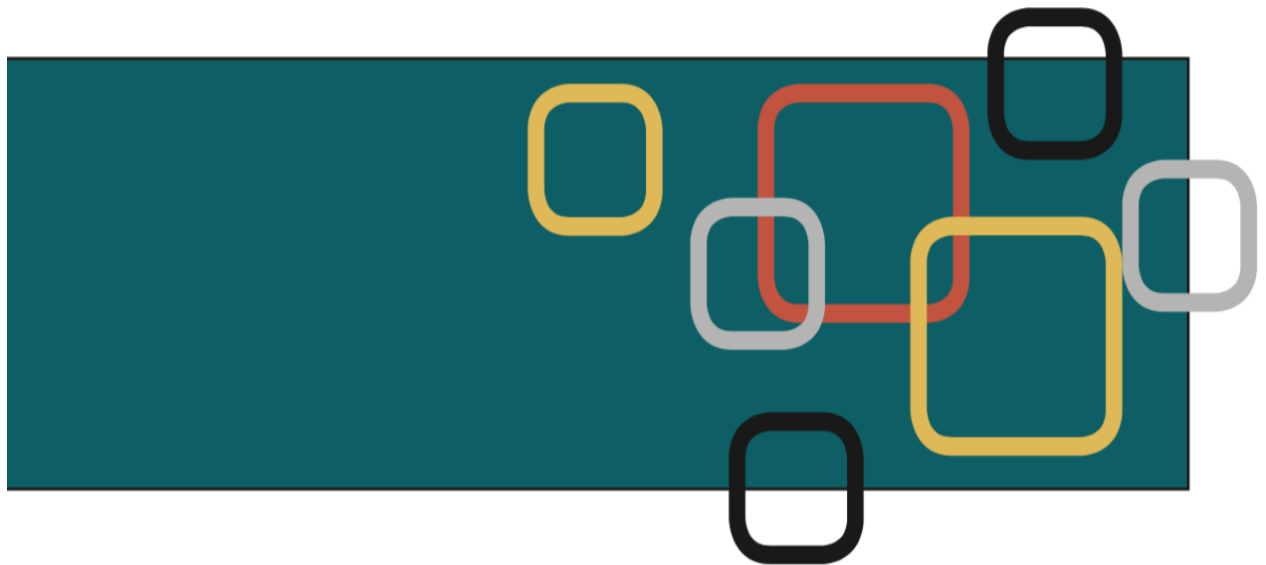


Person-centred Care Quality Indicators



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Preface

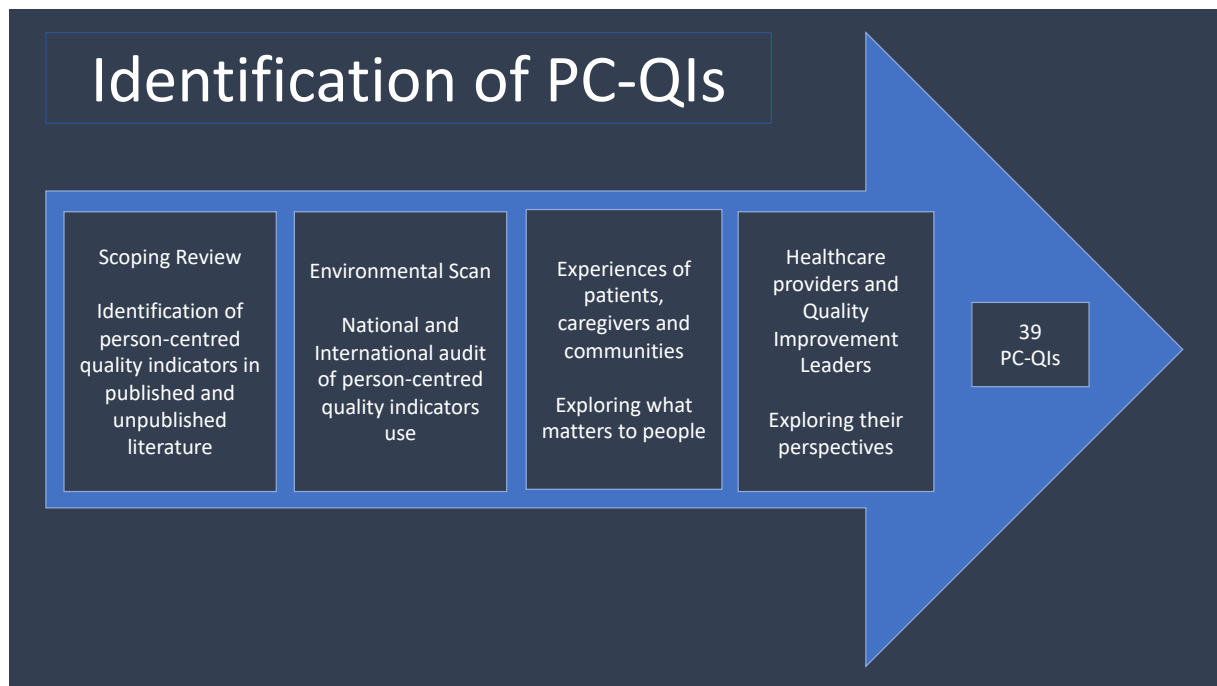
In the Institute of Medicine's 2001 seminal report *Crossing the Quality Chasm*,¹ patient-centred care (PCC) was identified as an essential foundation for healthcare quality and patient safety¹ and ever since has been recognized as a high priority for the delivery of healthcare services in many healthcare systems.²⁻⁶ PCC is defined as "care that is respectful and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."¹

The concept of PCC has been described through an array of alternative and more commonly adopted terms including patient- (and family) -centred care.^{1,7-11} In this monograph we use the words "person-centred care" as it emphasizes a more holistic meaning of care incorporating the whole individual including the person's well-being, ethno-cultural expression, preferences, and beliefs, and refrains from reducing the person to just their symptoms and/or disease.¹² Additionally, person-centred care is not limited to the care of the "patient" but rather allows for care of those who are not living with illness, including health promotion. Conceptually, PCC is a model in which healthcare providers are encouraged to partner with patients and families to co-design and deliver personalized care.

Traditionally, the quality of healthcare has been driven by policy-makers and healthcare managers, and evaluated solely through the lens of healthcare professionals. More recent policies emphasize that patient views not only complement healthcare provider perspectives, but also provide unique information about the effectiveness of healthcare.¹³⁻¹⁷ The provision of PCC is supported by evidence demonstrating its impact on healthcare quality including improvement of patient experiences and outcomes, involvement of people in their healthcare decisions, supporting health promotion initiatives, allowing people to look for lifestyle programs that suit their needs, decreases in healthcare services utilization and costs, and improvement in healthcare provider satisfaction.^{18,19} Based on this evidence and the need to address issues such as the growing aging population living with multiple complex conditions and sky-rocketing healthcare costs, many healthcare systems around the world are moving towards a PCC model.²⁰⁻²² A PCC model supports a healthcare system in which individuals co-design the delivery of services, providing people with the quality of care they need, and resulting in an overall improvement of healthcare system efficiency. Before PCC can be improved, however, it needs to be measured using reliable and valid measures of healthcare quality.

Quality indicators are performance measures designed to compare actual care against ideal criteria for the purposes of quality measurement, benchmarking and identifying potential opportunities for improvement.^{23,24} Quality indicators for PCC have previously been developed by health quality councils and other organizations. However, these indicators are usually derived from validated measures which lack of patient and family input, missing what matters most to people in their healthcare.

In our project we identified indicators through Phase one, which included the following steps depicted in the figure:



The goal of this monograph is to summarize the results of the development of PC-QIs, specifically a consensus method to select and develop quality indicators to measure and improve PCC during Phase two of this research. Consensus methods have been demonstrated to be an effective tool for facilitating decision making where there is insufficient information and also where there is an overload of contradictory information.²⁵ We employed a modified version of the RAND/UCLA Appropriateness Method (RAM), a reproducible and valid nominal group technique used in health services research to gather feedback and information from relevant experts.²⁶

The PCC Consensus Panel, a national and international panel of patients, family members, healthcare quality experts and community representatives from different diverse backgrounds, reviewed existing quality indicators in four rounds of review. They suggested revisions to these indicators, proposed new indicators, and selected the indicators that were most promising for measuring PCC. The findings of this research have been submitted for peer-reviewed publication.

The indicators have been developed with the intent of complementing existing quality measurement and improvement efforts in healthcare quality such as accreditation processes, national benchmarking projects and regional or local programs (e.g. institutional quality assurance programs). These generic indicators are designed to provide tools for healthcare development. The proposed indicators do not represent a comprehensive catalogue of potential measures, but rather are intended to be dynamic tools that should be continually modified and adapted in response to the evolving evidence-base and person-informed concept of PCC, as well as the quality improvement needs of healthcare organizations.

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Definitions

Patient: “an overarching term inclusive of individuals with personal experience of a health issue and informal caregivers, including family and friends.”²⁷

Patient-centred Care: PCC is defined as “care that is respectful and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.”¹

Person-centred Care: “person-centred care” emphasizes the holistic meaning of care incorporating the whole individual including the person’s well-being, ethno-cultural expression, preferences, and beliefs, and refrains from reducing the person to just their symptoms and/or disease.¹² Additionally, person-centred care is not limited to the care of the “patient” but rather allows for care of those who are not living with illness, including health promotion.^{12, 28} Conceptually, PCC is a model in which healthcare providers are encouraged to partner with patients and families to co-design and deliver individualized personalized care.

Quality Indicators: performance measures that compare actual care against ideal criteria. They are a tool for assessing the quality of care. The definition is derived from the Institute of Medicine’s definition of quality of care, “*The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with professional knowledge.*”

Person-centred Care Quality Indicators: “A PC-QI is the unit of measurement of healthcare system or organizational or individual performance, that quantify patients’ and families’ experiences with the care received and quantify the experience of any individual who comes in contact with healthcare services.”²⁸

Health Policy: according to the World Health Organization, “Health policy refers to decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people.”²⁹ A policy on person-centred care will include the vision and mission of the healthcare organization related to PCC. This policy will include the development of action/implementation plans to achieve person-centred care goals within the healthcare organization.

Protocol: a system of rules that explain the agreed conduct and procedures to be followed in formal situations.³⁰ For instance, a protocol on discriminatory care will include a set of rules to guide processes in healthcare that provide anti-discriminatory care.

Continuity of Care: the quality of care received by patients and offered by healthcare providers over time. In the PCC context, continuity of care is assessed by perspectives of both

the patient and the provider. For patients, continuity of care is based on patient experiences of a 'continuous caring relationship' with the healthcare provider. For providers, continuity of care refers to the delivery of care that is integrated and coordinated between different healthcare providers.³¹

Transitions of Care: “the movement of patients between healthcare practitioners, settings, and their home, as their condition and care needs change.”³²

Coordination of Care: includes a careful organization of patient care processes involving the sharing of information among all participants involved in the care of the patient. This means that the patient’s needs and preferences are known and communicated in a timely manner to all of the participants involved in the patient’s care to achieve safe and effective care.³³

Information supporting the PC-QIs

Relation to Quality - Six-Aims of Quality of Care¹

Safe: Avoiding harm to patients from the care that is intended to help them.

Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.¹

Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Type of Indicator – Based on the Donabedian model for measuring quality of care²⁹

PCC Structure Quality Indicators include PCC domains related to the context in which care is delivered and provides the foundation for PCC including the necessary materials, healthcare resources, and organizational characteristics.

PCC Process Indicators are designed to measure the quality of care associated with the interaction between patients and healthcare providers and any healthcare service personnel.

PCC Outcome Indicators are designed to measure the quality of care associated with the delivery of PCC.

The indicators are intended to examine select domains of PCC and be applicable across healthcare sectors, specialties, conditions and geographical areas.

Proposed Data Source: refers to what source is used to derive the indicator. For instance, protocols, measures, or surveys.

Definition: how the indicator is described, including numerators and denominators to define the indicator.

Benchmarking: “a process of measuring the performance of a company's products, services, or processes against those of another business considered to be the best in the industry, aka ‘best in class’.” The point of benchmarking is to identify internal opportunities for improvement.³⁰

Risk Adjustment: The extent to which the influences of factors that differ among groups being compared (e.g., across Canada) can be controlled or taken into account.

Information to Rate the PC-QIs

Quality Indicator Evaluation - what makes a good indicator? The National Quality Forum considers several criteria when evaluating a new measure:

1. Targets important improvements:

Importance: The PC-QI must be relevant to a large number of individuals including patients.

Validity: The measure must be valid. Validity implies that the indicator measures what it is intended to measure.

Face Validity: The ability of the PC-QI to capture aspects regarded as important by people (healthy and sick), and specialists in quality improvement.

2. It's measurable:

Utilization: Percentage of healthcare organizations and centres that used a specific PC-QI.

Usability: The results of any measure must be understood by the intended audiences (e.g., consumers, healthcare providers, and payers). Measures that are difficult to understand will not be translated into meaningful improvement.

3. It's interpretable:

Usability: Usability assesses whether the indicator is actionable and interpretable.

Risk Adjustment: The extent to which the influences of factors that differ among groups being compared (e.g., across Canada) can be controlled or taken into account.

4. It's feasible:

Feasibility: Data collection and data for reporting PC-QIs must be feasible to obtain. Some PC-QIs are readily available; others require extensive data collection from medical records. Measures based on data that are difficult to obtain must be extremely valuable or they will result in misspent resources.

Classification of the PCC QIs

A person-centred framework²⁸ was developed to classify the identified PC-QIs and to guide the development of the PC-QIs. The framework is organized like a roadmap, depicting practical PCC implementation in the order in which it should be implemented, starting from structural domains that are needed as pre-requisites in order to facilitate processes and influence outcomes needed to achieve PCC. This conceptual framework guides the implementation of PCC.²⁸

PCC Structure Indicators

PCC Structure Quality Indicator includes PCC domains related to the context in which care is delivered and provides the foundation for PCC: the necessary materials, healthcare resources, and organizational characteristics.

S1. Policy on Person-centred Care

Description of Indicator

Relationship to Quality	Medical care should be safe, effective, patient-centred, timely, efficient, and equitable
Type of Indicator	Healthcare System Structure Level
Proposed Data Sources	Policy (or policies) guiding and supporting the provision of PCC
Definition	Regional/provincial/national policy (or policies) that guides and supports the provision of PCC
Numerator	Number of hospitals and healthcare centres/organizations that have a policy (or policies) for PCC which includes the following five components: 1) Establishment of an operational definition for PCC; 2) Inclusion of PCC in the organization’s Mission and Vision; 3) Inclusion of PCC as part of the organization’s Core Values; 4) Allocation of resources to support and implement PCC; 5) Evaluation of PCC protocol and program implementation with the perspective of patients
Denominator	Number of all audited hospital and healthcare centres/ organizations
Benchmark	Not specified at present
Risk Adjustment	Geographic location (urban, rural, specific communities with diverse demographics), level of care (tertiary), type of healthcare centre (teaching, non-teaching)
Data Collection Tool Example	Patient- and Family-Centered Care Organization Self-Assessment Tool, Institute for Healthcare Improvement (2013) ¹

Summary

As the **central structure indicator for PCC**, ‘Policy on Person-centred Care’ is intended to identify whether hospitals and healthcare centres/organizations have a policy (or policies) in place to provide the strategic direction and support needed for the healthcare organization to achieve its goals for PCC.

The policy aims to make PCC a strategic organizational priority, and to provide a basis for the development of structures necessary for the provision of PCC. This includes the development of education programs, protocols, and use of metrics for quality improvement and public reporting. Specifically, a policy on PCC should include the presence of:

1. Establishment of an operational definition of PCC^{2,3}
2. Inclusion of PCC as part of the organization’s Mission and Vision, incorporated in the philosophy of the organization

3. Inclusion of PCC as part of the organization's Core Values, which should include the basic tenets of PCC, but is not limited to:
 - a. Partnership with patients, families, and communities to co-design, deliver, and improve healthcare services and environments²
 - b. Fostering a culture of healthcare that values humanity and upholds the rights of patients and healthcare staff, including staff & client) conduct (e.g., respectful relationships)
 - c. Enable healthcare staff to work collaboratively provide care that matters to patients, families, and communities
4. Allocation of resources to support and implement PCC (e.g., human resource policies that include core PC competencies, a code of conduct that is PC, and data sharing and communications policies, as well as visiting hour policies, etc.)
5. Evaluation of PCC protocols and programs implemented, with the perspective of patients, such as through the use of quality indicators for PCC or other metrics for PCC

This policy is actionable via the measurement of its key components in the form of the following six PC-QIs described in this monograph. Particularly, this policy indicator is actionable when measuring the existence and practice of education programs on PCC (PC-QI S2), assessing the provision of cultural competent care (PC-QI S3), appraising the creation of an environment that accommodates and supports the provision of PCC (PC-QI S4), evaluating if care is co-designed in partnership (PC-QI S5), gauging the use of health technology to support PCC (PC-QI S6), and assessing existing structures to report PCC performance (PC-QI S7).

Review of Literature & Evidence

The literature widely recognizes the importance of creating a PCC culture across the continuum of care, where governments⁴ and organizations play a key role in the development of clear and comprehensive policies, processes, and structures necessary for healthcare systems and healthcare providers to deliver PCC.⁵⁻⁸ Furthermore, healthcare systems have begun to implement person-centred care policy.⁹⁻¹¹

A common set of core values among all parties, as part of a strategic vision is essential in the provision and receiving of care that includes patients, healthcare providers, communities, and organizations within and outside of traditional healthcare services.¹²⁻¹⁵ Best practices demonstrate the need to standardize PCC language among patients, healthcare providers, policy makers, along with other key stakeholders in order to effectively foster a PCC culture of care.⁴⁻⁶

In addition, currently, primary care payment systems encourage physicians to increase patient volumes and reduce time spent with individual patients.¹⁵ Policy makers need to consider alternative provider payment methods and incentives to reward practicing PCC.^{16,17} Furthermore, to promote a supportive PCC work environment, Epstein et al. (2010) suggest creating "communities of care," which work to promote teamwork,

collaboration and communication among HCPs to collectively meet the needs of their patients.¹⁷

Importance

This indicator was identified in the literature as relevant and foundational to practicing PCC. The patients and citizens suggested the PCC culture as a community activity, not restricted to the walls of the healthcare organizations and services. On the other hand, physicians and other healthcare providers highlighted the need of support in providing PCC, as the actual model of care lacks resources (time and money) to provide PCC.¹⁸

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S2. Educational Programs on Person-centred Care

Description of Indicator

Relationship to Quality	Medical care should be patient-centred and equitable
Type of Indicator	Healthcare System Structure Level
Proposed Data Sources	Educational program(s) that focus on providing and practicing PCC are in place
Definition	<p>Educational program(s) in place describing PCC and how to practice PCC for all healthcare personnel (e.g. staff, physicians, nurses, allied health care professionals, caregivers). Training includes providing care that promotes co-design and partnership with patients, collaboration among the healthcare team, in addition to anti-discriminatory care, cultural competence and humility.</p> <p>Quality of training should be assessed by healthcare personnel and by patients to inform necessary gaps and improvements needed in educational programs. Process and outcome indicators can provide a patient perspective on the delivery of PCC.</p>
Numerator	Number of hospitals and healthcare centres, community-based organizations that have an educational program(s) for PCC
Denominator	Number of all audited hospital and healthcare centres, and community-based organizations
Benchmark	Not specified at present
Risk Adjustment	Geographic location (urban, rural, specific communities with diverse demographics), level of care (tertiary) type of healthcare centre (teaching, non-teaching)

Summary

This indicator is intended to assess whether there are PCC education programs in healthcare systems and community-based organizations (e.g., non-profit organization funded by the health authority) to train personnel (healthcare staff, physicians, nurses, allied health professionals). The development and implementation of the educational program(s) is the responsibility of each provincial health authority/healthcare organization. The indicator includes three domains:

- 1) Integration of educational programs into all healthcare sectors (e.g., laboratory, radiology);
- 2) Professional education and accrediting bodies (e.g., medical and nursing associations);
- 3) Translating into practice through continued professional education (e.g., continued medical education) and mentorship.

Quality of educational programs should be assessed by healthcare professionals (e.g. through pre and post surveys) to ensure training objectives are met, and to address any

gaps or needed improvements to training. Process and outcome indicators can provide the patient perspective on the delivery of PCC, and provide a measure of the effectiveness and impact of training.

Educational program (s) on PCC should include the following concepts:

- a. How to practice PCC, including¹:
 - Partnership with patients, families, and communities to co-design, deliver, and improve healthcare services and environments
 - Collaboration with multi-disciplinary teams to provide care that matters to patients, families, and communities
 - Providing a high-level of communication that provides sufficient information and is respectful
- b. Fostering a culture of healthcare that values humanity, inclusivity, anti-discriminatory care, and upholds the rights of patients and healthcare staff

Review of Literature & Evidence

The lack of emphasis on PCC in medical education remains a barrier to its implementation,² resulting in gaps between practices. Specifically, current education tends to focus on the biomedical model, is not standardized across healthcare sectors and professionals, and is not co-developed with patients and healthcare professionals, despite the availability of successful models that incorporate both perspectives in the development and implementation of training.^{2,3,4} With the rapid emergence and evolution of PCC, there is a need for innovative education programs that are endorsed by key stakeholders and champions in medical education, including medical faculty, deans, administrative directors, and accrediting bodies.³⁻⁵

Educational programs should also include administrative staff, volunteers, and allied professionals involved in healthcare, who are needed to support the cultural change.⁶ As integrating PCC into the healthcare curriculum does not necessarily translate into practice, PCC education programs should be designed to continue improvement through informal training, continued leadership development, and training through mentors and role models, eventually leading to a greater impact on culture change.^{2, 6}

Importance

This indicator was identified as important by the consensus panelists, where educational programs were seen to require a broad perspective of PCC, which would include education around engaging patients in their care, providing respectful, compassionate, and anti-discriminatory care, as well as cultural humility and competency. The content of educational programs on PCC were described by consensus panelists, including the need for assessment by healthcare professionals.

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S3. Culturally Competent Care

Description of Indicator

Relationship to Quality	Medical care should be equitable and patient-centred
Type of Indicator	Healthcare System Structure Level
Proposed Data Source	Survey assessing whether the organization delivers care with cultural competency, humility and safety
Definition	Percentage of healthcare facilities using a survey to assess organizational cultural competence
Numerator	Number of healthcare systems (hospitals and healthcare centres) assessing organizational cultural competence
Denominator	Number of all audited hospital and healthcare centres/organizations
Benchmark	Not specified at present
Risk Adjustment	Not applicable
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) ¹ , Cultural Competence Item Set (Weech-Maldonado et al. (2012)) ²

Summary

This indicator is intended to identify healthcare systems and organizations that assess cultural competence in healthcare for ethno-cultural communities. It is recommended that healthcare systems assess organizational cultural competence through the following domains²⁻⁴:

- 1) Clinical Cultural Competency Practices: the delivery of culturally competent care
- 2) Human Resources Practices
- 3) Diversity Training
- 4) Availability of Interpreter Services
- 5) Interpreter Services Policies
- 6) Quality of Interpreter Services
- 7) Translation of Written Materials
- 8) Leadership and Strategic Planning
- 9) Performance Management Systems and QI
- 10) Data Collection on Inpatient Population
- 11) Data Collection on Service Area
- 12) Community Representation

Review of Literature & Evidence

PCC that is culturally competent aims to reduce disparities in health and healthcare.³ The National Quality Forum defines culturally competent care as the ‘ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family-centred, evidence based,

and equitable.⁴ PCC that is culturally competent is necessary to meet the healthcare needs of diverse populations.⁴

Workforce diversity is important in promoting organizational cultural competence.⁵⁻⁷ Recruitment and retention of staff of diverse backgrounds is listed as one of the standards from the national standards for culturally and linguistically appropriate services (CLAS).⁶ Several studies have found the effectiveness of a diverse workforce in the delivery of culturally competent care.⁸⁻¹¹ For example, racial concordance of patient and healthcare provider has been linked with patient satisfaction and self-rated quality of care.⁸⁻¹⁰ Other studies have also found patients of ethno-cultural backgrounds to prefer healthcare professionals of ethno-cultural backgrounds as well, resulting in greater satisfaction with care and improved health outcomes, such as blood pressure control.¹² Studies have also demonstrated that physicians of ethno-cultural backgrounds are more likely to care for patients of ethno-cultural backgrounds than other physicians.⁸⁻¹¹

Cultural competence education has been found to improve the knowledge, attitudes, and skills of health professionals, as well as improving patient satisfaction.¹³ However, cultural competence education varies across schools and is not standardized, proving difficult to assess which method and format of training is most effective.⁷ A standardized approach to cultural competence education is necessary to assess its effectiveness in improving patient outcomes.

Researchers have proposed integration of cultural humility within the entirety of medical education.^{14,15} Cultural humility provides a different perspective to cultural competence by emphasizing reflection of one's self and acknowledging existing power imbalances between provider and patient.^{14,15} Cultural humility encompasses flexibility, acceptance of differences, and willingness to learn from others as cultural informants.¹⁵

Importance

Cultural competence education was identified as important for healthcare professionals (at all levels) in the scoping review. Respectful and compassionate care was identified as a priority for patient-centred care from focus groups with ethno-cultural communities and patient and family advisory groups. The inclusion of cultural humility in PCC education was considered to be important by consensus panelists. In order to truly deliver respectful patient-centred care, incorporating cultural competence and humility is necessary.

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S4. Providing a Supportive and Accommodating Person- centred Care Environment

Description of Indicator

Relationship to Quality	Medical care should be patient-centred, safe, equitable and efficient
Type of Indicator	Healthcare System Structure Level
Proposed Data Source	Survey
Definition	Healthcare systems with a protocol(s) for co-developing a supportive and accommodating physical PCC environment in healthcare facilities with patients
Numerator	Number of hospitals and healthcare centres/organizations with a protocol(s) for co-developing a PCC environment with patients
Denominator	Number of all audited hospitals and healthcare centres/organizations
Benchmark	Not applicable
Risk Adjustment	Not applicable
Data Collection Tool Example	CPES-IC (Canadian Patient Experiences Survey — Inpatient Care) ¹ , HCAHPS (Hospital Consumer Assessment of Health Providers and Systems) ²

Summary

This indicator is intended to identify whether healthcare systems have a protocol(s) for guiding the co- development of supportive and accommodating PCC environment in healthcare facilities with patients.³ This indicator refers to the extent the physical built environment is PCC friendly and promotes a positive and safe healing environment for patients. This protocol will assess whether healthcare centres/organizations are working with patients and families in making the built environment of the organization more accessible and PCC friendly. This indicator is not meant to encourage the development of new structures, but rather, to encourage co-developing with patients to improve the built environment.

Review of Literature & Evidence

A supportive and accommodating built environment is an essential aspect of PCC where co- design with patients is crucial to ensure that patients feel comfortable, welcomed, and have their needs met.⁴⁻⁶ Healing environments that support choice, dignity and respect have a positive impact on healthcare outcomes.⁷ The physical design of the healthcare environment influences patient safety (reducing errors, patient falls, infections, etc.), and patient experience (supporting privacy and comfort).⁷ Several well-established patient-centred organizations (i.e. Planetree⁸) provide consultation services to healthcare providers to develop PCC environments and support implementation.

Importance

Patients, healthcare professionals, healthcare leaders, and other healthcare providers high-lighted the importance of a built environment that was inclusive of patients and families in the planning and execution. For instance, the example of “steep ramps” was given as an example at the Round 2 consensus meeting. This indicator is important as informs quality improvement and program planning at the hospital level.

Sources

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S5. Co-designing Care in Partnership with Communities

Description of Indicator

Relationship to Quality	Medical care should be patient-centred, safe, equitable and efficient
Type of Indicator	Healthcare System Structure Level
Proposed Data Source	Protocol(s) guiding the development of partnership with communities in policies, procedures, and programs for the delivery of patient-centred care and culturally competent health services
Definition	Healthcare systems should have a protocol(s) guiding development of partnerships with communities for co-designing care, and should provide an opportunity for partners to evaluate the partnership regularly
Numerator	Number of hospital and healthcare centres/organizations with a protocol guiding the development of partnerships with communities for co-designing care
Denominator	Number of all audited hospital and healthcare centres/organizations
Benchmark	Not specified at present
Risk Adjustment	Not specified at present
Data Collection Tool Example	National Quality Forum Framework for Measuring and Reporting on Cultural Competency ¹ , Patient and Public Engagement Evaluation Toolkit ² , Engaging Patients in Patient Safety ³

Summary

This indicator assesses the existence and implementation of a protocol(s) for partnerships with communities, ensuring that the community, including patients and the public, is involved in all aspects of patient-centred care and culturally competent healthcare.¹

It is recommended the following questions should be addressed in developing a protocol:

1. Does the health system collaborate with communities in implementing programs to address health disparities?
2. Are communities or their representatives involved in the design, implementation, and evaluation of the effectiveness of cultural competency activities?
3. Does the health system use a community-based participatory research methodology when conducting research in the community as it involves all stakeholders in the research process?
4. Do community partners have an opportunity to evaluate their engagement/partnership?

Review of Literature & Evidence

Partnerships with communities have been outlined as a strategy by the World Health Organization for improving patient-centred care.⁴ The WHO policy framework outlines the need for promotion of social infrastructure that can support community participation and collaboration and developing community leaders who can advocate for involvement of communities in the delivery of health services¹. Community based partnerships have also been associated with provision of culturally competent care, and contributing to cultural humility.⁵

The National Quality Forum's consensus report provides a comprehensive framework for measuring and re-reporting cultural competency.¹ In the National Quality Forum framework, it is recommended that community partnerships should be developed and community development approaches be used to aid in organizational decision making, and help ensure the provision of culturally competent care.¹ The framework includes 1) collaborating with communities to implement programs addressing health disparities; 2) involvement of communities in the design, implementation, and evaluation of the effectiveness of cultural competency activities; and 3) utilizing a community-based participatory research methodology when conducting research in the community as it involves all stakeholders in the research process.⁵ Community-based partnerships have been utilized in the development of cultural competency training programs for nursing, providing opportunities for community partners to co-teach programs.⁶

Importance

Patient and caregiver partners, collaborators, and consensus panelists confirm patient and community engagement as an important aspect of co-designing a PCC healthcare system.

Sources

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S6. Healthcare Information System to Support Person-Centred Care

Description of Indicator

Relationship to Quality	Medical care should be safe, patient-centred, timely, effective and efficient
Type of Indicator	Healthcare System Structure Level
Proposed Data Source	Health information system used by healthcare systems to support and monitor PCC
Definition	Healthcare systems using health information technology to support and monitor PCC by: <ul style="list-style-type: none"> • Supporting patient-healthcare professional communication • Providing patients with information about their health and care • Supporting the coordination, continuity and transitions of care
Numerator	Number of hospital and healthcare centres/organizations using healthcare information technology to support and monitor PCC
Denominator	Number of all audited hospitals and healthcare centres/organizations
Benchmark	Not available
Risk Adjustment	Geographical area (e.g., urban, rural)

Summary

This indicator is intended to identify healthcare systems that use health information technology for supporting PCC – including e-health platforms to support patient-healthcare professional communication, patient management and other patient-centred processes. Assessment of this indicator may include PC-QIs related to PCC processes around communication, coordination and transitions of care, and engaging patients in self-management.

Review of Literature & Evidence

Developing a common e-health platform for health information exchange across providers and patients with the capacity to link all healthcare electronic data across the continuum of care must also be implemented.¹ Such structures include Electronic Medical Records, which have proven to support access, coordination, and safety in care delivery, through enhancing healthcare processes (information access, patient-healthcare professional communication, patient and family involvement, etc.).¹ E-health technologies should provide secure and private platforms and its adoption and implementation within the existing healthcare system should be supported by training. E-health technology integration involves both building and updating existing healthcare facilities, and effectively connecting patients and caregivers with practitioners throughout the continuum of care.^{2,3}

Importance

Healthcare leaders, physicians and other healthcare providers highlighted the need to use health information technology to support the provisions of PCC. Patients discussed the importance to have access to their information, such as an online patient-portal.

Sources

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2. Pelzang R. Time to learn: understanding patient-centred care. British Journal of Nursing. 2010;19(14).
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S7. Structures to Report Person-centred Care Performance

Description of Indicator

Relationship to Quality	Medical care should be safe, effective, patient-centred, timely, efficient, and equitable
Type of Indicator	Healthcare System Structure Level
Proposed Data Sources	Available reports on PCC performance for policy/decision-makers or managers, healthcare staff, patients and the public
Definition	Healthcare systems should report PCC performance based on feedback from patients and healthcare staff
Numerator	Number of hospital and healthcare centres/organizations reporting on PCC performance based on feedback from patients and healthcare staff
Denominator	Number of all audited hospitals and healthcare centres/organizations
Benchmark	Not available
Risk Adjustment	Geographic location (urban, rural), compliments, complaints, patient-reported outcomes

Summary

This indicator is intended to report the measurement of the PCC practice and ensure healthcare organizations are held accountable to their goals to improve the quality of PCC. The reports should synthesize data collected from patients and healthcare staff and be tailored to their audience (policy/decision makers or managers, healthcare staff, and patients and the public). This includes the use of patient experience surveys, patient-reported outcome measures in clinical care, patient complaints and compliments, alongside reported wins and lessons learned.²⁻¹⁴ Reports should be used to identify gaps in PCC and target needed improvements to PCC protocols, education, and processes of care.

Review of Literature & Evidence

Patients, healthcare professionals and policy makers should have available reporting systems on PCC performance based on feedback from patients, in order to promote PCC practice. Measurement approaches include the use of patient experience surveys, patient-reported outcome measures in clinical care, patient complaints and compliments, alongside reported wins and lessons learned.²⁻¹⁴ Utilizing existing public reporting systems present an ideal platform for PCC measuring, reporting, and providing accountability¹⁵ Healthcare systems are developing innovative programs to collect data from patients and report this information back to patients and healthcare providers in an accurate and timely manner via visual dashboards.¹

Feedback should also be tailored to the audience. For instance, while patients may be concerned with access to care and relationships with healthcare providers, policy makers may utilize the information in assessing healthcare utilization and costs.

Importance

Healthcare leaders, physicians and other healthcare providers highlighted the need of a protocol describing the integration of health information technology and its support in providing PCC. Patients discussed the importance to have access to their information, such as an online patient-portal.

Sources

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PCC Process Indicators

PCC Process Indicators are designed to measure the quality of care associated with the interaction between patients and healthcare providers and any healthcare service personnel. The indicators are intended to examine select domains of PCC and be applicable across healthcare sectors, specialties, conditions and geographical areas.

P1. Compassionate Care

Description of Indicator

Relationship to Quality	Medical care should be patient-centred
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients that reported receiving compassionate care during their visit with a healthcare professional (e.g. doctors, nurses, allied health professionals) across healthcare settings and home care
Numerator	Total number of patients responding receiving compassionate care during their visit with a healthcare professional (e.g. doctors, nurses, allied health professionals) across healthcare settings and home care
Denominator	Total number of patients responding to the question(s) who reported receiving compassionate care
Benchmark	Not applicable
Risk Adjustment	Not specified at present
Data Collection Tool Example	PEECH (Patient Evaluation of Emotional Care during Hospitalisation) ¹ , see Strauss <i>et al.</i> (2016) for more measures ²

Summary

This indicator is intended to measure whether the patient received compassionate care. Compassionate care enhances communication and encourages patient and family engagement, both important factors in the provision of high quality of care.^{2,3}

Surveys often focus on the extent to which the professional exhibits compassion, which is the capacity to recognize “suffering”.¹ Compassion is an attempted response to and relief of the suffering of another.^{3,4}

Review of Literature & Evidence

Compassion involves three elements: kindness, mindfulness and common humanity. The feeling that arises in witnessing another's suffering which motivates a subsequent desire to help”.³ Strauss et al. (2016)² proposed a new definition of compassion to be a cognitive, affective, and behavioral process consisting of the following five elements that refer to both self and other compassion: 1) Recognizing suffering; 2) Understanding the universality of suffering in human experience; 3) Feeling empathy for the person suffering and connecting with the distress (emotional resonance); 4) Tolerating uncomfortable feelings aroused in response to the suffering person (e.g. distress, anger, fear), so remaining open to and accepting of the person suffering; and 5) Motivation to act to alleviate suffering.

With effective communication comes the provision of compassionate care. This includes being responsive to patient preferences, needs, and values⁵ through acknowledging the patient's personal, cultural, religious and spiritual values while expressing empathy, sympathy and reassurance, and responding to the patient's emotions.⁴ Providing respectful care fosters relationship building and has been shown to promote healing and better outcomes.³

In order to provide respectful and compassionate care, one must acknowledge the patient as an expert in their own health, and through this, develop partnerships that allow for sensitivity to emotional and psychological needs and empathetic responses. It has been shown that compassion decreases in the latter years of medical training meaning they may become more desensitized to empathic processing over time.⁴ Compassion-cultivation programs, including mindfulness implemented throughout medical training have been shown to have effective and long-lasting results.⁶

Importance

Patients emphasized the importance of this indicator during focus groups, and prioritized this as one of the key areas for PCC during the study report back/dissemination events.

During the interviews, healthcare professionals, leaders, and other healthcare providers highlighted respectful and compassionate care to patients and families as a key piece in building partnership and supporting communication in the PCC model.

The American Medical Association's (AMA) Principles of Medical Ethics, with Item 1 stating that "A physician shall be dedicated to providing competent medical services with compassion and respect for human dignity."³

Sources

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6. Goetz JL, et al. Compassion: and evolutionary analysis and empirical review. 2010, *Psychol Bull*. 2010 May; 136(3): 351–374.

P2. Equitable Care

Description of Indicator

Relationship to Quality	Delivery of care should be equitable and patient-centred
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients that reported that they received inequitable access to care and treatment because of their race/ethnicity, education level, gender, language, religion, and/or sexual orientation
Numerator	Total number of patients reporting that they received equitable access to care and treatment
Denominator	Total number of patients responding to the questions assessing equitable access to care and treatment
Benchmark	Not applicable
Risk Adjustment	Not specified at present
Data Collection Tool Example	DISTANCE Survey (Moffet et al. 2009) ¹

Review of Literature & Evidence

Perceived discrimination has been associated with dissatisfaction in care, diminished well-being, and greater depressive symptoms.² Studies have found perceived discrimination linked to increased stress which influences healthcare utilization, and affects patient-provider relationship values such as trust and communication.³⁻¹⁰

Importance

Equitable treatment was identified in the scoping review as important to the provision of culturally competent care. Experiences of discrimination in healthcare were shared by focus group participants, indicating gaps in the quality of care. Equitable care is one of the six aims of healthcare quality improvement.¹¹

Sources

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P3. Trusting Relationship with Healthcare Provider

Description of Indicator

Relationship to Quality	Medical care should be patient-centred
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients that reported a high level of trust with their healthcare provider
Numerator	Total number of patients responding highly to the questions assessing trust
Denominator	Total number of patients responding to the questions assessing trust
Benchmark	Not applicable
Risk Adjustment	Not specified at present
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence Item Set ¹ , Wake Forest Physician Trust Scale ²

Summary

This indicator is intended to measure whether the patient reported having a trusting relationship with their healthcare provider. An example of how this indicator can be measured is through the Consumer Assessment of Healthcare Providers and Systems Cultural Competence Item Set¹ (Note: these questions can be modified to fit with other care settings).

Example questions:

1. Do you feel you can tell this doctor anything, even things that you might not tell anyone else? [Yes/No]
2. Do you trust this doctor with your medical care? [Yes/No]
3. Do you feel this doctor always tells you the truth about your health, even if there is bad news? [Yes/No]
4. Do you feel this doctor cares as much as you do about your health? [Yes/No]
5. In the last 12 months, how often did you feel this doctor really cared about you as a person? [Never/Sometimes/Usually/Always]

Review of Literature & Evidence

A trusting relationship between the patient-provider is necessary for the delivery of patient-centred care. Thom *et al.* (2002) found patients with lower levels of trust in their healthcare provider were less likely to adhere to treatment, and also reported dissatisfaction with their care.³ Lack of trust between patient-provider has been found to result in delay in seeking care, impacting early diagnosis of conditions such as cancer.⁴ A trusting relationship between the

patient and their provider has been noted to be important in the delivery of quality care.⁵ A measure for assessing cultural competence by Weech-Maldonado *et al.* (2012),¹ includes trusting relationships as one of the domains within the measure. Developing interpersonal relationships can contribute to creating trust, increased communication, kindness, and respect.⁵

Patient trust can be conceptualized as having the following five overlapping domains: 1) fidelity (caring and advocating for patient's interest & avoidance of conflict of interests); 2) competence; 3) honesty; 4) confidentiality; and 5) global trust.⁵ The Wake Forest Physician Trust Scale can be another scale used to assess patient trust, which encompasses the 5 domains.⁵

Importance

A trusting relationship was identified as important from the focus group participants and the scoping review of patient-centred quality indicators for measuring cultural competence.

Sources

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P4. Accessing Interpreter Services

Description of Indicator

Relationship to Quality	Medical care should be safe, patient-centred, timely, and equitable
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients that reported access to interpreter services in multiple languages across health care settings
Numerator	Total number of patients reporting receiving access to interpreter services
Denominator	Total number of patients responding to the questions assessing access to interpreter services
Benchmark	Not applicable
Risk Adjustment	Not specified at present
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence Item Set ¹

Summary

This indicator is intended to measure whether the patient reported having access to interpreter services if they needed it. This indicator is linked to S3. Culturally Competent Care

An example of a measure assessing access to interpreter’s services is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence Item Set.¹

The following questions can be asked:

1. In the last 12 months, did you use friends or family members as interpreters because there was no other interpreter available at this doctor’s office? [Yes/No]
2. In the last 12 months, how often did your visit with this doctor start late because you had to wait for the interpreter? Do not include friends or family members. [Never/Sometimes/Usually/Always]
3. In the last 12 months, was there any time when you needed an interpreter and did not get one at this doctor’s office? Do not include friends or family members. [Yes/No]

Review of Literature & Evidence

Access to trained, professional interpreter services has been linked to improving healthcare quality.² Non-english speaking patients face barriers to quality care, and report dissatisfaction

with care.¹ Care without interpreter services impacts communication, care seeking behavior, and healthcare utilization.^{1,2} The National CLAS standards (Culturally and Linguistically Appropriate Services Standards) highlight four standards under communication and language assistance, including: offering language assistance in a timely manner, informing individuals of the availability of language assistance services, and avoidance of un-trained interpreters and minors.³ These standards have been incorporated within the (CAHPS) Cultural Competence Item Set to ensure patients are able to report on their experiences with care.

Importance

From focus groups with ethno-cultural communities, language barriers were mentioned by participants as a priority for PCC.

Sources

1. Weech-Maldonado R, Carle A, Weidmer B, Hurtado M, Ngo-Metzger Q, Hays RD. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence (CC) Item Set. *Medical care*. 2012;50(9 0 2):S22.
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P5. Communication with Healthcare System

Description of Indicator

Relationship to Quality	Medical care should be safe, patient-centred, timely, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients that reported a high level of communication between patients and healthcare staff (e.g. health-line attendant, office assistants) at the time of accessing healthcare and throughout patient and family interactions with the healthcare system
Numerator	Total number of patients responding positively to the question(s) assessing communication with healthcare staff
Denominator	Total number of patients responding to the overall questions assessing communication
Benchmark	Not specified at present
Risk Adjustment	Not specified at present
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centred Medical Home ¹ /Clinician and Group Survey ² , Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ³

Summary

This indicator is intended to measure communication between patient and healthcare staff (health-lines attendant, office assistants).

The indicator can be derived from the question specific to surveys Consumer Assessment of Healthcare Providers and Systems (CAHPS; clinics and primary care)¹ and the Canadian Patient Experiences Survey — Inpatient Care (acute care)²

Examples of questions:

1. During your visit, how often did someone from the providers' clinic listen carefully to you? Would you say...[Never/Usually/Always/Don't know/Prefer Not to Answer]
2. During your visit, how often did someone from the providers' clinic explain things in a way you could understand? [Never/Usually/Always/Don't know/Prefer Not to Answer]

Review of Literature & Evidence

Communication in the medical interaction plays a central role in decisions about subsequent interventions, and can influence patient adherence, satisfaction with care, and health outcomes.⁴⁻⁶

Importance

Patients highlighted the need of appropriate and sufficient communication as a key piece in the provision of PCC.

Sources

1. Agency for Healthcare Research and Quality. About the CAHPS Patient-Centred Medical Home (PCMH) Item Set 3.0. 2015. Retrieved from: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/item-sets/PCMH/about_pcmh-item-set-cg30-2314.pdf
2. Agency for Healthcare Research and Quality. CAHPS Clinician and Group Survey. Version 3.0. 2015. Retrieved from: <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/survey3.0/adult-eng-cg30-2351a.pdf>
3. Canadian Institute for Health Information. Canadian Patient Experiences Survey-Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
4. Roter D, Hall JA. Doctors talking with patients/patients talking with doctors: improving communication in medical visits: Greenwood Publishing Group; 2006.
5. Epstein RM, Fiscella K, Lesser CS, Stange KC. Why the nation needs a policy push on patient-centered health care. *Health affairs*. 2010;29(8):1489-95.

P6. Communication between Patient and Healthcare Provider – Nurse

Description of Indicator

Relationship to Quality	Medical care should be safe, patient-centred, timely, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey – communication domain
Definition	Percentage of patients that reported a high level of communication between patient and nurses
Numerator	Total number of patients responding positively to questions assessing overall communication with nurses
Denominator	Total number of patients responding to questions assessing communication with nurses
Benchmark	Not specified at present
Risk Adjustment	Socio-demographic characteristics of patients and nurses
Data Collection Tool Example	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ¹ /Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ²

Summary

This indicator is intended to measure communication between patient and healthcare providers – nurses. Measures could also be adapted to assess communication with allied healthcare professionals.

Examples of questions that can be asked to measure this indicator:

1. During this hospital stay, how often did the nurses listen carefully to you? Would you say...
[Never/Usually/Always/Don't know/Prefer Not to Answer]
2. During this hospital stay, how often did the nurses explain things in a way you could understand?
[Never/Usually/Always/Don't know/Prefer Not to Answer]

Review of Literature & Evidence

Communication in the medical interaction plays a central role in decisions about subsequent interventions, and can influence patient adherence, satisfaction with care, and health outcomes.³⁻⁶ Beginning with cultivating communication, evidence has shown that when a patient's values, needs, and preferences are incorporated into healthcare practice, communication better enables patients to be active participants in their own care.⁷⁻¹⁵

Communication skills include listening to patients (i.e. gathering information through active listening and seeking patient's informational needs), sharing information and discussing care plans with patients, etc. When combined, these qualities facilitate PCC and enhance patient care. Techniques such as using open-ended questions to invite patients to reflect on their condition, pain, symptoms, and other areas of life that may be linked to this and eliciting the patient's reactions to the information given should be practiced to initiate and continue engaging in PCC dialogue.¹⁶

Special considerations addressing communication barriers should be taken for patients and family representatives with English as a second language.¹⁷

Importance

Patients, healthcare professionals, healthcare leaders, and other healthcare providers highlighted communication as a key piece in the provision of PCC model.

Sources

1. Hospital Consumer Assessment of Healthcare Providers and Systems. CAHPS hospital survey: Centers for Medicare & Medicaid Services, Baltimore, MD. Retrieved from: <http://www.hcahpsonline.org/home.aspx>.
2. Canadian Institute for Health Information. Canadian Patient Experiences Survey- Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
3. Weech-Maldonado R, Carle A, Weidmer B, Hurtado M, Ngo-Metzger Q, Hays RD. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence (CC) Item Set. *Medical care*. 2012;50(9 0 2):S22.
4. Santana M-J, Feeny D. Framework to assess the effects of using patient-reported outcome measures in chronic care management. *Quality of Life Research*. 2014;23(5):1505-13.
5. Roter D, Hall JA. *Doctors talking with patients/patients talking with doctors: improving communication in medical visits*: Greenwood Publishing Group; 2006.
6. Epstein RM, Fiscella K, Lesser CS, Stange KC. Why the nation needs a policy push on patient- centered health care. *Health affairs*. 2010;29(8):1489-95.
7. Teutsch C. Patient–doctor communication. *Medical Clinics of North America*. 2003;87(5):111- 45.
8. Beck RS, Daughtridge R, Sloane PD. Physician-patient communication in the primary care office: a systematic review. *The Journal of the American Board of Family Practice*. 2002;15(1):25-38.
9. Laidsaar-Powell RC, Butow P, Bu S, Charles C, Gafni A, Lam W, et al. Physician–patient– companion communication and decision-making: a systematic review of triadic medical consultations. *Patient Education and Counseling*. 2013;91(1):3-13.
10. Kim S, Brock DM, Hess BJ, Holmboe ES, Gallagher TH, Lipner RS, et al. The feasibility of a multi- format Web-based assessment of physicians' communication skills. *Patient education and counseling*. 2011;84(3):359-67.
11. Byrne PS, Long B. *Doctors talking to patients. A study of the verbal behaviour of general practitioners consulting in their surgeries*. 1976.
12. Glass RM. The patient-physician relationship: JAMA focuses on the center of medicine. *JAMA*. 1996;275(2):147-8.

13. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL. Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care. *Journal for Healthcare Quality*. 1997;19(3):43.
14. Stewart ME, Roter DE. *Communicating with medical patients*: Sage Publications, Inc; 1989.
15. Roter DL, Hall JA, Katz NR. Relations between physicians' behaviors and analogue patients' satisfaction, recall, and impressions. *Medical care*. 1987;437-51.
16. Berry LL, Seiders K, Wilder SS. Innovations in access to care: a patient-centered approach. *Annals of Internal Medicine*. 2003;139(7):568-74.
17. Ahmed S, Lee S, Shommu N, Rumana N, Turin T. Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis. *Patient Experience Journal*. 2017;4(1):122-40.

P7. Communication between Patient and Healthcare Provider - Physician

Description of Indicator

Relationship to Quality	Medical care should be safe, patient-centred, timely, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey – communication domain
Definition	Percentage of patients that reported a high level of communication between patient and physicians
Numerator	Total number of patients responding positively to the questions assessing communication with physicians
Denominator	Total number of patients responding to the questions assessing communication with physicians
Benchmark	Not specified at present
Risk Adjustment	Socio-demographic characteristics of patients and physicians
Data Collection Tool Example	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ¹ /Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ²

Summary

This indicator is intended to measure communication between patient and healthcare providers – physicians.

Examples of questions that can be asked to measure this indicator:

1. During this hospital stay, how often did the doctor listen carefully to you? Would you say...
[Never/Usually/Always/Don't know/Prefer Not to Answer]
2. During this hospital stay, how often did the doctor explain things in a way you could
[Never/Usually/Always/Don't know/Prefer Not to Answer]

Review of Literature & Evidence

Communication in the medical interaction plays a central role in decisions about subsequent interventions, and can influence patient adherence, satisfaction with care, and health outcomes.³⁻⁶ Beginning with cultivating communication, evidence has shown that when a patient's values, needs, and preferences are incorporated into healthcare practice, communication better enables patients to be active participants in their own care.⁷⁻¹⁵ Positive associations between physician communication skills have been associated with positive patient outcomes such as increased patient satisfaction, recall, understanding, and adherence to therapy.^{15,16}

Communication skills include listening to patients (i.e. gathering information through active listening and seeking patient's informational needs), sharing information and discussing care plans with patients, etc. When combined, these qualities facilitate PCC and enhance patient care. Enabling physician competency in practicing patient-centred communication through teaching has been shown to be an effective way to implement this style of communication.¹⁷ Techniques such as using open-ended questions to invite patients to reflect on their condition, pain, symptoms, and other areas of life that may be linked to this and eliciting the patient's reactions to the information given should be practiced to initiate and continue engaging in PCC dialogue.¹⁷

Special considerations addressing communication barriers should be taken for patients and family representatives with English as a second language.¹⁸ Considerations are outlined under Ahmed et al. (2017) "Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis."¹⁸

Importance

Patients, healthcare professionals, healthcare leaders, and other healthcare providers highlighted communication as a key piece in the provision of PCC model.

Sources

1. Hospital Consumer Assessment of Healthcare Providers and Systems. CAHPS hospital survey: Centers for Medicare & Medicaid Services, Baltimore, MD. Retrieved from: <http://www.hcahpsonline.org/home.aspx>.
2. Canadian Institute for Health Information. Canadian Patient Experiences Survey- Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
3. Weech-Maldonado R, Carle A, Weidmer B, Hurtado M, Ngo-Metzger Q, Hays RD. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence (CC) Item Set. *Medical care*. 2012;50(9 0 2):S22.
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11. Byrne PS, Long B. Doctors talking to patients. A study of the verbal behaviour of general practitioners consulting in their surgeries. 1976.
12. Glass RM. The patient-physician relationship: JAMA focuses on the center of medicine. *JAMA*. 1996;275(2):147-8.
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14. Stewart ME, Roter DE. *Communicating with medical patients*: Sage Publications, Inc; 1989.
15. Roter DL, Hall JA, Katz NR. Relations between physicians' behaviors and analogue patients' satisfaction, recall, and impressions. *Medical care*. 1987;437-51.
16. King A, Hoppe RB. “Best practice” for patient-centered communication: a narrative review. *Journal of graduate medical education*. 2013;5(3):385-93.
17. Berry LL, Seiders K, Wilder SS. Innovations in access to care: a patient-centered approach. *Annals of Internal Medicine*. 2003;139(7):568-74.
18. Ahmed S, Lee S, Shommu N, Rumana N, Turin T. Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis. *Patient Experience Journal*. 2017;4(1):122-40.

P8. Information about Taking Medication

Description of Indicator

Relationship to Quality	Medical care should be safe, timely, patient-centred, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients responding that the healthcare provider explained to them their medication, including the purpose, side effects, and potential changes to the treatment
Numerator	Total number of patients responding that the healthcare provider explained to them about their medication, including the purpose, side effects, and potential changes to the treatment
Denominator	Total number of patients responding to the question(s)
Benchmark	Regional, provincial/territorial, national and international levels
Risk Adjustment	Socio-demographic characteristics of patients and nurses
Data Collection Tool Example	Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ¹

Summary

This indicator is intended to measure communication related to medication information between patient and healthcare providers. The form in which medication information is shared should also be taken into consideration (e.g. written, spoken).

An example measure could be Canadian Patient Experience Survey – Inpatient Care (CPES-IC)¹ which could potentially be modified to be used across healthcare sectors:

1. Before giving you any new medicine, how often did your provider tell you what the medicine was for? [Never/Sometimes/Usually/Always]
2. Before giving you any new medicine, how often did your provider describe possible side effects in a way you could understand? [Never/Sometimes/Usually/Always]
Providers include doctors, nurses, and pharmacists.

Importance

Medication compliance is positively associated with communication of information, good provider–patient relationships and patients’ agreement with the need for treatment.² Patients

from the focus group discussions and consensus valued having adequate information about their treatment and care.

Sources

1. Canadian Institute for Health Information. Canadian Patient Experiences Survey- Inpatient Care. 2019. Retrieved from:
https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
2. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*. 201

P9. Communicating Test Results

Description of Indicator

Relationship to Quality	Medical care should be patient-centred
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients that responded that they received and understood information about their test results
Numerator	Total number of patients responding that they received and understood information about their test results
Denominator	Total number of patients responding to the question(s) about receiving and understanding information about their test results
Benchmark	Not specified at present
Risk Adjustment	Not specified at present
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey ¹ , Health Quality Council of Alberta Primary Care Patient Experience Survey ²

Summary

This indicator is intended to measure whether the patient received information about their test results.

Example question:

At last visit, when your doctor sent you for a blood test, x-ray or other test, how often did someone from your doctor's office follow-up to give the test results. [Never, Almost Never, Sometimes, Usually, Almost Always, Always]

Importance

Patients and caregivers highlighted the importance of having information about their test results as they often do not receive follow-up on test results when the results are positive in the focus group discussions and consensus. This is based on local cultural norms of “no news is good news.” This was seen to lead to increased patient and caregiver stress about test results.

Sources

1. Agency for Healthcare Research and Quality. CAHPS Clinician and Group Survey. Version 3.0. 2015. Retrieved from: <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/survey3.0/adult-eng-cg30-2351a.pdf>
2. Health Quality Council of Alberta. Primary Care Patient Experience Survey. 2018. Retrieved from: <https://www.hqca.ca/surveys/patient-experience-survey/>

P10. Coordination of Care

Description of Indicator

Relationship to Quality	Medical care should be safe, timely, patient-centred, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	Percentage of patients that reported that their care was coordinated well. Care coordination means that patient care activities and information is shared among all of the participants concerned with a patient's care, and collaborating in a shared plan of care which includes the patient and family as part of the team.
Numerator	Total number of patients responding to having received coordinated care
Denominator	Total number of patients responding to the questions assessing coordination of care
Benchmark	Regional, provincial/territorial, national and international levels
Risk Adjustment	Socio-demographic characteristics of patients and healthcare providers
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey ¹ , Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ²

Summary

This indicator is intended to measure coordination of care between healthcare providers with whom that a patient interacts with throughout their care journey.

Review of Literature & Evidence

The AHRQ definition of care coordination describes it as a process of care in which patient's needs and preferences are known ahead of time and communicated in a timely manner to their healthcare providers, and used to facilitate access to other relevant services in a timely manner.

Importance

Patients and consensus panelists identified coordination of care as a key element to PCC.

Sources

1. Agency for Healthcare Research and Quality. CAHPS Clinician and Group Survey. Version 3.0. 2015. Retrieved from: <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/survey3.0/adult-eng-cg30-2351a.pdf>
2. Canadian Institute for Health Information. Canadian Patient Experiences Survey-Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf.

P11. Patient and Caregiver Involvement in Decisions about Their Care and Treatment

Description of Indicator

Relationship to Quality	Medical care should be patient-centred, safe and efficient
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Survey
Definition	The percentage of patients/caregivers that reported their healthcare provider involved them as much as they wanted in decisions about their care and treatment
Numerator	Number of survey respondents who reported that their healthcare provider involved them as much as they wanted in decisions about their care and treatment
Denominator	Number of respondents who answered the survey question(s) on involvement in decisions about their care and treatment
Benchmark	Not specified at present
Risk Adjustment	Not specified at present
Data Collection Tool Example	Health Quality Ontario Priority Indicators for Patient Experiences (pg. 22) ¹ , Primary Care Patient Experience Survey (PCPES) ² , Commonwealth Fund Survey ³ , Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ⁴ , Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey ⁵

Summary

This indicator is intended to measure whether the patient and/or caregiver received the information needed about conditions and treatment, and whether or not healthcare providers responded to patient and caregiver needs; discussed treatment or interventions with possible outcomes and adverse events/side-effects; discussed while building capacity of patients for self-management and self-care; acknowledged and discussed uncertainties; and created a shared understanding. In general, this indicator can be derived from the question included in the Health Quality Ontario Priority Indicators for Patient Experiences¹/Primary Care Patient Experience Survey (PCPES)²:

When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment?

The data source for international and provincial comparisons is Commonwealth Fund International Health Policy Survey of Adults:

When you need care or treatment, how often does your regular doctor or medical staff you see involve you as much as you want to be in decisions about your care and treatment?

At hospital level, this indicator is derived from Canadian Patient Experience Survey – Inpatient Care (CPES-IC)⁴ – using these two questions:

1. Were you involved as much as you wanted to be in decisions about your care and treatment? [Never/Sometimes/Usually/Always]
2. Were your family or friends involved as much as you wanted in decisions about your care and treatment? [Never/Sometimes/Usually/Always/I did not want them to be involved/I did not have family or friends to be involved]

Questions can also be derived from the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey (CG-CAHPS)⁵ “Making Decisions About Your Care” section:

1. At your last visit, did your doctor recommend a treatment for a health problem that was bothering you? [Yes/No]
2. At your last visit, did your doctor ever say there was more than one treatment option to consider for your care? [Yes/No]
3. At your last visit, when there was more than one treatment to consider, did your doctor give you enough information about each option? [Yes/No]
4. At your last visit, when there was more than one treatment to consider, did your doctor ask which treatment option you preferred? [Yes/No]

Importance

Patients, healthcare professionals, healthcare leaders, and other healthcare providers highlighted involvement in decisions about treatment and care as a key piece in the provision of PCC model.

Sources

1. Health Quality Ontario. Indicator Technical Specifications: Quality Improvement Plan 2016/2017. 2015. Retrieved from: <http://www.hqontario.ca/portals/0/Documents/qi/qip-indicator-specifications-1511-en.pdf>
2. Health Quality Ontario. Quality Improvement. 2019. Retrieved from: <https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/quality-improvement-in-primary-care>
3. Canadian Institute for Health Information. Commonwealth Fund Survey 2016. 2016. Retrieved from: <https://www.cihi.ca/en/commonwealth-fund-survey-2016>
4. Canadian Institute for Health Information. Canadian Patient Experiences Survey-Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
5. Agency for Healthcare Research and Quality. CAHPS Clinician and Group Survey. Version 3.0. 2015. Retrieved from: <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/survey3.0/adult-eng-cg30-2351a.pdf>

P12. Engaging Patients in Managing their Own Health

Description of Indicator

Relationship to Quality	Medical care should be safe, effective and efficient
Type of Indicator	Healthcare System Process, Individual Level
Proposed Data Source	Survey
Definition	Percentage of patients and caregivers that report being engaged in self-managing their condition, which includes: 1. Shared decision-making; 2. Goal-setting; 3. Supporting self-care management; and 4. Care plans being accessible to patients/caregivers/healthcare providers
Numerator	Total number of patients and caregivers that responded positively to being engaged in self-management
Denominator	Total number of patients and caregivers that responded to the question(s) assessing engagement of self-management
Benchmark	Not applicable
Risk Adjustment	Socio-demographic characteristics of patients and healthcare providers
Data Collection Tool Example	Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS; Brownson et al. 2007) ¹ , Assessment of Chronic Illness in Care (ACIC; Bonomi et al. 2002) ² ; Patient Assessment of Chronic Illness Care (PACIC; Glasgow et al. 2005) ³

Summary

This indicator is intended to describe how patients and caregivers are engaged in managing their health. Communication between patients, family representatives and healthcare providers is the foundation for engagement, and this includes co-designing care. This indicator has the following sub-domains:

- 1) Shared decision-making;
- 2) Goal-setting;
- 3) Supporting self-care management;
- 4) Care plans being able to be accessed by patients and healthcare providers.

The measure is the final overall score of these four sub-domains.

Review of Literature & Evidence

Engagement of patients in self-management is important, as it effectively influences both the overall healthcare experience, and improves healthcare provision^{4,5} allowing both patients and care providers to feel respected, listened to, and empowered. When providers are engaged with their patients, they are less likely to make mistakes.^{6,7} Engagement includes co-designing care plans, which includes aspects of shared decision making, goal-setting and support, all of which

assist clinical management and contribute to better health outcomes, improved quality of care,^{5,6} and improved patient safety.⁸

Importance

In the focus groups, interviews, and during the consensus process, patients, healthcare professionals, healthcare leaders, and other healthcare providers highlighted engaging patients and families in their care as a safe and effective way to support care, especially in chronically ill patients.

Sources

1. Brownson CA, Miller D, Crespo R, Neuner S, Thompson J, Wall JC, Emont S, Fazzone P, Fisher EB, Glasgow RE. A quality improvement tool to assess self-management support in primary care. *The Joint Commission Journal on Quality and Patient Safety*. 2007 Jul 1;33(7):408-16. Survey retrieved from: http://www.diabetesinitiative.org/support/documents/PCRS2008_October2013.pdf
2. Bonomi AE, Wagner EH, Glasgow RE, VonKorff M. Assessment of chronic illness care (ACIC): a practical tool to measure quality improvement. *Health services research*. 2002 Jun;37(3):791-820. Survey retrieved from: http://www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35
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5. Boivin A, Currie K, Fervers B, et al. Patient and public involvement in clinical guidelines: international experiences and future perspectives. *Qual Safety in Health Care* 2010;19:1-4.
6. Shiparski LA. Engaging in shared decision making: Leveraging staff and management expertise. *Nurse Lead* 2005;3:36-41.
7. Prins MA, Verhaak PF, Smolders M, et al. Patient factors associated with guideline-concordant treatment of anxiety and depression in primary care. *J Gen Intern Med* 2010;25:648-55.
8. The King's Fund (UK). *Leadership and engagement for improvement in the NHS* [Internet]. The King's Fund Leadership Review (UK); 2012 [cited 2016 Oct 15]. Available from: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf
9. Coulter A. Patient engagement—what works? *J Ambul Care Manage* 2012;35:80-9.
10. Coulter. Effectiveness of strategies for informing, educating, and involving patients. *BMJ* 2007;335:24.

P13. Timely Access to a Primary Care Provider

Description of Indicator

Relationship to Quality	Medical care should be timely, safe, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Surveys
Definition	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed
Numerator	The number of respondents who answered "same day" and "next day" in response to the following patient and client survey question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually saw him/her or someone else in their office?"
Denominator	The number of respondents who registered an answer of the following patient and client survey question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually saw him/her or someone else in their office?"
Benchmark	Not specified at present
Risk Adjustment	None
Data Collection Tool Example	Health Quality Ontario Priority Indicators for Patient Experiences (pg. 21-22) ¹ , Health Quality Ontario Quality Improvement Plans ²

Summary

The present quality indicator is derived from Health Quality Ontario Quality Improvement Plans:

The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually saw him/her or someone else in their office in person or via telephone/video?

- Same day
- Next day
- 2 - 19 days (enter number of days: _____)
- 20 or more days
- Not applicable (don't know/refused).

Importance

Patients, healthcare professionals, healthcare leaders, and other healthcare providers highlighted timely access to care as a safe and effective way to optimize health and healthcare services utilization, especially in chronically ill patients.

Sources

1. Health Quality Ontario. Indicator Technical Specifications: Quality Improvement Plan 2016/2017. 2015. Retrieved from: <http://www.hqontario.ca/portals/0/Documents/qi/qip-indicator-specifications-1511-en.pdf>
2. Health Quality Ontario. Quality Improvement. 2019. Retrieved from: <https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/quality-improvement-in-primary-care>

P14. Patient Preparation for a Care Plan at a Healthcare Facility

Description of Indicator

Relationship to Quality	Medical care should be timely, safe, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Surveys
Definition	This indicator measures the percentage of patients reporting that they had enough information about their care and treatment when admitted into a healthcare facility (homecare, hospital, mental health institution)
Numerator	Number of patients reporting that they had enough information about their care and treatment when admitted into a healthcare facility
Denominator	Number of patients admitted into the healthcare facility
Benchmark	Regional, provincial/territorial, national and international levels
Risk Adjustment	None
Data Collection Tool Example	Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ¹

Summary

This indicator is describing one of the transition phases across healthcare sectors. It is derived and modified from one question of the Canadian Patient Experience Survey – Inpatient Care (CPES-IC)¹:

Before coming to the healthcare facility, did you have enough information about what was going to happen during the admission process?" [Not at all/Partly/Quite a bit/Completely].

Review of Literature & Evidence

This indicator was described by Canadian Institute for Health Information as one of the measures that could *'inform quality improvement and program planning at the hospital and community levels.'*²

Importance

Patients, healthcare professionals, healthcare leaders, and other healthcare providers highlighted the importance of transitions and continuity of care across different healthcare settings during the focus groups with patients. This importance is reinforced by Accreditation Canada.³

Sources

1. Canadian Institute for Health Information. Canadian Patient Experiences Survey-Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
2. Canadian Institute for Health Information. Canadian Preliminary Core Patient-Reported Experience Measures: Summary and Technical Notes. 2015. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_reported_experience_measure_technotes_enweb.pdf
3. Accreditation Canada. Safety in Canadian Health Care Organizations: A Focus on Transitions in Care and Required Organizational Practices. 2013.

P15. Transition Planning

Description of Indicator

Relationship to Quality	Medical care should be timely, safe, efficient and effective
Type of Indicator	Healthcare System Process Level
Proposed Data Sources	Surveys
Definition	Percentage of patients that reported receiving information and discussing their needs to manage their condition in preparation for care transition across care sectors
Numerator	Number of patients that reported receiving information and discussing their needs to manage their condition in preparation for care transition across care sectors
Denominator	Total number of patients completing the survey
Benchmark	Regional, provincial/territorial, national
Risk Adjustment	Not available
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey ¹ , Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ² , Health Quality Ontario Quality Improvement Plans ³

Summary

This indicator is intended to monitor processes to support patients and their families as they transition across care sectors. Most measures available focus on transitions from acute to community care. The following questions are examples:

1. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? [Yes/No]
2. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? [Yes/No]
3. Before you left the hospital, did you have a clear understanding about all of your prescribed medications, including those you were taking before your hospital stay? [Not at all/Partly/Quite a bit/Completely/Not applicable]
4. Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? [Not at all/Partly/Quite a bit/Completely]

5. When you left the hospital, did you have a better understanding of your condition than when you entered? [Not at all/ Partly/Quite a bit/Completely]

This indicator could also assess timely follow up with healthcare staff and discharge summaries provided, using indicators from the Health Quality Ontario Quality Improvement Plans.³

Importance

Discharge planning is essential to facilitate the care needs of patients and may help to reduce patients' length of stay and readmission rates.^{4,5} Patients, healthcare professionals, healthcare leaders, and other healthcare providers highlighted the importance of timely follow up to ensure patient safety and communication.

Sources

1. Hospital Consumer Assessment of Healthcare Providers and Systems. CAHPS hospital survey: Centers for Medicare & Medicaid Services, Baltimore, MD. Retrieved from: <http://www.hcahpsonline.org/home.aspx>.
2. Canadian Institute for Health Information. Canadian Patient Experiences Survey- Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
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4. Shepperd S, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL. Discharge planning from hospital to home. The Cochrane Database of Systematic Reviews. 2013. 15.
5. Joseph-Williams N, Elwyn G, Edwards A. Knowledge is not power for patients: a systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making. Patient Education and Counseling. 2014.

P16. Using Patient-reported Outcome Measures (PROMs) to Deliver Patient-centred Care

Description of Indicator

Relationship to Quality	Medical care should be safe, effective, patient-centred and efficient
Type of Indicator	Healthcare System, Process and Organization Level
Proposed Data Sources	Surveys – generic patient-reported measures
Definition	Percentage of clinics/hospitals/health centres using PROMs in healthcare decision making including point of care management and policy
Numerator	Number of clinics/hospitals/health centres in a jurisdiction using PROMs in clinical care
Denominator	Total number of clinics/hospitals/health centres in a jurisdiction
Benchmark	National, provincial, jurisdictional
Risk Adjustment	Not available

Summary

Patient-reported outcome measures, PROMs, are tools that support the delivery of PCC. When PROMs are used in routine clinical care, there are improvements in patient-provider communication, engagement, shared decision-making, clinical management and patient outcomes.¹⁻⁷ PROMs are concerned with the outcomes of a patient's health condition or disability; including measures of symptom burden that report the frequency, severity, and impact of symptoms.¹⁻⁷

This indicator assesses whether or not clinics/hospitals/health centres use PROMs in clinical care to support the management of patients and improve health outcomes.

Review of Literature & Evidence

PROMs measure the effectiveness of PCC. Evidence has shown that when PROMs are integrated in routine clinical care, patient outcomes including survival¹ and quality of life improve.²⁻⁷ For instance, for individuals living with a chronic illness, the integration of PROMs provides vital and often missing information that the healthcare team can use to support patient care while promoting self-management and decision-making.²⁻⁷

Importance

This indicator was developed through the consensus process. A working group comprised of panelists (three researchers, two patient/caregivers) was formed to develop the indicator and propose it to the consensus panel for rating.

Sources

1. Santana MJ & Feeny DH. Framework to assess the effects of using patient-reported outcome measures in chronic care management. *Quality Life Research*. 2013; 9(3): 371–379.
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5. Santana MJ, Feeny D, Johnson JA et al. Assessing the use of health-related quality of life measures in the routine clinical care of lung-transplant patients. *Quality Life Research*. 2010: 19, 371–379.
6. Snyder CF, Aaronson NK, Choucair AK, et al. Implementing patient-reported outcomes assessment in clinical practice: A review of the options and considerations. *Quality Life Research*. 2012: 21, 1305–1314.
7. Basch E. Patient-Reported Outcomes — Harnessing Patients’ Voices to Improve Clinical Care. *New England Journal Medicine*. 2017; 376:105-108. DOI: 10.1056/NEJMp1611252

PCC Outcome Indicators

PCC Outcome Indicators are designed to measure the quality of care associated with the delivery of PCC. The indicators are intended to examine select domains of PCC and be applicable across healthcare sectors, specialties, conditions and geographical areas.

O1. Overall Experience

Description of Indicator

Relationship to Quality	Medical care should be timely, safe, efficient and effective
Type of Indicator	Healthcare System Outcome Level
Proposed Data Sources	Surveys
Definition	Percentage of patients reporting their overall experience within the facility
Numerator	Number of patients rating their overall experience within the facility as “Very good” (top box)
Denominator	Total number of patients rating the hospital their overall experience within the facility
Benchmark	Regional, provincial/territorial, national
Risk Adjustment	Not available
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey ¹ , Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ² , Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey (CG-CAHPS) ³

Summary

This indicator measures the overall experience their overall experience within the facility.

Question:

Overall... where 0 is “I had a very poor experience,” and 10 is “I had a very good experience)

Importance

Agreed by the consensus panel to that it would be beneficial to keep an overall rating PC-QI for reporting.

Sources:

1. Hospital Consumer Assessment of Healthcare Providers and Systems. CAHPS hospital survey: Centers for Medicare & Medicaid Services, Baltimore, MD. Retrieved from: <http://www.hcahpsonline.org/home.aspx>.
2. Canadian Institute for Health Information. Canadian Patient Experiences Survey- Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
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O2. Cost of Care – Affordability

Description of Indicator

Relationship to Quality	Medical care should be affordable to patients
Type of Indicator	Healthcare System Outcome Level
Proposed Data Sources	Surveys – affordability Affordability cost = individual mean healthcare cost/household income
Definition	Percentage of patients reporting that they can afford the cost of their healthcare treatment (e.g. medications, treatment program, equipment)
Numerator	Number of patients reporting that they can afford the cost of their healthcare treatment
Denominator	Total number of patients reporting the cost of their healthcare treatment
Benchmark	Not available
Risk Adjustment	Not available
Data Collection Tool Example	To be developed

Summary

This indicator measures whether or not the cost of care is affordable to individuals and their families. This A question could be asked to patients yearly. This question could be part of the Canadian Patient Experience Reporting System. Data collected on affordable care could be used to adjust and inform local and national budgets, identify inequality gaps, compare jurisdictions across Canada – who is doing better? Why?

Review of Literature & Evidence

The lack of healthcare service affordability can have a negative impact on patients and families. For instance, ambulance and emergency care, and pharmaceutical costs can hinder access to care, which has implications for patient safety. A PCC model acknowledges the structures that may result in financial barriers, as well as other determinants of health care access.¹ Addressing issues related to costs of care can help patients secure appropriate and preferred healthcare at the right time to promote improved health outcomes while reducing costs to the healthcare system.²

Importance

In the focus group discussions, patients and caregivers identified affordability of care as one of the top barriers to PCC and one of the main priorities to address. In interviews with clinician scientists and quality improvement leads, some noted the importance of addressing the social

determinants of health, including cost barriers. This was also deemed an important aspect of PCC by some consensus panelists, particularly from the patient/caregiver perspective.

Sources

1. Levesque JF, Harris MF, Russel G. Patient-centred access to health care: conceptualizing access at the interface of health systems and populations. *Int J Equity Health*. 2013; 12:18.
2. Andersen RM., Davidson PL, Baumeister SE. "Improving access to care." *Changing the US health care system: Key issues in health services policy and management*. 2013: 33-69.

Global Indicators

The Global Quality Indicators are designed to measure the overall quality of care provided to patients. The indicators are intended to examine global experience with care.

G1. Global Indicator – Friends and Family Test

Description of Indicator

Relationship to Quality	Medical care should be timely, safe, efficient and effective
Type of Indicator	Healthcare System Outcome Level
Proposed Data Sources	Surveys
Definition	Percentage of patients reporting recommending the hospital/health facility to friends and family
Numerator	Number of patients answering ‘Definitely yes’ when asked if they would recommend the hospital/health facility to friends and family
Denominator	Number of patients answering the question asking if they would recommend the hospital/health facility to friends and family
Benchmark	Regional, provincial/territorial, national
Risk Adjustment	Not specified at present
Data Collection Tool Example	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey ¹ , Canadian Patient Experience Survey – Inpatient Care (CPES-IC) ² at hospital level, National Health Service Friends and Family Test (FFT) ³

Summary

This indicator is a global indicator of overall experience with care. How did the patient’s overall experience reflect how PCC was delivered?

Question:

Would you recommend this hospital/health facility to your friends and family? [Definitely no/Probably no/Probably yes/Definitely yes]

Health facility includes out-patient clinics, general family clinic and any community-based care including specialty care.

Importance

Agreed by the consensus panel to that it would be beneficial to keep an overall global PC-QI for reporting purposes.

Sources

1. Hospital Consumer Assessment of Healthcare Providers and Systems. CAHPS hospital survey: Centers for Medicare & Medicaid Services, Baltimore, MD. Retrieved from: <http://www.hcahpsonline.org/home.aspx>.
2. Canadian Institute for Health Information. Canadian Patient Experiences Survey- Inpatient Care. 2019. Retrieved from: https://www.cihi.ca/sites/default/files/document/patient_expsurvey_inpatient_en.pdf
3. National Health Service. Friends and Family Test (FFT). 2013. Retrieved from: <https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/>

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