ARTICLE

Patient-centered care: what consumer health organisations say and do

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Abstract

Concepts such as patient-centered care and shared decision-making are increasingly prominent topics in discourse on quality in healthcare with the growing prevalence of chronic disease. Although patient-centered care has been touted as a way forward, it remains an ambiguous concept with variable application in healthcare. Greater clarity is needed around the concept of patient-centered care alongside a stronger knowledge base on the perspectives of patients with complex needs and service providers, including those outside the formal healthcare system, such as consumer health organizations (CHO). This study explored CHO patient-centered policy, related practice and organizational views on the potential value of pharmacy delivered patient-centered care. In-depth interviews were conducted with 15 organizational representatives until no new themes emerged. Data were concurrently thematically analyzed by 3 researchers from a public health or pharmacy background. Participants called for a paradigm shift away from the paternalistic biomedical model to shared power that values patient choice and promotes active engagement in health. There was disparity between articulation of policy and practice, with CHOs often more patient-centered than they claimed to be. Participants described a wealth of innovative and often patient-centered services and ascribed under-utilization of these resources to limited awareness. Selected CHOs adopted strategies that health professionals can learn from, such as combining multiple elements of patient-centered care and seeking to build patient capacity to self-manage. Health professional education, current infrastructure and remuneration were cited as barriers to more widespread delivery of patient-centered care. However, participants suggested creative solutions to address selected factors, some specific to pharmacy. Both pharmacy and CHOs are under-utilized healthcare resources and there is potential for synergy between these sectors to promote patient-centered care. Pharmacy could benefit from insight into the CHO perspective of patient-centered care and also increase utilization of CHO services through direct referral.

Keywords

Chronic illness, community pharmacy, consumer health organizations, healthcare service, individual patients, patient-centered care, self-management

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Introduction

Concepts like patient-centered care, autonomy, empowerment and shared decision-making are being touted as an ‘ethical imperative’ and are formalized in international documents such as the ‘Salzburg Statement on Shared Decision Making’ [1-6]. Understanding and applying these concepts in the delivery of healthcare and context of evidence-based medicine is increasingly important [6] given the growing prevalence and related burden of long term medical conditions (chronic disease), the ageing population in Australia and worldwide and
rising numbers of people with multiple co-morbidities [7-10]. Despite significant advances in healthcare, the burden or ‘work’ of managing multiple chronic conditions has disproportionately shifted to the health consumer, leading to psychological distress and negative impacts such as absenteeism and financial burden for individuals and families [3,11-14]. The ‘work’ of managing chronic conditions can include health system navigation as a patient; co-ordinating healthcare across multiple providers; negotiating relationships with health providers; adhering to complicated treatment regimens and learning to monitor disease progression, treatment effectiveness or both [15]. This level of complexity has resulted in significant treatment burden with respect to medications, time, travel, financial and healthcare access burden [12].

Continued emphasis on disease specific treatment guidelines contributes to this complexity and prioritizes the chronic condition(s) over the person. A ‘minimally disruptive’ approach to medicine has been recommended which prioritizes the patient perspective, accommodates their daily life and beliefs, considers related treatment burden and explicitly addresses the complexity of multiple co-morbidities [3]. However, not all health professionals are able to recognize when people become overwhelmed by treatment burden [3], acknowledge or build on patient capacity to self-manage chronic condition(s) [16], or effectively involve patients in their own care [1]. Consumer health organizations have attempted to address these gaps in the formal healthcare system through more patient-centered services that empower patients and promote self-management [17]. Examples include programs or member support services that inform, provide psychological support and develop patient and carer capacity to self-manage [17-19]. The World Health Organization recognized the potential of CHO to provide support, promote capacity building and encourage effective partnerships between patients, communities and healthcare providers in a policy framework document for people-centered healthcare [20]. The value of self-management programs has been recognized through allocation of significant financial resource in Australia [21]. However, there have been calls that effective use of such resource relies on minimizing barriers to uptake experienced in other countries, such as limited patient awareness and lack of health professional engagement [21]. Although CHO operate in parallel to formal healthcare services and can improve the patient experience of illness, utilization of CHOs by Australian patients and health professionals can be variable [18,19].

Even though there is a global drive towards patient-centered care and shared decision-making [1,5], substantial ambiguity is associated with these concepts [22-25]. Greater clarity is needed on how patient-centered care is conceptualized in the health system [3], alongside a stronger knowledge base on the perspectives of health consumers with multiple chronic conditions and service providers, including those that operate outside or in parallel to traditional healthcare services, such as CHO. Researchers have used a range of frameworks to conceptualize patient-centered care [22,24-28]. In a recent concept analysis, Morgan and Yoder described 4 key domains of a higher-order model of person-centered care: holistic, individualized, respectful and empowering care [26]. Holistic care has been defined as an approach to care that recognises, understands and values the entire person beyond a singular dimension like a chronic disease or medication use and responds to their needs in this context. Respectful care identifies people as active health consumers competent to make decisions about their own care, supports their strengths and abilities and recognises their right to choose healthcare aligned to their preferences and beliefs [26]. Empowering care has been defined as care that “encourages autonomy, self-confidence and self-determination, facilitates a person’s participation in decision-making through effective communication and negotiation” [25]. Empowering care featured prominently in a systematic review exploring the benefits of patient-centered care and was linked to patient satisfaction and perceived quality of care [25]. However, risk of bias limits the conclusions that can be drawn from a number of the studies reviewed. Patient-centered care has also more traditionally been viewed from the health professional perspective [22] and greater clarity is needed from patients, carers and parallel service providers such as CHOs.

The aim of this study was to explore the insights of CHO representatives from 3 perspectives: the treatment burden encountered by the patients or carers who access their services, the organization’s views of patient-centered care and on the potential for community pharmacy to further support patient members in managing their chronic conditions. Exploration of the CHO perspective on patient-centered care sought to understand how it was articulated as policy and integrated with CHO programs or services. This paper reports CHO perspectives on patient-centered care and related implications for community pharmacy. Specific questions pertaining to treatment burden and community pharmacy have been addressed elsewhere [29,30].

**Methods**

Fifteen semi-structured, in-depth interviews were conducted with senior representatives from 12 Australian CHOs between January and March 2012. Interviews explored the organisational policy and perspective of the CHO on patient-centered care, particularly as it related to the consumers or carers they represent. In-depth interviews were considered the most appropriate method due to the exploratory nature of the study [31]. They provide a safe environment for participants to provide detailed perspectives that may not be forthcoming using alternative data collection methods such as focus groups [32]. The sampling framework was guided by national health priorities (e.g., asthma, cardiovascular disease, arthritis) [33] and developed in consultation with the project Advisory Board; CHO representatives and practitioners from medicine, nursing and pharmacy. Participants were purposively sampled to reflect diversity across the CHOs. Additional participants were identified during the course of the interviews via the snowballing technique as a means of...
recruiting people less likely to be identified by formal recruitment methods [34,35]. To limit bias towards either policy development or service implementation, at least 2 participants with contrasting roles within the CHO were interviewed from 5 of the organisations. For example, a CHO board member and a program director or personnel that delivered relevant support services.

**Table 1 Interview framework for questions relating to patient-centered care**

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you please briefly outline your current position in [CHO name] and what this involves?</td>
<td>Help participant understand their role.</td>
</tr>
<tr>
<td>Do you interact directly with “your members”? If so, please elaborate on this.</td>
<td>Explain direct interactions with members.</td>
</tr>
<tr>
<td>Could you describe the range/different types of members or membership categories that [CHO name] represents?</td>
<td>Provide a diverse range of perspectives.</td>
</tr>
<tr>
<td>Could you describe the different types of services that are provided to each of the member categories to support them in managing their chronic illness(es)?</td>
<td>Describe services delivered.</td>
</tr>
<tr>
<td>What is [CHO name]’s mission statement or chief organizational aim and what are the types of things it is doing or planning to do to achieve this?</td>
<td>Align mission with service provision.</td>
</tr>
<tr>
<td>Does [CHO name] actively involve its members in the planning and implementation of policies and activities being undertaken to achieve its mission?</td>
<td>Show active involvement of members.</td>
</tr>
<tr>
<td>Could you please tell me what [CHO name]’s perspective is on patient-centered care?</td>
<td>Understand perspective on patient-centered care.</td>
</tr>
<tr>
<td>Can you tell me about a typical consumer member, their chronic illness(es), early diagnosis and disease progression and other typical co-morbidities?</td>
<td>Provide specific member details.</td>
</tr>
</tbody>
</table>

*The interview framework is a guide and questions were adapted according to each participant’s organisation and position or background.

Upon verbal agreement to participate, the study information sheet and interview guide were e-mailed to each participant and informed consent was obtained. Interviews were conducted by experienced researchers (AS, SM), either face-to-face or via the telephone. The first 10 interviews were conducted by both researchers together to limit interviewer bias. Participants were asked to speak on behalf of the CHO that they were representing, rather than provide individual views when responding to questions. That is, they were asked to articulate the CHO’s policy on or philosophy of patient-centered care and describe related services or programs. An interview guide was developed, piloted with a senior member of a CHO and refined prior to the commencement of the interviews (Table 1). Fortnightly analysis discussions amongst the research team throughout data collection facilitated further refinement of the interview guide to accommodate relevant themes as they emerged. The average interview duration was 64 minutes. Seven interviews were conducted face-to-face and the remaining via telephone. Initially, participants were asked to describe the typical members of their organization, the services provided and organizational perspectives about patient-centered care. Interviews were conducted until no new ideas were heard according to the interview guide [36]. All interviews were recorded and transcribed *verbatim* and any identifying information was removed. The transcripts were returned to selected participants on request to ensure that they represented a valid reflection of the participant views [37]. The study received ethical approval from the University Human Research Ethics Committee (Ref: PHM/12/11/HREC).

**Data analysis**

Thematic analysis was used to review the in-depth interviews. Thematic analysis is a commonly adopted approach to analysing qualitative data in healthcare research, particularly when it is exploratory in nature [38]. To prepare the data for thematic analysis, written summaries were disseminated to the research team for their review following each interview. Two researchers with a pharmacy background and one public health researcher read and re-read the transcripts to familiarise themselves with the data. These researchers then used the electronic qualitative data analysis package QSR NVIVO 9 to code the data into themes and sub-themes. The key elements of patient-centered care proposed in Morgan and Yoder’s recent concept analysis were used as a framework for data analysis [26]. One researcher (FK) took responsibility for coding and describing specific theme(s) across the patient-centered care related data according to this framework. Ongoing discussions amongst the 3 researchers during the analysis allowed for reflection, revealing nuances in the data which may have otherwise been missed. These also provided opportunities to develop and refine coding frameworks, limit researcher bias and ensure that findings were authentic and credible [37].

**Results**

Fifteen interviews were conducted with people representing 12 CHOs, 4 participants were male with the remaining female. Nine of the 12 organisations operated at a state level (i.e., Queensland, Australia) and the others at a national level. Although the importance of patient-centered care was acknowledged, existing conceptual ambiguity was also reinforced. Although ambiguity was reflected in the patient-centered care spectrum described, there was consensus on the need to move beyond the one-dimensional biomedical model and redress long-established power imbalances between health professionals and patients. Three concepts commonly mentioned were: (i) patients being at the centre of or in control of their care, (ii) shared decision-making or patients engaged as partners in care and (iii) individualized care tailored to meet the specific needs of patients. Terminology used by CHO representatives included patient engagement, control, responsibility, power, patient voice, shared decision-making and patient choice. These terms reflect a perceived need for active consumer engagement as part of the healthcare team.
Participant descriptions of patient-centered care contrasted between a broad conceptual approach and articulation of specific domains of patient-centered care or practical examples of application. However, the description of what CHOs considered patient-centered care to be was sometimes superficial when compared to narratives of the patient-centered services or programs delivered by that organisation. This may reflect ambiguity in the literature, emphasis on program delivery over policy articulation, or a more informal approach to patient-centered care. Alternatively, patient-centered care may be so integrated into the CHO philosophy or practice that it has become habitual and therefore more difficult for people to describe the individual processes. When the framework proposed by Morgan and Yoder [26] was applied to the data, it became apparent that different CHOs utilized the key elements of patient-centered care to varying degrees. Greater detail is provided below describing the status quo across these CHOs in the context of this framework, identifying potential opportunities for community pharmacy and highlighting areas for further exploration.

**Elements of patient-centered care**

Only a minority of participants described policy that encapsulated all 4 elements of patient-centered care. Those that did were from CHOs that emphasised the importance of developing consumer resilience and capacity to self-manage:

“We encapsulate that [patient-centered care]… by what we call a resilience statement. I’ll read the statement out and this is primary - everything that we do. To uphold and maintain a resilience-based approach by acknowledging the right and capacity of each individual to make choices, decisions and to take responsibility for their lives, actions and direction. To effectively work within a partnership model to maintain the individual resilience within each person. So that’s how we would encapsulate a client-centered approach.”

Individualized care, followed by holistic care, were the domains most frequently mentioned by participants. Although there was an emphasis on shared decision-making, underpinning concepts conceivably critical to this such as empowering care, were at times absent in participant accounts. However, the limited description of patient-centered care in CHO policy was juxtaposed with CHO programs, which were clearly aligned to varying degrees with one or more elements of patient-centered care. For example, empowering care varied from more passive consumer education to active development of self-management skills. Figure 1 provides an overview of the key findings for each element of patient-centered care.

**Individualized care**

Individualized care was the attribute most frequently discussed when participants were asked what their organization considered patient-centered care to be.

Participants acknowledged the importance of not applying a ‘one size fits all’ approach for particular chronic diseases and CHOs appeared to utilize an array of strategies to both identify and address individual needs of consumers and carers:

“It’s not just about learning to get on the bus again, but it’s about living a life that’s going to be meaningful for them and purposeful. Obviously, that’s unique to every individual.”

These strategies, aligned with descriptions of individualized care in the literature [25], entailed exploring the patient journey, considering unique patient health concerns, personality or preference and delivery of customised interventions. Individualized care was viewed as integral to capacity building and respectful care, particularly in those organisations where all 4 domains of patient-centered care were encapsulated in service delivery:

“Patient-centered care is saying to the consumer, or the patient, what are your needs, tell us about your journey so far with your condition, what’s been good, what’s been bad, you know...how could we fix it...so that’s how we’re working on patient-centered care and that’s what we’re trying to promote in other health professionals.”

Organisations used innovative and multi-layered services to accommodate factors such as geographical isolation, competing commitments, severity of, or changes in health condition and continuing access to the social benefits of services once health had improved. Partnerships emerged as an important sub-theme of individualized care. Examples included partnerships with individuals through service delivery, involving consumers in resource development or service delivery, active engagement with community leaders and relevant cross-referral to other services through inter-organisational collaboration:

“Her continuing to come to the social group here with people that she knows, still at that regular Friday time it’s been really supportive for her. So I think making some of those exceptions within your services for the good of the client and for their therapeutic needs and their goals is what person centered care is about.”

“Our resources are developed in consultation with them [clients]. Also, in the way we deliver, that our workers mostly work after hours and on weekends because, again, with new arrivals, the priority is to take care of themselves and their families.”

**Holistic care**

Organisational representatives described holistic care from 2 perspectives: care for health consumers and health system infrastructure. A central theme was the need to move away from a singular dimension or episode of ‘problem solving’ care to consider the whole person in a ‘cycle’ of ongoing care:
“That’s where patient-centered care is falling down... People are still just getting episodes of care, they’re going to their GP, their GP is just saying, oh what’s your problem? Addressing the problem and then they go away again, rather than a planned and coordinated cycle of care that somebody with diabetes needs on an annual basis.”

That meant transitioning from the ‘body-centric’ approach that labels patients (e.g., an asthmatic or diabetic), prioritizes a single aspect of medical care and limits focus to specific therapeutic measures of success, to conferring equal priority to patients’ state of wellbeing or psychosocial health:

“It becomes a very body part-centric approach and the reality is most people have co-morbidities and they also are a person first and then they have a condition. They don’t want that condition to define them as such.”

“They [health consumers] really want the health professional, and this would equally apply to community pharmacy, to not just, say, focus on their biomedical measure like their blood glucose level, but how are they going and how are they coping and what are the issues for them and what are their needs?”

When CHOs actively embraced the philosophy of holistic care, every contact with members was viewed as an opportunity to consider the social context beyond the issue at hand. There was emphasis on building the service around the patient and their needs by considering factors such as location, age and cultural beliefs. Many participants recognised a need to collaborate with other providers when patient requirements were beyond the remit of their organisation. This reflects more proactive processes than the traditional reactive, problem solving approach to health:

“We also try to ascertain what else we might be able to help this person with, so again….it’s taking that holistic approach….that a person might well phone in about one particular thing … when you are talking to that person … it opens up a whole series of other things that we can actually help them with.”

Although participants in this study espoused the importance of considering the person beyond the health condition, they described examples of a more narrow approach by health professionals and attributed this to particular health conditions and particular social factors such as age:
“… I think that if you’ve got a diagnosed mental illness… quite often your physical health is neglected - I think that’s by health professionals as well. I think quite often their physical ailments or symptoms are overlooked and it’s written off as being psychological… it’s also true in reverse. I think that people who are frail aged, aren’t necessarily treated for their psychological ailments. I think that they’re just quite often written off as just being old. I think that there is a great need for a more holistic approach regardless of age or disability.”

Holistic care features less frequently in the literature than other domains and the complexity of engaging in a person’s social context has been assessed as a factor [25]. Participants acknowledged that transitioning to holistic care relied on health professionals acquiring skills such as motivational interviewing. Currently, vocational health education incorporates selected aspects of communication skills and health beliefs to encourage a more patient focused approach. However, these can be delivered as stand-alone modules and the continued dominance of evidence-based medicine may mean that they are not considered to be as relevant as therapeutic topics. Integrating motivational interviewing with therapeutic content could improve perceived relevance, provide important context on the value of using evidence in shared decision-making [6] and promote skill development. More recent recognition of the significance of peoples’ cultural beliefs in health professional competency standards and education may translate to a more holistic approach by new graduates [39-41]. However, this does not consider other factors integral to a holistic approach such as age and co-morbidities, or how to promote behaviour change across the entire health sector. Participants felt that health system infrastructure limits holistic care through remuneration models driven by fee-for-service (e.g., fee for appointment or volume of medicines dispensed), generic government initiatives, lack of co-ordinated care and health professionals working in isolation. Greater insight is needed into the need for change in individual practitioner views, tertiary curricula and health system infrastructure.

Respectful care

Participants recognised that respectful care also required going beyond a ‘one size fits all’ philosophy, associating it with both the right to choose and the importance of promoting capacity to make informed decisions. Although some participants merely acknowledged that people should have the right to choose, others emphasised the importance of taking time to understand these decisions and ensure that they are informed. Tension emerged when selected health professionals working for CHOs appeared resistant to patients questioning their clinical recommendations, describing it as challenging to accommodate choices not aligned with evidence-based treatment guidelines. Such tension may reflect reluctance amongst health professionals to transfer power in healthcare to patients, identify deficits in health professional education, or signal patient misperceptions of clinical evidence. For example:

“Obviously, you tailor your care as a professional person to each individual patient with respect to his or her wishes.”

“As practitioners, we want all of our patients to be compliant because we perceive ourselves to be the experts and we know what’s best, as opposed to actually saying, the person with the illness that - the patient, the client actually has a right to live a life.”

Managing patient and carer capacity to decide was described along a spectrum from recognising those disinclined to control decisions about healthcare, to targeted development of patient capacity to self-manage. This included recognition of the need to avoid assumptions and the potential for positive relationships to facilitate conversations exploring individual preferences:

“We actually are getting feedback that some people just like to be told what to do and then they don't have to take responsibility and they don't have to think about it.”

“I think personally that patient-centered care has to be a choice thing though and I feel that's a really important issue….. I don't think it's on to impose patient-centered care across the whole spectrum.”

The findings of Schembri and Sandberg reflect a similar spectrum categorised as 3 types of patients: those who wanted direction from their doctor (passive), those who wanted to be in control (monitoring) and those who were inclined to control decisions about healthcare, to targeted development of patient capacity to self-manage. This included recognition of the need to avoid assumptions and the potential for positive relationships to facilitate conversations exploring individual preferences:

“… I think that if you’ve got a diagnosed mental illness... quite often your physical health is neglected - I think that’s by health professionals as well. I think quite often their physical ailments or symptoms are overlooked and it’s written off as being psychological... it’s also true in reverse. I think that people who are frail aged, aren’t necessarily treated for their psychological ailments. I think that they’re just quite often written off as just being old. I think that there is a great need for a more holistic approach regardless of age or disability.”

Empowering care

Empowering care is the element of patient-centered care that has been associated with tangible benefits in a systematic review of randomised controlled trials [26]. It has been defined along a spectrum from increasing health patients’ desire for or building on their knowledge about chronic illness, through to strategies that build patient capacity to engage more as partners in their care. Empowering care featured less commonly in participants’ description of organisational policy, yet was clearly apparent in descriptions of selected CHO services. Accounts of empowering care indicated that participants valued building patient capacity to actively engage with their healthcare more than passive provision of health related information. The goal of this approach was for patients to become more self-reliant and have diminishing need for CHO services as their capacity to self-manage increased. Building confidence, knowledge and skills were all viewed as integral to increasing patient capacity to self-manage:

“A person can't become a patient at the centre of their care unless they have adequate knowledge and adequate skills so the self-management programs are designed to give them knowledge and skills.”
“We should in the long run do ourselves out of a job. We’re not there to create dependence. We’re there to get people to be functioning to their optimum performance…independent of us.”

Although there was clear acceptance that enabling self-management is positive, current power imbalances in the health system may restrict this, ultimately detracting from patient empowerment. For example, time-restricted, problem-focused appointments with general practitioners who ‘prescribe medication not information, not education.’ There was appreciation of the potential for more empowering care delivered via community pharmacy given that it is considered a less threatening environment and is a frequent point of contact for patients. This finding aligns with research exploring key themes of patient-centered professionalism amongst pharmacy, patient and other health stakeholders [43]. However, in the CHO study it was tempered by a perception that pharmacists are generally too busy to provide patient-centered care and that significant change management was required to realize the opportunity:

“My view has always been the pharmacists have never made the most of that. If you want to deliver patient focused care, how on earth can it be done with the chemist sitting out the back doing scripts.”

The traditional task focused dispensing role of community pharmacy could limit introduction of patient-centered care, particularly whilst it remains the mainstay of remuneration for pharmacy services. The introduction of pharmacy-based professional services that consider the person beyond the prescription could represent initial steps towards pharmacy becoming a more patient-centered health destination [29]. Even so, if a patient-centered approach was adopted by all pharmacy staff it could nurture relationships with patients and carers and reinforce the notion of pharmacy as a ‘safe’ health space.

Interviews revealed the existence of innovative initiatives and commendable role models for delivering empowered care amongst CHOs. Principles to guide delivery of such care were evident in participant anecdotes and included establishing and building on realistic goals, relating strategies to consumer priorities and encouraging reflection on how strategies have worked. Strategies employed ranged from limited consultation with patients, through to more interactive strategies such as patients and health professionals discussing care plans together and patients writing their own case notes:

“We want people to set a realistic goal, achieve it, build on success and move on to another one.”

“We might have a carer that rings up and says I’m really exhausted and I can’t cope et cetera. We have an option right then, we can say I know what you need - you need a night off and we’ll put somebody in there. We can turn around to that person and say, what has worked for you in the past? So one approach looks at a Band-Aid but the other approach looks at building resilience that will help in the long-term.”

Although the notion of empowering care is proclaimed as beneficial, the evidence supporting this is not comprehensive and it lacks insight into who it actually benefits; patients or health professionals [25]? Existing evidence suggests that it can encourage health professionals to ask questions and improve patient perceptions of service quality. However, it is important to note that positive health outcomes are more likely to be associated with strategies that facilitate active patient and carer engagement through improved confidence [25]. Greater insight into patients’ actual experiences of empowering care is needed to explore the concept further and inform development of relevant healthcare models.

Discussion

It became clear that CHOs deliver a plethora of patient-centered services or programs and participants described variable service utilization with missed opportunities for patients and carers. They attributed this to lack of patient awareness or limited referral from health professionals. Articulation of the value of these programs and services needs to improve alongside increased referral by health professionals. There is opportunity to address this via health professionals frequently visited by patients, including general practitioners and community pharmacists. For community pharmacists this reflects an opportunity to become part of the cycle of care by assessing peoples’ needs, providing medicines management advice and acting as a referral agent to relevant CHO services [29] similar to services incorporated into pharmacy contracts in the United Kingdom [44,45]. Although participants saw value in both pharmacist referral to CHO and pharmacist delivered patient-centered care, they proposed a number of barriers, including, limited pharmacist accessibility when dispensing, the retail oriented image of pharmacy and limited relationships between patients, carers and pharmacists. The ‘traditional’ pharmacist was viewed as a reactive, problem solver, rather than a health professional who would take a proactive and holistic approach to a person’s wellbeing. Significant changes in attitudes, behaviour and the pharmacy environment are needed, alongside a major culture change, to dispel the image of pharmacists as ‘shopkeepers’.

This study explored patient-centered care from a service-provider perspective, providing first-hand insight into the perceptions of key stakeholders from CHOs. Sampling was guided by national health priorities and unique perspectives of CHOs representing other chronic illness may not be reflected, both representing potential limitation. Purposive sampling was deemed the most appropriate method of ensuring that diverse perspectives amongst stakeholders were included across these priority areas [33]. The research relied on cross-sectional data to explore stakeholder perspectives which provides important insight, but does not account for changes in healthcare policy over time. Although self-reported data (in-depth}
Interviews (455) can introduce social desirability responses and interviewer bias, it was deemed the most appropriate method for this exploratory study. Interviewer bias was minimized through the use of a standardized interview framework and the 2 interviewers conducted the initial 10 of 15 interviews together for this purpose also. Although involvement of researchers from both pharmacy and public health backgrounds strengthened the study, it does not account for the interpretative view-points of other health-related disciplines, people who work for CHOs or analysis through the lens of a patient with a chronic health condition.

Conclusion

These findings provide important insights into the status quo of how CHOs view and deliver patient-centered care and underscore the importance of a healthcare model where patients feel that they are valued and respected. A collaborative, multidisciplinary healthcare environment is needed which will ensure that patients feel supported in managing their chronic health condition(s), thus helping to alleviate potential treatment burden.

The wide range of innovative patient-centered services available to the Australian public is reportedly underutilized by patients and referral from health professionals appears limited. Pharmacy is also underutilized as a healthcare resource and both sectors have a common goal to increase access to relevant support for consumers with chronic health condition(s). There is opportunity for a synergistic relationship between the community pharmacy and CHO sectors. Pharmacy could gain valuable insights from CHO perspectives on patient-centered care and cross referral between these sectors could increase patient access to relevant services.

Acknowledgements and Conflicts of Interest

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