell a doctor concerns I have even when he or she does not ask.</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td>I am confident that I can follow through on medical treatments I may need to do at home</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>8.</td>
<td>I know how to prevent problems with my health</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>9.</td>
<td>I am confident I can figure out solutions when new problems arise with my health.</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>10.</td>
<td>I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.</td>
<td>Disagree Strongly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Patient level of activation linked to behaviour

<table>
<thead>
<tr>
<th>Hypertension Self-care Behaviors</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take Rx as recommended</td>
<td>31</td>
<td>55</td>
<td>88</td>
<td>73</td>
</tr>
<tr>
<td>Know what BP should be</td>
<td>13</td>
<td>17</td>
<td>27</td>
<td>58</td>
</tr>
<tr>
<td>Monitor BP weekly</td>
<td>16</td>
<td>14</td>
<td>33</td>
<td>31</td>
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<tr>
<td>Keep BP diary</td>
<td>0</td>
<td>9</td>
<td>8</td>
<td>21</td>
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Source: US National sample 2004
Patients who get more support from their provider are more activated

<table>
<thead>
<tr>
<th>Experience with Healthcare Providers</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
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</thead>
<tbody>
<tr>
<td>Help them to set goals to improve their diet</td>
<td>49.3%</td>
<td>65.3%</td>
<td>83.6%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Helped them to set goals for exercise</td>
<td>42.2%</td>
<td>61.6%</td>
<td>73.6%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Taught them how to self-monitor their condition</td>
<td>43.5%</td>
<td>66.5%</td>
<td>80.9%</td>
<td>84.7%</td>
</tr>
</tbody>
</table>

Source: Center For Studying Health System Change 2007 Household Tracking Study
Differences between level 4 and other levels significant at p<.05
Strategies to increase activation

• Emphasise patient ownership
• Partner with patients
• Identify small steps
• Frequent follow up visits to cheer successes and/or problem solve
• Show caring and concern for patients
Tailoring - Level 1 techniques

• Open and accepting if patient is unlikely to take on behaviour change immediately
• Use techniques to invite contemplation of behaviour change
• Use reflection and empathy
• Discuss and explore behaviour change at each consultation.
Tailoring - Level 2 techniques

- Discuss the patient’s importance for change
- Explore the pluses and minuses of change.
- Ask what patient uses to manage health
- Explore patient successes and failures
- Build confidence through small changes they suggest
- Be excited and curious about small changes.
Tailoring - Level 3 techniques

- Be curious about successes
- Support the patient to problem-solve
- Ask for patient permission before offering suggestions
- Focus on behaviour more than outcomes
Tailoring - Level 4 techniques

- Encourage problem solving
- Introduce new techniques for when problems arise or previous attempts fail
Health Coaching

- Ask-tell-ask
- Closing the loop
- Agenda setting
- Know your numbers
- Action plans.

“Give a person a fish, and you feed them for a day. Teach them how to fish and you feed them for a lifetime.”
Collaborative Decision Making

Patients are active in decisions about their plan

- Provide tailored information centred on the patient’s values and cultural needs
- Use shared decision making tools to support a collaborative approach to decisions
- Encourage patient self-monitoring and recording
Examples of improvement

• **Self monitoring** and **agenda setting** reduces **hospitalisations**, ED visits, unscheduled visits to the doctor and days off work or school for people with asthma

• **Goal setting** for older women with heart conditions reduces days in hospital and overall **healthcare costs**

• **Telephone support** may improve **self care behaviour**, improved glycaemic control, and symptoms of diabetes patients

• **Motivational interviewing** improves **self efficacy**, patient activation, lifestyle change, and perceived health status

• **Individual education and group sessions** improves **symptoms** for people with high blood pressure
Patient Partnership in care

You can help improve the quality of life for people living with chronic conditions. Your opinions are valuable.

Your feedback will help the doctor/health professional improve advice and support given to patients

- All information will be kept anonymous and confidential
- The clinician will not see your answers, so please give honest feedback

Please mark the box like this ☑️ with a ballpoint pen. If you change your mind just cross out your old response and make your new choice.

Simply fill in the questionnaire, seal it in the envelope and return it to reception.

As a result of your visit to the doctor/health professional today, how would you rate the following:

Please tick which applies

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
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1. The ability of your practitioner to ask you what you wanted to talk about
2. The ability of your practitioner to give you the information you wanted to know
3. The opportunity to talk about your concerns and fears
4. The ability of the practitioner to really listen to you
5. Your understanding of your health condition
6. Your practitioner’s understanding of your personal situation when discussing your care
7. Your understanding of how your health care will be managed as a result of today’s visit
8. Your practitioner’s support in helping you feel you can manage your care
9. The information given to you by your practitioner about how to get answers to future questions
10. Your practitioner’s follow up on your health care from your last visit
11. Your partnership with your practitioner in your care

The following questions give us general information about the range of people who have filled in this survey. This information will not be used to identify you and will remain confidential.

Are you:
- Female
- Male

How old are you in years?
- Under 25
- 26 - 59
- 60+

How often have you seen this practitioner?
- First visit
- More than once

Have you been admitted to hospital for your chronic disease in the last:
- 3 months
- 6 months
- 12 months

Thank you for your time and assistance in completing this questionnaire.
Value in partnering with patient to co-create value to achieve Quadruple Aim

- **Improved patient experience of care**
  - Care tailored to the needs of an individual
  - Coordinated and comprehensive care
  - Safe and effective care
  - Timely and equitable access
  - Increased skills and confidence to manage one’s own care

- **Improved health outcomes and population management**
  - Reduced disease burden
  - Increased focus on prevention
  - Improved quality of care
  - Improvement in individual behavioural and physical health

- **Improved cost efficiency and sustainability in health care**
  - More efficient and effective service delivery
  - Increased resourcing to primary care
  - Improved access to primary care, reducing demand on hospitals

- **Improved health care provider experience**
  - Increased clinician and staff satisfaction
  - Increased flexibility and scope for innovation
  - Evidence of leadership and team-based approach
  - Quality improvement culture in practice