Patient-Centred Care
Health System Planning and Physician Practice

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Topics

• Health Care System
  – Integration
  – Access
  – Funding
  – Chronic Disease Focus

• Physician Practice
  – Communicating with patients
  – Helping patients make decisions
The Health Care System in Ontario – Patient Centred?
What is A Patient-Centred Care System?

• One where patients can move freely along a care pathway, no matter which resource they need at that moment.
• One that treats patients with respect and dignity
• One that considers their individual needs.
What do we need?

• Integration of care across the system.

• Access – matching demand to capacity and doing so with minimal delay.

• Different funding models.

• Transformation of the system from one that focuses on acute care to one that includes a focus on chronic disease management.
Integration

• One of the most difficult challenges facing the Ontario health care system.

• Our system often fails when patients move from one part of the system to another – from GP to specialist, from home to long-term care, from hospital to home.

• Not alone – OECD & EU countries report that care coordination is a problem and that it is worse at the interface between health care sectors and health care providers.
Integration – Transition issues

– Specialists report that GPs don’t send them comprehensive referral information; GPs report that specialists don’t send them enough info after consult to coordinate care for their patients.

– Too many steps for patients being discharged, with lots of opportunity for error.

  • Example: Change Foundation found 1 hospital with 247 steps in the hospital to home process, 9 databases, 35 forms, and 11 handoffs of patients.

– Health Quality Ontario reports that 1 in 3 patients discharged from hospital do not know who to contact with questions or problems.
Possible Solutions to Integration Problems

• EMRs- improve communication among physicians and between various sectors of health care such as hospitals and physicians.

• MOHLTC has pilot projects in integrated client care.

• Care coordinators - being tried in some hospitals to help patients with the transition to home. Case managers - used effectively in other countries.
Access

1. Need to match demand to capacity with minimal delay.
   – Access to physicians is a problem
     – Both patients and physicians see access as a problem.
   – Have overcrowding in emergency rooms and patients in acute care beds who could be discharged but there is nowhere for them to go.
     – So, two places where there is a bog in the hospital system, where demand exceeds supply – at the front end and the back end.
   – Lack of community programs to help patients self manage chronic diseases such as COPD and diabetes.
Access

2. System is inefficient
   – Inappropriate diagnostic testing
   – Physicians don’t communicate well among themselves.
   – Patients don’t have timely access to their physicians.
Who has most difficulty with Access?

• Our most vulnerable patient populations
  – Frail elderly
  – The less educated or less health literate
  – English as a second language
  – Those with mental health or substance abuse illnesses
Possible Solutions to Access Issues

• MOHLTC has wait times strategy to decrease wait times in selected areas, and an aging at home strategy to help keep seniors in the community and out of long-term care homes and acute care hospitals.

• There are pilot projects to reduce the numbers of steps in the hospital to home process using more efficient processes and case managers.
Possible Solutions to Access Issues (2)

• Internationally, most countries (and Ontario) suggest the solutions lie in reducing the need for high-cost hospitalizations.

• Physicians should consider using other means of communication such as email and telephone calls; same-day appointments are another option.
Funding

- Funding systems for hospitals, long-term care facilities, and community mental health and addiction facilities do not promote care coordination.
  
  - Hospitals are now funded on a global basis, so few incentives to work together.
  
  - Community mental health and addictions funding is based on transfer payments for specific programs.
  
  - Long term care funding is a mix of across-the-board percentage increases and a funding formula.
Chronic Disease

• Healthcare system is designed for acute care.
• Because of improvements in technology and pharmaceuticals, people are living longer with conditions that are controllable but not curable.
• Inactivity and excessive dietary input increase risk for chronic disease.
Number of Chronic Conditions by Age Group

- Age 30-64
  - 0 conditions: 46
  - 1 condition: 19
  - 2 conditions: 28
  - 3 conditions: 26
  - 4 or more: 14

- Age 65 and older
  - 0 conditions: 16
  - 1 condition: 23
  - 2 conditions: 15
  - 3 conditions: 6
  - 4 or more: 5
Who is at Most Risk for Chronic Disease?

• Aged.

• Those with poor lifestyle habits – inactivity, poor and excessive dietary input, smoking, excessive alcohol consumption.

• Those who are overweight or obese.
Possible Solutions to Increased Prevalence of Chronic Disease

• Increased focus on chronic disease management in primary care.

• More focus on prevention.

• Stratification of services such that the most complex patients receive the most care coordination (KP model).

• Better clinical guidelines and guidelines that address comorbidities.

• Engagement of patients and their families in shared decision-making and self-management of chronic disease.

• Better use of electronic medical records for care coordination.
Summary – Ontario’s Health Care System

• We need to transform the Ontario health care system into one that is centred on patients, that is integrated, that provides access for patients, and that focuses on chronic disease as well as acute care.

• We’ll need to evaluate our efforts as we go along.
Physician Practice – Communication and Decision-making
Keys to patient-centred care by physicians

- Communicating with patients
- Assisting them to participate in decision-making
Communicating with Patients

• Demonstrating respect for patients
• Assessing health literacy
• Communicating risk
• Patients with special problems
Patient Health Literacy

• Assessing the patient’s health literacy is a necessary prelude to communicating information.

• The OMA thinks this is important – we have a background paper on patient health literacy and its implications for physicians and for the health system.
Percentage of Canadians with Insufficient Literacy Skills, Aged 16 and Older, 2003

- Document rate: 48.6%
- Prose rate: 47.7%
- Numeracy rate: 55.1%
- Problem solving rate: 72.2%
Literacy skills

• About half the population has insufficient literacy skills for prose and numbers
  – patient education brochures, consent forms, medication labels will be hard to understand.

• Problem solving rates are even worse.
  – Making decisions among treatment options is beyond the capability of some patients
  – Self-management of chronic conditions will be challenging for some patients.
Literacy skills

• Special populations of patients are particularly challenging
  – Children
  – Patients with mental health illnesses
  – Patients with substance abuse illnesses
Assessing literacy – the “teach back” method

- Generally, physicians don’t assess patients’ literacy – they assume that patients understand.

- The “teach back” approach.
  - Example: Can you tell me, in your own words, the changes we’ve just planned for dealing with your high blood pressure?
  - Example: Can you tell me the changes you’ve agreed to make in the timing of your medications?

- If the patient does not understand, the physician can clarify and re-assess.
General tips about communication

• Health care providers should not ask patients if they understand – they’ll say they do.

• Patients who do not read or do not read well may try to mask that.

• For patients with mental health illnesses, their communication ability is best predicted by cognitive ability, not psychotic symptoms.
Showing Respect for Patients

• Physicians and other health care providers need to ensure that patients coming to their practices feel respected -- by physicians, by members of the healthcare team and by those who are their first contact – those on the front desk and the telephones.
Summary – Communicating with Patients

• Health literacy, its importance, and how physicians can assess patients’ literacy to better communicate with them.

• The importance of showing respect for patients.

• Those with mental health illnesses are potentially more problematic to communicate with; there are other special populations as well.
Physician Practice – helping patients make decisions
Helping Patients to Make Decisions

• Informed consent.

• Health literacy and decision risk.

• Self-management of chronic conditions.

• Systematic biases called “framing effects”.

• End of life decisions.
Informed Consent

• Physicians are required to obtain informed consent from patients for surgical procedures or other major medical interventions.

• Patients have the right to make what the physician considers “bad decisions”

• In law, a decision is always the patient’s decision.

• In practice, patients rely heavily on the expertise of physicians.
Literacy and Risk

• The higher the patient’s literacy and the lower the risk of the decision, the more the patient will be engaged.

• Conversely, the higher the risk and the lower the patient’s literacy, the less the patient will be engaged.

• Engagement will also be influenced by the patient’s personality, education, and experience.
Impacts of Health Literacy and Risk Level on Decision-Making

- Higher level of engagement by patients
- Lower level of engagement by patients
Patient Self-Management of Chronic Conditions

• Helping patients to self-manage their chronic conditions is an important feature of patient-centred care.

• Leads to improved outcomes for patients.

• Helps patients to live well.

• Increasingly important as more and more patients have chronic conditions.
Example of Decision-Making

Problem given: Which treatment do you prefer?

Example 1

Surgery: Of 100 people having surgery, 90 live through the post-operative period, 68 are alive at the end of the first year and 34 are alive at the end of five years.

OR

Radiation therapy: Of 100 people having radiation therapy, all live through the treatment, 77 are alive at the end of one year and 22 are alive at the end of five years.
Example of Decision-Making

Problem given: Which treatment do you prefer?

Example 2

Surgery: Of 100 people having surgery, 10 die during surgery or the post-operative period, 32 die by the end of the first year and 66 die by the end of five years.

OR

Radiation therapy: Of 100 people having radiation therapy, all live through the treatment, 77 are alive at the end of one year and 22 are alive at the end of five years.
Example of Decision-Making

• Logically equivalent:

• Surgery: Of 100 people having surgery, 90 live through the post-operative period, 68 are alive at the end of the first year and 34 are alive at the end of five years.

• Surgery: Of 100 people having surgery, 10 die during surgery or the post-operative period, 32 die by the end of the first year and 66 die by the end of five years.
Decision Biases – Framing Effects

• Decades of research shows that people do not make logical decisions in situations that involve risk, i.e,
  – outcomes of possible treatments or
  – risks and benefits of particular drugs.

• “Framing effects” explain how decisions are biased based on whether the decision choice is worded or framed in a positive or negative light. People choose the positive frame.
What should the physician do about framing effects?

• Frame choices both positively and negatively.

• Example: When discussing treatment options, indicate the positive and negative outcomes for each choice.

• Example: When explaining side effects of medication, indicate the percentage that will be negatively affected and the percentage that will not.
End of life Decisions

• Difficult for patients and their families and for physicians.

• Best results occur when decisions are informed, shared, and responsive to the needs and values of individual patients and their families.

• Otherwise, interventions may be provided to those who would not choose them and withheld from those who would.
Summary of Topics - Helping Patients to Make Decisions

• Realize the patient’s right to make decisions.

• Patient health literacy & the risk of the decision influence patients ability & willingness to make decisions.

• Helping patients to self-manage chronic conditions helps them to live well.

• When making decisions, patients are subject to biases called “framing effects”.

• Physicians can help patients and their families to make end of life decisions.
Summary – Physician Practice

- Patient-centred care entails showing respect for patients, communicating with them in a way they understand, and helping them to make informed decisions.
Key Points – Patient-Centred Care

• What we have now is disconnected institutions and physician practices.

• Health care stakeholders need to work together to transform the system.

• Physicians can help to transform the system in their practices and by working with other health care stakeholders.

• We’ll need to build in evaluation strategies.
Contact Info and Links

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OMA Policy: Patient-Centred Care

OMA Policy on Chronic Disease Management

OMA Background Paper: Health Literacy: Implications for Physician Practice and Planning: