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CONTEXT

Individuals with multiple chronic conditions (MCCs) have two or more chronic health conditions. While healthcare has traditionally focused on the needs of single-disease patients, increasing evidence suggests that MCCs may be becoming the norm, rather than the exception. MCC patients have multiple needs that require assessment and care from multiple providers, who need to integrate diverse perspectives, information, and interventions. Since case mixes and populations have high patient-to-patient variability, standardized protocols and disease-specific treatment guidelines are of limited applicability. In fact, patient-centered care implies a dynamic, adaptive, and interactive process of configuring the components of a health system around individuals' multiple needs.

The two broad categories of patient-reported measures are patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). PROMs contain questions on experiential domains of health; whereas PREMs contain questions regarding patients' experiences receiving care, such as accessibility, quality of communication, care coordination and decision-making. The potential of patient-reported measures as tools for fostering a patient-centered approach to care can only be maximized by considering the processes through which they are meant to affect change.

OBJECTIVES

The objective of this paper is to encourage practitioners, policy makers, and evaluators considering the use of patient-reported measures to think critically about how their use may impact care in unanticipated ways.

ARGUMENTS

The introduction and evaluation of patient-report initiatives should be accompanied by continual vigilance for unplanned effects on patient care. Firstly, prioritizing and enacting high-quality dialogues between patients and providers requires time and human resources. This places greater onus on the qualitative dimension of consultation as a means of understanding and addressing the problems of unique and complex individuals. Policy mechanisms, such as the mandatory use of PROMs and financial or accreditation incentives for achieving patient experience benchmarks, prompt organizations and providers to change their behaviours and policies. In a time- and resource-constrained environment, this also means that less time and resources go into other priorities, such as continuous access to the same provider – an arguably central aspect of a patient-centered approach for patients with MCCs given the level of time needed to assess each individual's complex needs.

Secondly, modern health systems consisting of diverse and geographically dispersed providers requires use of information technology (IT) to share data and develop multi-disciplinary care plans. However, many healthcare IT systems today are characterized by incompatible hardware and software, and lack of common nomenclature and coding structures. Without proper precautions and planning, the addition of more patient-reported data may contribute to confusion in developing effective and shared protocols. Making data available to providers that is erroneous, contextually inappropriate, or impossible to reconcile with other sources compounds, rather than mitigates, the challenges associated with formulating a coherent, adaptive picture of patient needs and progress.

CONCLUSIONS

In this commentary, an attempt was made to stimulate discussion and encourage critical reflection concerning the use of patient-reported measures. Becoming knowledgeable about problems and familiar with the contexts in which patients with MCCs are addressed is essential for solving them and for preventing unintended harms. There is no intention of categorically rejecting initiatives that employ patient-reported measures, and rather, the intention has been to encourage critical thought on these topics as it is essential to the success of patient-centered initiatives in a complex and unpredictable world.