The Collaborative Patient/Person-Centric Care Model

Introducing a new paradigm in patient care involving an evidence-informed approach

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The term “patient-centred care” or “collaborative care” is being increasingly used in healthcare professional literature. Perceptions of this term, and its feasibility, may differ greatly across regulated healthcare professions and also among individual professionals, patients and family members. It is also uncertain whether a model exists that encompasses an optimal approach to patient-centred care. To address these issues, this article examines the traditional models of patient care and explores the concept of patient-centred care through the eyes of various members of the healthcare team. In addition, a new model of patient-centred care is presented, based on collaborative discussions among healthcare team members.

Traditional patient care models

Biomedical model

Patient care has traditionally been guided by the conventional paradigm known as the medical or *biomedical* model, whose roots can be traced back to the era of reductionism and mind-body

dualism, which separates the mental from the somatic.[1] In this model, *disease* is defined as a biophysical malfunction.[1] In the biomedical model, the goal of treatment is to correct the malfunction in order to cure the disease.[1] As such, this traditional medical model places the pathophysiology of the disease, objective tests and therapeutic interventions at the centre of patient care.[2] Such a model offers a one-dimensional approach to patient care that excludes the patient experience of illness and how this might impact other facets of the patient's life (e.g., work disability, finances, social networks), because they are believed to lie outside of medicine's responsibility and authority.[1,2]

Bio-psycho-social model

By incorporating other psychological (e.g., thoughts, emotions, behaviours) and social dimensions of the patient into the care plan, one moves towards the *bio-psycho-social* (BPS) model of patient care.[3] The BPS model was first theorized by a psychiatrist, Dr. George L. Engel, in 1977.[1] In this model, patient care is based on the belief that psychological and social dimensions also contribute significantly to human functioning within the context of disease or illness and, as such, need to be considered when providing care to a patient.[1] Specifically, the biological component examines the cause of the illness and how it affects the functioning of the body.[1] The psychological component of the model explores any potential psychological causes for the illness (e.g., lack of self-control, emotional stressors, negative-thinking).[1] Finally, the social component considers how different social factors (e.g., socioeconomic status, religion, culture) impact illness.[1] In order to address all aspects of this three-dimensional model, an integrated team approach involving allied healthcare professionals, such as physicians, nurses, psychologists, pharmacists, social workers and rehabilitation specialists, are critical for ensuring

that more comprehensive patient care is provided.[3] Overall, the underlying premise of the BPS model is that the body and mind are intricately connected and what affects one will affect the other.[4,5] While this model advances patient care and can address the "dis-ease" that exists within the disease, it still does not encompass the patient as a "whole" or consider all the multitude of facets that make up the individual.

Recovery model

An alternative model to the biomedical and BPS models of care is the *recovery* model. In this model, the patient is involved in a lifelong recovery process that involves a number of incremental steps across various facets of his or her life.[6] The primary illness is seen as only one dimension in the patient's recovery process.[6] Other key aspects of this model include negotiating treatment approaches between patients and practitioners such that the patient feels empowered.[6] Moreover, this model enables patients to regain their dignity and identity beyond the illness.[6] As such, this model takes the BPS model and advances it forward to include other patient dimensions in the provision of care. Thus, the underlying ethos of this model for the patient is one of hope and optimism.[6]

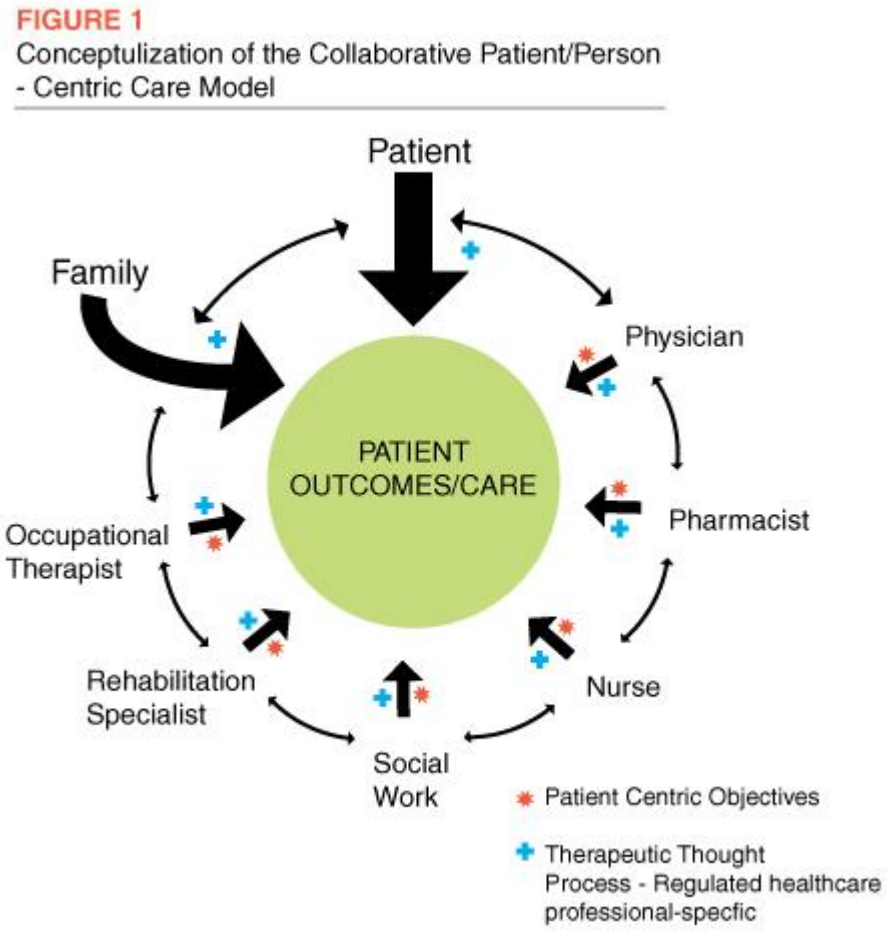
A recent study conducted in 10 European countries aimed to examine the recovery model of patient care in order to identify aspects of care that key stakeholders believed to be most important in promoting recovery, specifically in patients with mental illness.[6] Eleven important domains of care were identified by stakeholders in this study: (1) social policy and human rights, (2) social inclusion, (3) self-management and autonomy, (4) therapeutic interventions, (5) governance, (6) staffing, (7) staff attitudes, (8) institutional environment, (9)

post-discharge care, (10) caregivers, and (11) physical health care.[6] The authors also found that there was generally a high consensus between groups and countries on these 11 identified domains, with only some modest differences in priorities noted.[6] Interestingly, therapeutic interventions, a central piece of the more traditional medical model of care, was rated as the most important aspect of care.[6] The authors suggested that stakeholders may still hold therapeutic interventions as the most important aspect of care because such interventions form the foundation and 'raison d'être' of health care.[6] Thus, it may be difficult for practitioners to step away from convention and embrace a new paradigm of patient care.

Patient-centred care model

Incorporating various aspects of the BPS and recovery models of patient care, a *patient-centred care* (PCC) model has evolved over the past several years to replace the conventional biomedical model of care.[7] The Institute of Medicine (U.S.) has stated that embracing a PCC model will help to close the "quality chasm" often present in the care provided to patients.[8] In a PCC model, the patient's individuality is central.[9] The patient has the right to have his or her needs, desires, beliefs, values and goals respected and placed at the centre of the care plan.[7,9] Such respect of the patient's individuality is part of the team's commitment to understand the patient's perspective of his or her own health status and subsequent care.[9] The underlying ethos of this model of care is that the patient has the right to respect, dignity and care that focuses on the person and situation versus the disease process.[9]

Developing a New Patient Care Model



A two-step process was used in the attempt to develop an optimal model of patient-centred care. First, a cross section of professions within allied health was selected to participate in discussions on patient-centred care. This was followed by a collaborative review session, during which all participants worked together from their individual professional perspectives to incorporate their thoughts and beliefs regarding patient-centred care with those of the other group members. The

end result of these discussions and collaboration was the development of a new model of patient care: the collaborative patient/person-centric care model (CPCCM).

Step 1: Perceptions of Patient-Centred Care

Each member of the working discussion group was tasked with the objective of writing a 500-word review on his/her professional perceptions relating to patient-centred care by answering two questions: "*What does patient-centred care mean?"* and "*How can this be achieved?*" There were no restrictions on content. Only the two lead authors were aware of the individual reviews up to the point of the collaborative review. The following sections summarize the perspectives of various healthcare professionals on patient-centred care.

A Medical Student's Perspective

Palliative care (from Latin *palliare*, 'to cloak') involves the management of disease symptoms, but it offers much more. It offers dignity to the dying, and it brings them and their loved ones a sense of peace. Palliative care cloaks the dark spectre of death, and moves the patients and loved ones of those it touches towards an acceptance of the fact that death is only a matter of time, and that how one lives is infinitely more important than time of death. In essence, palliative care is patient-centred care, in that while the physician facilitates care it is the patient who directs it. The principles guiding palliative care should not be reserved for the dying, however; the same principles should be the goals of every patient-physician relationship.

In my first month of medical school I was made to consider who I am, who I expect to become, and how my self-perceptions can and will impact my future patients. Patients will entrust their

most valued possessions to my care: their health, their life, their legacy, and their loved ones. I learned that a "Good Doctor" has responsibility not only to treat a patient's disease, but to work with the patient to understand and protect these most valued possessions. Finally, in these first weeks of medical school I was made to ask myself: *"What if there was a doctor who believed in the individual, as true patient-centred care absolutely requires?"*

Anatole Broyard, a dying man, lends a unique perspective on patient-centred care: *"To the typical physician, my illness is a routine incident in his rounds while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity . . . I just wish he would . . . give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way."*[11]

If doctors could perceive, if only in part, each patient's world, then they could truly move from treating disease to treating illness. We could offer hope in times of despair, function in times of disability, peace in times of pain, and dignity in times of death. By putting the patient where they belong – at the centre of the care that is offered – the doctor really can give his/her whole mind to a patient. Only then can the physician offer the knowledge and empathy that is required to achieve better care.

A Nursing (Graduate Student) Perspective

Nursing has a strong history deeply rooted in the valuing of patient-centred care. Nursing theorists, such as Peplau, Watson, Parse, Rogers, Leininger and Allen recognized the importance of providing care focused on the patient. Providing holistic care based on mutual trust and

respect, are the base components of patient-centred care; however, these alone are not enough to ensure patient centeredness. According to the Registered Nurses Association of Ontario (RNAO),[12] patient-centred care is an approach that values the 'whole' person and involves elements of advocacy, empowerment, respect for patient autonomy, and recognition of a patient's right to self-determination and participation in decision-making. A strong therapeutic alliance between nurse and patient is central to this approach.

The importance of such care has been outlined in its relationship to improved patient care outcomes, quality of care, satisfaction with care, improved patient engagement, and in the promotion of teamwork among staff.[8,13,14]

At the clinical level, nurses can practise patient-centred care in several ways. Nurses can engage in therapeutic relationships built on mutual trust and respect, recognize the patient as being an expert of his/her life, share decision-making while emphasizing freedom of choice, and provide care that is driven by the patient's values and needs.[12-15] Ultimately, engaging in patient-centred care provides a space where the patient's voice is heard and valued, and where it becomes a driving force in the plan of care.

Nurse scholars suggest that to adopt a truly patient-centred approach, we must also challenge the current hierarchical nature of the healthcare system.[14,16] Perhaps we can begin by first challenging those who are considered experts and the 'holders' of knowledge. While nurses hold great health-related expertise, it is ultimately the client who is an expert of his/her life, health and personal needs. Through a therapeutic alliance, nurses are able to work with the patient in

identifying needs and developing a plan inclusive of and based on the patient's self-identified values, beliefs, attributes, needs and desires. However, a shift in power and power relations in the healthcare system is needed to provide a space that truly honours and values the knowledge held by the patient and the knowledge exchange that can occur between nurse and patient. Healthcare contexts and environments are not always conducive to such an approach and can make it difficult for the nurse to fully engage in patient-centred care. Shifting current care models to promote patient-centred approaches requires involvement from nursing and hospital leadership to prioritize and support patient-centred efforts.[16]

In looking to the future, it may be valuable to recognize that patients are people.[14] Perhaps a shift in language from *patient* to *person* would emphasize the essence of patient-centred care: the valuing of the patient as a unique person beyond the illness process who is more than simply a 'recipient' of care, but an active participant.

A Social Work Students' Perspective

Patient-centred care from a social work perspective stems from the idea that a patient's biological, psychological, social, spiritual and economic needs are being met and are congruent with the patient's treatment path choices. Patient-centred care provides feasible and accessible care options to a patient's needs while in the hospital, and creates a strong continuity of care for a patient's transition path from hospital to the community. Although the medical model effectively treats the physical body, a patient-centred approach to health care incorporates other aspects of a patient's unique needs that are being met, while also allowing for the patient to be in control of their care. At times, humans are affected by factors that are conducive to disregarding

the medical treatment if they are incongruent to a person's bio-psycho-social, economical, and spiritual need, thus affecting recovery and perhaps leading to a relapse. From a social work standpoint, a patient-centred approach implies cooperation of allied health, medicine, and the patient in formulation of the treatment plan. By including the patient in this process, the allied healthcare team can not only empower the patient, but also utilize the patient's strengths and resources.

Varying levels of practice exist today; however, social work has focused on a holistic approach to a person's treatment, which is a vital aspect of patient-centred care. In social work, viewing the patient as the main component of treatment planning is an empowering approach for the patient in the decision-making process. Moreover, it facilitates recovery and compliance during hospitalization and particularly after discharge. Initial treatment planning by social work upon hospital admission typically includes the patient and family in order to gather useful information for supports and needs outside the hospital. Utilizing this information, the social worker provides a full portrait and plan with the allied health team. Instead of the patient receiving the most common medication for the condition, the social worker can help navigate the needs of the patient and work with the doctor and pharmacist to help select a drug that will have fewer side effects with respect to the patient's functioning in key areas of his/her life. Above and beyond, social workers can advocate and refer patients to key community resources such as Ontario Works, Community Care Access Centre and the Trillium Drug Plan. With this, patients are not only receiving care for their medical needs while in hospital, but they are also provided with information and direct linkages to community resources. This aids in patients being able to afford medication, access community care, and find financial support prior to discharge or

shortly thereafter. These interventions provide protective factors for patients, which lessens the chance of readmission (the 'revolving door syndrome'). Furthermore, occupational therapists can work with social work to advocate that housing is attuned to the client's physical and cognitive needs. This, in turn, will prevent further injury and thus prevent readmission. Finally, patient-centre care also involves clinical interventions such as crisis intervention, psychoeducation or psychotherapy. These can aid in strengthening the client's abilities and coping mechanisms. A team approach incorporating all these services should produce a higher quality treatment plan, increase the quality of life for patients, and potentially increase cost efficiency in health care.

A Rehabilitation Specialist's Perspective

It is nearly impossible to ignore, or diminish, the imperative role that patient-centred care has on the ever growing population of persons with disabilities. This includes persons with physical and developmental disabilities, severe injuries (both work- and non-work related), and those with chronic mental health illnesses.

In our existing medical system, one can easily observe the multiple challenges that are faced by this diverse population. Examples of such challenges include: access to services, understanding the array of disease-modifying drugs, intervention and treatment options, transportation barriers, financial barriers and social stigmas. However, the one dark horse that seems to overshadow these challenges is the "disconnect" between what a person with a disability values and the objectives of our current model of health care. Perhaps a better approach would involve

collaboration between physicians, specialists, insurers, employers (in the case of work-related injuries/short-term and long-term disability claims) and rehabilitation professionals.

For a person with a disability, it is not only the reduction in physical abilities, but more importantly, the subsequent intimate experience and perception of what the term 'quality of life' means to them. This perception may change across time while the person adjusts to their functional limitations and gains overall acceptance of their circumstance. For a person with a disability, the focus of care should be a concern for their overall health and consideration of the psycho-social-vocational dimensions. The importance of these dimensions should not be diminished as they are perceived by many persons with disabling conditions to supersede those of the physical ramifications and limitations. The medical model approach appears to place sole value on the physical component of functionality. For example, disease-modifying medications may become the centre of the treatment plan because they may support the physical demands of employment and overall functionality and, thus, satisfy employers and insurers. Although physical functionality is extremely important, without a broad understanding of the patient's perception of quality of life and the desired level of functioning, the overall needs of the individual cannot be captured adequately.

A more seamless integration of both medical care and non-clinical services (e.g., social and vocational services) is needed in order to address what tends to matter most to individuals with a disability: quality of life, societal belonging and fulfillment. How can this be accomplished? How can the gap between clinical and the non-clinical care be bridged? Ultimately, uniting these two would mean building a solid, collaborative and patient-centred framework around ***all***

patients. However, for those with disabilities, the level of vulnerability and need for individualized care is much higher. Such care can be achieved once the diverse needs of this population have been recognized and the treatment plan reflects the person as a 'whole' versus focusing solely on the level of physical functioning. Thus, a collaborative patient-centred approach should facilitate successful individualized patient outcomes.

A Pharmacy Resident's Perspective

Patient-centred care is the practice of providing the highest quality of care to each individual to ensure optimal patient outcomes. Furthermore, the well-being of the patient is the highest priority throughout the provision of care. It also means looking at the patient as a whole and not just a specific medical condition or complaint. All aspects of the patient need to be evaluated and considered. This encompasses their social, financial and physical condition, lifestyle and, most importantly, their own concerns, beliefs and values. This requires a shift from the paternalistic approach to one that encourages patient autonomy. In school, we learn that the decision for a specific drug therapy is based on external evidence, therapeutic knowledge, clinical experience and patient preferences. How often do we ask a patient what their expectations and desired outcomes from drug therapy are, or how important they view their medication? Providing patient-centred care involves the patient and/or their families in treatment options to foster joint decision-making and shared responsibility for health outcomes. Once a decision is made, appropriate monitoring and follow-up must be maintained to ensure continuity through the transitions of care.

Provision of patient-centred care presents challenges between theoretical and real-life constraints. A lack of time and resources are significant barriers that impede the delivery of such care as it is difficult to provide high quality care to each individual patient in the limited hours of a day. As a result, we target those patients considered high priority or those that could benefit the most. Another barrier is the lack of communication between healthcare providers, as well between healthcare providers and patients. Sometimes decisions are made and not relayed to others involved in the patient's care or even the patient. One example is when patients are discharged from hospital with a list of new medications without any explanation or education. This sets the patient and family up for confusion, frustration and negative outcomes when they return to the community, demonstrating the existence of a fragmented care system where patients move through many stages of care with a lack of continuity.

It is possible to provide patient-centred care by overcoming the barriers. To begin, we must step out of our professional silos and collaborate with other members of the healthcare team. A multidisciplinary team allows for efficient use of specialized knowledge and skills, the sharing of ideas, and the pooling of resources to ensure the best possible care is provided at the individual patient level. Patient-centred care can be promoted by including it in professional education and ensuring it is integrated into undergraduate curriculums. More interprofessional interactions during university and in the workplace could promote more open communication between professions. Finally, one of the best ways to learn is by doing and observing others. In my experience, I have learned the most by observing those dedicated preceptors that practice quality and collaborative patient-centred care.

Providing patient-centred care is what we should be striving towards. Ideally, it should be timely, universal and accessible. We should serve each patient as a unique individual, address his/her concerns, promote shared decision-making, and ensure transitions of care are coordinated and efficient. This will make patients feel respected, empowered and more responsible for their own health. Most importantly, our decisions should reflect the best interest of the patient and not our own. We need to be dedicated to changes in how we care for our patients and share our successes with others to move patient-centred care from an ideal to a reality.

Step 2: Defining a New Patient-Centred Care Model

After independently assessing the perceptions of patient-centred care and its feasibility through the eyes of different members of the contemporary healthcare team, these group members participated in a collaborative review session to define an optimal patient-centred care model. Each member took their individual contributions and combined them with viewpoints of the other professions. The group subsequently hypothesized that the medical and bio-psycho-social models act as an essential foundation for a new, more functional, patient-centred model: the *collaborative patient/person-centric care* model (CPCCM).

Collaborative patient/person-centric care model

Our new model requires a paradigm shift in the deliverables of patient care. It involves talking to patients and family, listening to their desired outcomes, collaborating with allied health team members in order to help facilitate these patient goals, and formulating an individualized care plan that combines the patient's wishes with the clinical endpoints derived from a uniform therapeutic thought process. The root of this theory is enmeshed in goal-driven outcomes, as is

the case for the other models. However, the goals are driven by the patient and then filtered through the professional lenses of the members of the treating team as opposed to having them defined and driven by the medical team alone. This *evidence-informed* approach is more patient-centric than an evidence-based approach, where clinicians in a traditional hierarchical structure determine outcomes independently. The proposed approach also allows the current structure to be realigned to fit a more horizontal/linear model of care versus the traditional top-down structure of care.[10]

Collaborative patient/person-centric care is a specific, achievable and realistic target that requires the patient to be seen as multifaceted. According to the Diagnostics and Statistic Manual (DSM-IV-TR),[17] the patient exists on five facets (also known as Axis 1 to 5). ***Axis 1*** is the primary mental health condition. ***Axis 2*** is anything psychiatric that aggravates Axis 1. ***Axis 3*** examines other medical conditions with which the patient has been diagnosed. ***Axis 4*** consists of all psycho-social stressors. Finally, ***Axis 5*** is the patient's Global Assessment of Functioning (GAF).

When examining the conventional medical model of patient care, we see that, in essence, this model of care focuses on two dimensions of the patient: Axis 1 and Axis 3. The shift to the bio-psycho-social model involves the inclusion of two additional dimensions: Axis 2 and Axis 4. The current paradigm shift towards the collaborative patient-centred care model (CPCCM) adds a fifth dimension, as it considers and optimizes patient functionality (Axis 5). Moreover, this new model makes the patient's individual goals central to how care is delivered. Each allied health professional then takes these five patient dimensions in combination with the patient's

desired outcomes and filters them through their own clinical lens. Thus, all members of the team have a unique approach and set of skills to offer in order to meet the individual needs of the patient.

Discussion

When we examine the perceptions of the collaborative patient/person-centric care model from the perspectives of various healthcare professions, the clinical approaches that are reflected through the individual professional filters and lenses are clear. For example, we see from the social work passage that while their care takes into account all five patient facets (Axis 1 through 5), their expertise lies in Axis 4. Similarly, the rehabilitation specialist also considers the patient on each facet, but focuses on Axis 5 as their expertise lies in optimizing functionality. Nursing has the most ongoing contact with the patient and, as such, has the unique opportunity to discover the patient's desires and goals. Consequently, nursing is able to deliver holistic care that is based upon an understanding of all five patient dimensions. While medicine is inherently focused on Axis 1, 2 and 3, this new care model allows them to look beyond the illness and see the person across their myriad of facets. Ultimately, this allows medicine outcomes to be individualized and delivered in such a way as to optimize the goals of the patient and overall functionality. Traditionally, pharmacy has provided their expertise regarding medications for treatment of conditions seen on Axis 1 and 3. However, as pharmacists move towards this new model of care and our role in a collaborative team environment evolves, pharmacists can utilize a sound therapeutic thought process that addresses the patient's psycho-social needs (Axis 4). Moreover, the pharmacist can also use their pharmacology knowledge to optimize functionality

(Axis 5) by helping select medications that will have minimal side effects and drug interactions and, therefore, improving a patient's ability to function within society.

Conclusion

Whether in a community or hospital setting, a collaborative and patient-centred approach to care is achievable if all parties work towards the same patient goals and collaborate to overcome any obstacles that may arise. As such, our new collaborative patient/person-centric model of care considers the patient from a myriad of facets, brings the patient and their values to the centre of the care provided, and encourages healthcare professionals to use their clinical expertise to deliver holistic and individualized care. This paradigm shift in patient care has the potential to vastly impact and improve patient outcomes and diminish morbidity and mortality, as it views the patient fundamentally as a person instead of an illness. At this point we have a case series of evidentiary data to support the CPCCM methodology, however further research into the economics and further roll-out is encouraged. Parameters that could be addressed include admission, readmission, length of stay and cost of medications utilized.

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