Just Ask Just Tell

Better sharing between you and your doctor and health professionals

Patient and Family-Focused Care

Communication
Background Information
Primary Care

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Related document: Patient and Family-Focused Care: Promoting Communication *Tools* "How to Use the Tools *Kit*"

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Backgrounder Information

Patient and Family-Focused Care

*Patients are "at the centre of collaborative care since they are the very reason behind the interdependency of the professionals." (*D'Amour and Oandasan , 2004)

Older adult patients in primary care often have health care or social care needs beyond their immediate problem. These secondary needs are not often discussed and are thus left unmet, with an equal amount owing to the behaviour of both patient and provider. When older people seek help they may not be aware, or may not inform the health professional of unmet needs and conversely, the provider does not often inquire about other health or social needs beyond the immediate problem (Smith and Orrell, 2007).

The patient's perspective on illness revolves around the patient's concerns, which includes having clear explanations about the cause of the illness and sets expectations for the provider-patient encounter. It differs from the physician's disease- and diagnosis- centred perspective in that it arises from a context based on personal, family, and cultural beliefs of which the healthcare provider is typically unaware (Lang et al, 2002).

The patient's perspective on illness can be elicited by non-directive facilitating techniques – open questions that encourage patients to share more of their concerns, and also by actively exploring cues communicated by the patient that imply the patient's concerns. However open questioning and active listening to elicit and to explore these cues are often undeveloped clinical skills (Simpson et al, 1991)

Most common unmet need is information (Iliffe et al, 2004; Smith and Orrell, 2007).

The quality of clinical communication, the ability to uncover unmet needs, and the skill to solicit the patient's perspective on illness all contribute to a patient-centred approach and to positive health outcomes like patient satisfaction, lowered anxiety, better adherence with therapy, and improved health measures and general functioning.

Older People's Preferences in Styles of Health Care Communication

Research efforts have identified a number of health provider characteristics that increase patient satisfaction and are likely to improve communication with older people (summarized in Greene et al, 1994):

1) Showing warmth, friendliness, courtesy, and a supportive, reassuring interpersonal style
2) Ensuring that there is adequate information-giving
3) Communicating with a style that does not demonstrate uncertainty
4) Facilitating a patient-centred interview that is not dominated by the health provider
5) Giving patients the opportunity to participate in decision-making and negotiation
6) Ensuring patients' needs are addressed
7) Including discussion of psychosocial issues
8) Making efforts to release tension (e.g. laughter)

Multiple Co-morbidities in Older Adults Makes Clinical Decision-making Highly Complex

Health care decision making in frail older adults is highly complex. While evidence-based best practice guidelines provide a framework to optimize outcomes in patients with individual conditions, "best practice" is not as clear in the patient with multiple conditions and these guidelines may not be as useful in these scenarios (Tinetti et al, 2004). The frail older adult brings multiple medical, functional, and social problems to the health care encounter, and it is seldom a simple path to find an appropriate balance in managing these problems in order to maximize desired outcomes, whilst accommodating differing patient perspectives and beliefs.

Clinical complexity can affect the interpretation of benefits and risks when considering best practice evidence from clinical trials. For instance, an 81 year old woman with no comorbidities has a life expectancy of 13.8 years after being diagnosed with stage 1 colon cancer, while an 81 year old woman with three comorbidities has a life expectancy of 4.9 years (Gross et al, 2006). As another example, the benefit-to-harm ratio of warfarin vs aspirin therapy to prevent stroke in non-valvular atrial fibrillation patients may actually reverse depending on the comorbidities which are present (Fraenkel and Friend, 2010). Individualized decision making is necessary to address different sets of priorities where the benefit of therapeutic interventions may be valued differently when compared to functional and lifestyle compromises.

Continued .....Multiple Co-morbidities in Older Adults Makes Clinical Decision-making Highly Complex

Collaboration between care providers and patients has been shown to have positive outcomes in many different ways. Involvement in health decision-making increases patients' responsibility towards their own care, decreases distress about their illness, increases satisfaction with their medical experience, improves their health measures and functional status, and encourages higher commitment and treatment adherence to plans that are jointly decided (Martin et al, 2001). Moreover, the recognition of patient autonomy and their rights to be informed about and involved in their medical care needs to be respected (Kassirer, 1994).

A number of studies have investigated older patients' preferences during health encounters with physicians and the patients' desire to be involved in their own care. A common finding in these studies is that older people wish to be well informed about their health and about treatment options. However, the desire to be involved in treatment decision-making differs widely. Several studies have shown that, while some patients wish to use information and actively take part in treatment decisions, the majority of them prefer to delegate decision-making authority to their physician (Bastiaens et al, 2007; Levinson et al, 2005; Robinson and Thomson, 2001).

Some barriers to patient participation may be type of illness and comorbidity, level of health and/or general literacy, cultural values, socioeconomic level, and the stakes of the proposed health outcome/medical decision (reviewed by Longtin et al, 2010). While some patients may not wish to participate in health decisions, it is also highly likely that others simply do not know how (Cegala, 2003).

Interventions to Help Involve Older Adults in Primary Care Encounters

While most recommendations in the literature tend to advocate patient involvement in health decision making, there isn't full agreement on the degree of autonomy that is best. While research does suggest that patients want to exchange information with their healthcare professional, there is less agreement amongst patients over their preferred degree of participation in treatment options and clinical decision-making (Benbassat, Pilpel, and Tidhar, 1998). Some efforts to increase patient participation in decision making have been met with improved physical functioning and treatment adherence, while other studies have shown increased anxiety, decreased satisfaction with care providers, and other negative psychological outcomes (reviewed in Flynn and Smith, 2007). Other studies in primary care involving a pre-visit booklet and a pre-visit session were shown to bring about more questioning behaviour

during the medical visit, more self-reported active behaviour, and more satisfaction with interpersonal aspects of care, although health related outcomes were not measured (reviewed by Wetzels et al, 2008).

A recent intervention looked at the impact of a patient-centred education process to improve seniors' attitudes and behaviours in primary care safety self-advocacy (Elder et al, 2008). A two-part intervention (both group and individual) was offered that provided education on how to identify and prevent common errors in primary care, and on how to communicate with health care providers. All demographic groups in the study with a high school education or less, demonstrated significant improvement in their beliefs and self-reported safety behaviours.

In other work, the use of a shared decision-making tool was shown to encourage older patients to express preferences regarding their care (Naik et al, 2005), suggesting that a simple written communication tool might facilitate discussion and agreement on treatment goals and plans between patient and provider. In addition, a survey of older persons with multiple competing morbidities revealed that they had a tendency to discuss and prioritize global cross-disease outcomes such as physical functioning rather than disease-specific measures in their health care decision-making (Fried et al, 2008). These studies suggest that communication tools may help solicit patient preferences, and that prompting older patients to prioritize functional outcomes when considering multiple competing disease priorities may help define mutual treatment preferences.

Collectively, these results all support the notion that older patients can be encouraged and supported to participate in health care decision making. Good communication and willing information sharing remains a stable foundation to the success of these processes.

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Six Interactive Components to the Patient-Centred Clinical Method

1) Exploring both the disease and the illness experience
   - assessment of disease (e.g. history, physical, labs)
   - dimensions of illness (e.g. feelings, fears, ideas about what is wrong, effects on function, expectations of health care provider/team)
2) Understanding the whole person
   - the person (e.g. life history, personal and developmental issues, behaviours and responses to illness and care, spirituality)
   - the proximal context (e.g. family history and family dynamics, employment, social support)
   - the distal context (e.g. culture, community)
3) Finding common ground
   - problems and priorities
   - goals of treatment/management
   - roles of patient and health care provider
4) Incorporating prevention and health promotion
   - health enhancement
   - risk avoidance
   - risk reduction
   - early identification
   - complication reduction
5) Enhancing the patient-provider relationship
   - caring and compassion
   - balance of power
   - awareness of self and each other
6) Being realistic
   - time and timing
   - team building and teamwork

(Brown, 2004)

Benefits to a Patient-Centred Approach

1) Increases patient satisfaction
2) Improves patient adherence with therapy (Starfield et al, 1981)
3) Improves patient outcomes (Stewart et al, 2000)
   - improved measures in blood pressure and blood sugar
   - emotional health
   - general functioning
4) Positive impact on health care utilization costs
5) Greater health provider satisfaction
6) Lowered malpractice claims

(Brown, 2004)

Lessons Learned from Interventions to Improve Medication Adherence in Older Adults

Therapy using medications is the most common healthcare intervention. Adherence to this therapy, particularly among older adults where it has been estimated to be between 26% and 60% (Morrow et al, 1988; van Eijken et al, 2003), is a complex issue involving many variables. Non-adherence to medication programs is also associated with unfavourable health outcomes, and perhaps up to 10% of hospital admissions and 23% of nursing home admissions (Peterson et al, 2003; Gurwitz et al, 2003). Factors which contribute to poor medication adherence include (reviewed in Banning, 2009):

1) poor or lack of access to medicines
2) complex medication regimens due to multiple conditions
3) inappropriate titration of treatment doses
4) avoidance due to risk of adverse drug effects
5) dexterity problems
6) undiagnosed cognitive or substance abuse problems
7) uncertainty with physician instructions
8) poor communication with prescriber and patient
9) poor relationship with health care providers
10) inadequate follow up processes
11) patients' perspective on illness and/or health beliefs
12) lack of social support

Interventions to improve adherence to medications have been reviewed and include (Banning, 2009; Lakey et al, 2009):

1) Medication Support Devices – drug compliance aids, blister packaging, drug calendars, reminder charts, pill boxes and easy-open containers
2) Educational Interventions – individual or group teaching sessions and discussions, written instructions, medication cards and charts
3) Health Care Professional Involvement – medication reviews, patient consultations, drug check ups

Continued.....Lessons Learned from Interventions to Improve Medication Adherence in Older Adults

Numerous studies have shown varying degrees of success with these interventions (reviewed by Banning, 2009). However, many of the reviewed studies which demonstrate success have a common element. At the core of this, is the ability of the clinician to communicate with the patient in a manner that encourages partnership (Pound et al, 2005). This helps to foster trust and encourages the patient to share their health beliefs and their concerns over the role of medicines in their health as well as the relative dangers (Phatak and Thomas, 2006). A good clinician-patient alliance can also help to establish mutual priorities over the health benefits of a medication program and lead to reducing the complexity and quantity of medications administered – this in itself has been shown to increase adherence rates (Schroeder et al, 2004). When the patient's abilities, educational needs, and personal needs have been considered, providing education combined with written instructions has demonstrated a significant impact on medication adherence (Esposito, 1995; Elliot, 2003). Likewise, medication support devices such as blister packaging have been shown to be useful only when combined with interventions that address patients' perceptual and practical barriers such as their cognitive capacity (Higgins and Regan, 2004; Horne et al, 2005). The provider-patient relationship is undoubtedly a key element in the safe use of medications.

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