

**Discussion Paper**  
**Person-Centered Care and the eConsultBASE™ Service**

**June, 2021**

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*The principles of Person-Centered Care empower individuals and caregivers to participate in the design, implementation and evaluation of eConsultBASE™ Service's strategies to ensure they are grounded in individual and community healthcare values, goals and preferences. The Service provides timely and equitable access to health information to help individuals make informed choices about their preventative and responsive care in partnership with their primary care providers, supported by healthcare specialists, and linked to coordinated, continuing care options in the community. An improved person-centered care experience through better coordinated team-based healthcare leads to better outcomes and improved clinical and personal experiences, while also lowering costs. Evaluation is an important aspect of recognizing what's working and what's not working. This is accomplished through the application of measures of the Quadruple Aim Framework and a robust qualitative research agenda to ensure individuals and caregivers, and their professional care providers have an incremental positive impact on the quality of healthcare delivery.*

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## Section 1: Introduction and Purpose

This discussion paper is the result of a brief review of policies, programs and practices that place person-centered care at the forefront of the delivery of healthcare. There are multiple sources of thinking that have been referenced for definitions, principles and implementation scenarios about the application of *person-centered care (often called patient-centered care)*.

The core content of this paper is based solely on the review by the author, conducted in mid 2020, that was supplemented by advice provided by colleagues at the Bruyère Research Institute in Ottawa, Ontario; comments provided a group of eConsultBASE™ Service Patient Partners and discussions at the eConsultBASE™ Service Long-Term Care Advisory and Steering Committees. (See Annex A – Afterward on the Impact of the Discussion Paper).

The document is aligned with the author's thinking about the importance of involving persons<sup>1</sup> and caregivers in a high-quality health care delivery system that continuously focuses on improving the *healthcare experience*.

In this context, the paper suggests strategies and associated initiatives that the eConsultBASE™ Service has and will continue to consider as part of its contribution to high quality care for persons, supported by their caregivers, through primary care provider-to-specialist consultation. The examples, comments and recommendations are presented to focus discussions on the eConsultBASE™ Service's commitment to person-centered care, as part of its contribution to high quality health care service delivery.

The paper is intended to provide a template for future discussions that support person-centered care in the spread and scale-up initiatives undertaken by the eConsultBASE™ Service.

1 The term 'person' includes individuals and patients living and receiving care in the community and residents in long-term care.

## Section 2: Understanding Person-Centered Care

As a reference for discussion, a composite definition of person-centered care, from multiple sources, was created:

*Person-Centered Care puts individuals at the forefront of their personal and health care by being respectful of and responsible to their values, goals and preferences that guide healthcare in promoting continuous wellness and equity while treating acute and chronic illness through coordinated, continuing care by multi-disciplinary teams. It allows persons and caregivers, to move freely along care pathways using relationships with primary care and other healthcare providers, healthcare delivery institutions and community services and long-term care when required at critical milestones in their care journey. High quality care is sustained by the exchange of clear information, support for self-managed care and the collection of results and performance information.*

The following examples provide an overview of established frameworks and selected initiatives related to person-centered care in healthcare service delivery. This section describes the principles and practices of person-centered care and caregiver partnership and engagement with healthcare professionals and service deliverers.

### **Principles and Practices of Person-Centered Care**

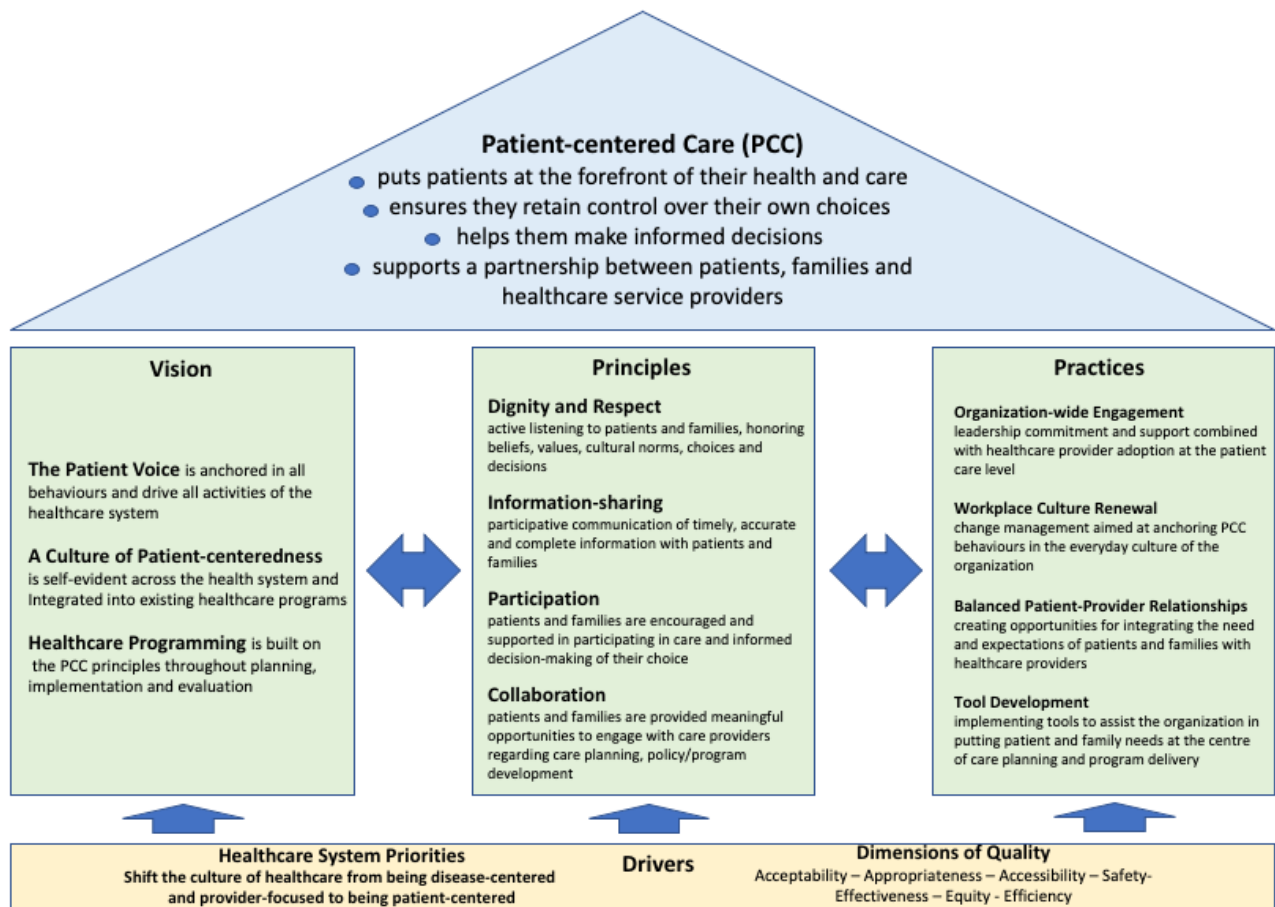
The Picker Institute defines principles of person-centered care, which were developed through research starting in 1987. These principles “continue to be used as an inter-nationally recognized framework to support the delivery of consistent, high-quality care” [1] and are:

- Effective treatment delivered by trusted professionals;
- Continuity of care and smooth transitions;
- Involvement and support for family carers;
- Clear information, communication, and support for self-care;
- Involvement in decisions and respect for preferences;
- Emotional support, empathy and respect;
- Attention to physical and environmental needs.

Further to the principles defined above, the Province of British Columbia defined principles and practices of patient/person-centered care. As part of its strategic planning, the Province placed person-centered care at the forefront of its healthcare service delivery system to ensure individuals had control over their own healthcare choices by assisting them and their caregivers in making informed decisions as part of the approach to *team-based healthcare*.

Their 2014 Strategic Plan [2] introduced a Vision that supported the patient voice and a culture of person-centeredness principles related to health care programming and focused on two change initiatives: 1) healthcare system priorities that would focus on shifting the culture of health care from being totally disease-centered to being inclusive of all elements of patient need, and 2) the following dimensions of quality would characterize proposed changes – acceptability, appropriateness, accessibility, safety, effectiveness, equity and efficiency.

The province would deliver healthcare as a service built around the individual, not the provider and government administration. It would define policies, practices, service delivery and accountability, program design and training around this vision. Person-centered care would be at the forefront of their healthcare service delivery system; ensure individuals had control over their own choices; assist patients in making informed decisions, and support partnerships among patients, their caregivers and health care service providers. Person-centered care incorporated the following key components: self-management, shared and informed decision-making, an enhanced experience of healthcare; improved information and understanding, and the advancement of prevention and health promotion activities.



The following core principles were identified to support these components:

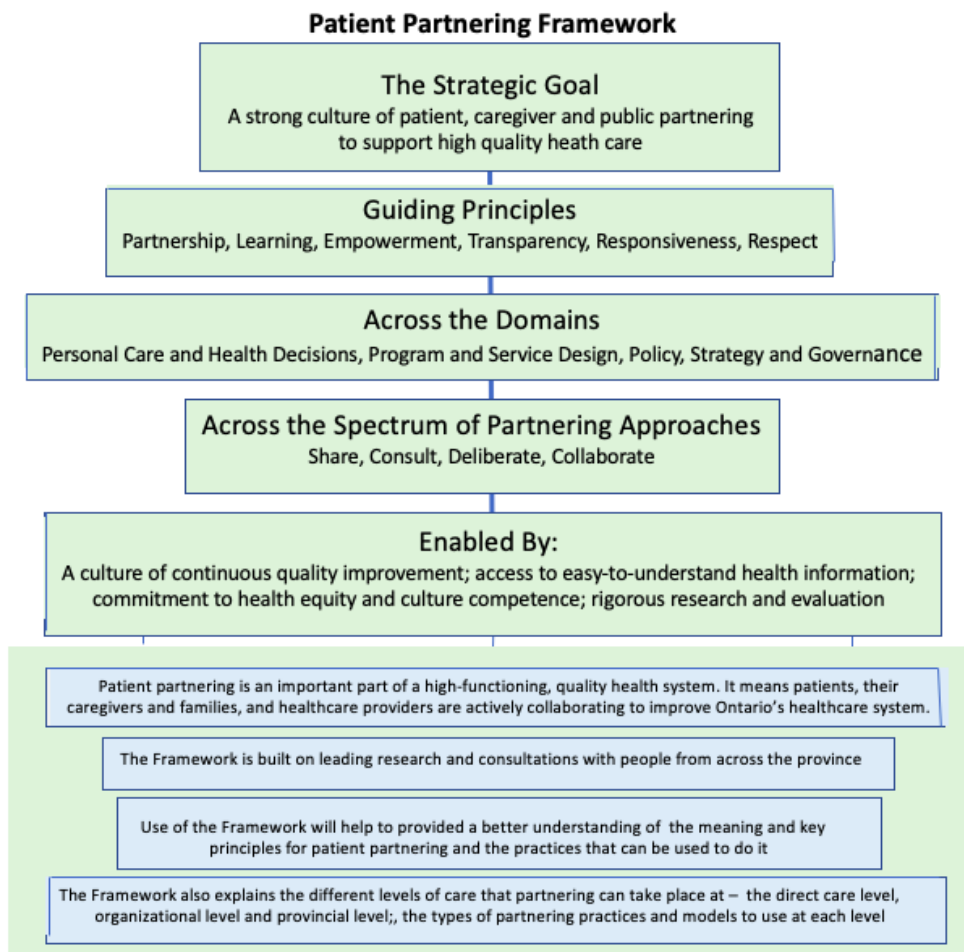
- **dignity and respect** by supporting active listening to patients and their families and honoring their choices and decisions;
- **information-sharing** through participative communication of timely, accurate and complete information with patients and their families on what decisions would be taken by validating what they heard and understood;
- **participation** of patients and their families in care through informed decision- making at a level at which they would feel comfortable with their choices, and
- **collaboration** through meaningful opportunities to engage with care providers and leaders in a continuum of quality improvement, policy and program development, implementation and evaluation.

The following practices were identified to support the vision and these principles:

- **engagement** demonstrated by the support by healthcare providers for person-centered care at the patient level;
- **cultural renewal through a shift** in thinking from a ‘medical model’ of care (providing information, guidance and expert decision-making) to a model of care where the patient would be a partner in making care decisions; healthcare providers would receive education and clinical support opportunities to ensure person-centered activities became part of their day-to-day work;
- **balance in the patient-provider relationship** would recognize the patient’s understanding of the pressures on healthcare providers’ timely care, and
- **person-centered tool development** would focus support on planning, delivering and evaluating healthcare programs and services with the voice of the patient at the center.

**Principles and Practices of Patient/Caregiver Partnership**

The *Patient Partnering Framework*, developed by Health Quality Ontario [3], is an important part of a high-functioning quality health system involving patients, caregivers, advisors and healthcare providers in active collaboration to improve the healthcare system. The elements of the Framework support the understanding of the meaning of key principles and practices that explain the different levels of care that



partnering can take place at, and the types of partnering practices and models to use at each level. The focus is on building deeper, longer-term relationships among participants that lead to improved healthcare quality. Within the Framework, effective partnering requires proactive engagement by patients, advisors, partners and caregivers (PAPC's) in continuous learning to achieve meaningful coordination.

The three domains of the Framework define where patients and caregivers can be meaningfully engaged to improve quality health care.

**Personal Care and Health Decisions** suggest healthcare professionals partner with patients and their caregivers in processes of shared decision-making and care. **Program and Service Design** suggests health organizations initiate engagement activities that invite patient and caregiver input for purposes of improving specific health programs, services or other organization-wide projects such as quality and safety improvement initiatives. **Policy, Strategy and Governance** suggest health organizations and government partnering with patients and caregivers to identify and help bring into creation, more accountable health priorities, policies and governance models. Effective engagement requires PAPC's, inter alia, to maintain an awareness of:

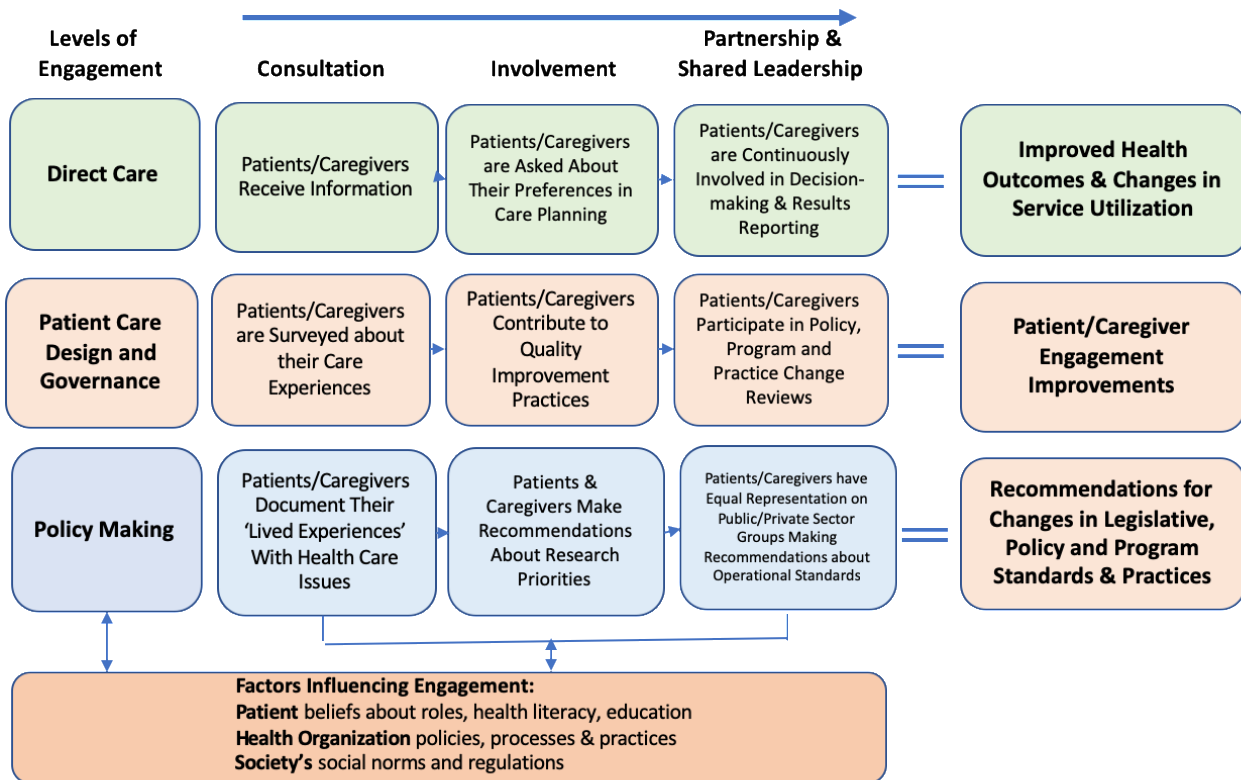
- (1) the connection to legislative initiatives that are in play at the provincial, regional and community levels; contributors to the health care services continuum in each of these areas who bring a unique set of insights that impact on the evolution of infrastructures, processes, policies, programs and practices; person-centered care initiatives that remain connected to the legislative, policy and program priorities of the national and provincial governments and impact on PAPCs' ongoing participation in care;
- (2) transitions in care across healthcare services that can impact on person-centered care implementation; PAPC's can act as important 'go-betweens' by providing insights on the best ways of engaging patients in each of the key phases/elements of care in the healthcare delivery system, i.e. home, community institutions and long- term care, supported by hospital and community services; and
- (3) available education and training that can provide team learning opportunities, particularly those that bring together PAPC's in initiatives that focus on the identification of healthcare innovations, i.e. medical, administrative and data technology.

### ***The Continuum of Person/Caregiver Engagement***

The National Academy of Medicine [4] defined a model of 'a continuum of engagement' that describes the forms that patient engagement can take, from consultation to partnership and shared leadership which includes decision-making authority. It examined the levels at which patient engagement can occur throughout the healthcare system, in direct care, organizational design and governance and policy making.



## A Continuum of Engagement of Patients/Caregivers



Source: Presentation by M. Weir & C. Lindsay at Workshop  
 On Advancing Frailty Care in the Community, February 19<sup>th</sup> & 20<sup>th</sup>

Basis: Adapted from the National Academy of Medicine, Washington, D.C., *Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care*, January 2017

Patient engagement can be characterized by how much information flows between patients and their caregivers and providers, how active a role the patient has in care decisions and how involved the patient becomes in health decisions and policy making.

At the level of **Direct Care**, engagement integrates patient values, experiences and perspectives related to prevention, diagnosis and treatment, including managing a patient's health and selecting healthcare coverage and providers. It involves interaction with primary care providers. Patient engagement at this level ranges from a patient simply receiving information to being an active partner in the care team, setting goals, making decisions and proactively managing individual health needs. Patients communicate with primary care providers about their health status to understand the risks and benefits associated with care choices, to ask questions, and to access and help create their medical records. Primary care providers give patients timely, complete and understandable information; elicit patient values, beliefs and risk tolerance regarding care choices; give patients encouragement and support; and involve family and friends according to the patient's wishes.

Patient values, experiences and perspectives, as part of **Patient Care Design and Governance** can be integrated into the design and governance of health care organizations. Patients and their caregivers can participate as partners in the development of quality improvement projects and serve on advisory groups. Some patients can engage in local health **Policy, Program and Practice** development by collaborating with community leaders and policy makers and participating in health and clinical research.

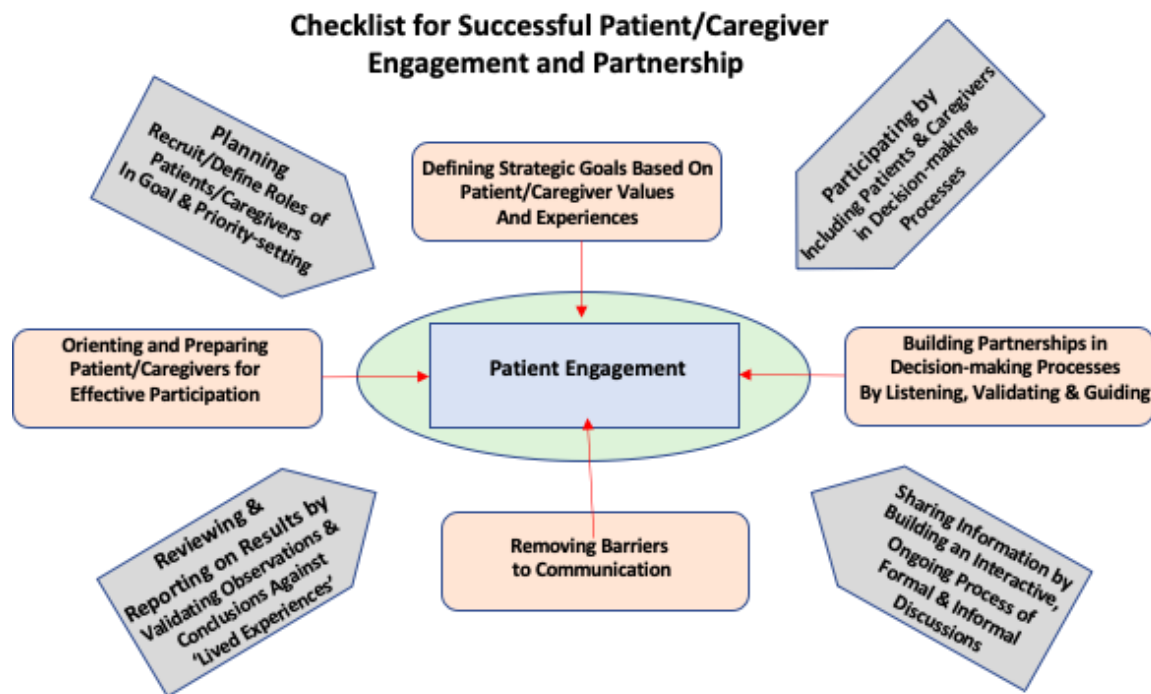
Individual **Factors Influencing Engagement** can affect patient (and caregiver) motivation, willingness and ability to engage within and across different levels of awareness that can include knowledge research to create an understanding of attitudes and beliefs about the patient role, experience, the healthcare system, self-efficacy and functional capacity, such as health literacy, health status and functioning.

The health organization can encourage a patient to engage by demonstrating that patient participation and leadership are central to the achievement of improvement goals and by responding positively to patient efforts. There is a requirement to recognize that patients and organizations operate within a broader social and political environment and are influenced by social norms and national, provincial and local policies, programs and practices.

In summary, a continuum of engagement:

- can help characterize the extent to which patients and their caregivers are involved in decision-making
- can underscore the possibility that a greater impact can be achieved by implementing interventions across multiple levels of engagement, and
- can identify factors that can influence patient engagement such as knowledge and motivation.

An integrated checklist of considerations that can be used to ‘benchmark’ the involvement of patients and caregivers in the health care service delivery continuum was suggested by M. Weir and C. Lindsay at the February 2020 Canadian Foundation for Healthcare Improvement and *Canadian Frailty Network’s Advancing Frailty Care in the Community Collaborative Workshop* (Toronto, ON, February 2020) [5].



The framework includes engagement outcomes resulting from patient and family caregivers’ involvement in meaningful and continual decision-making at all levels – personal at the point of care, organizational with regard to quality improvement, and at the macro-level to guide policy development.

Better engagement can occur through a **culture** that recognizes the delivery of compassionate and effective care that cannot be separated from the job experience of those delivering that care and their relationship with patient and family caregivers; **care** that refers to the sharing of emerging knowledge that supports shared decision-making and processes for eliciting patient and family caregiver goals that are planned, delivered, managed and continuously improved to support partnerships that integrate their preferences, values and desired health outcomes; **health** that demonstrates high quality delivery; **indicators** that yield better results as measured by shared decision-making interventions, care management support and training; **tailored education** that accommodates patient health literacy levels; and **lower costs** that are based on more appropriate spending and utilization for patients and family caregivers, health care organizations and payers.

### ***Applying Person-Centered Care in a Change Initiative: The Province of Ontario Experience***

The Province of Ontario defined the need to design and deliver person-centered healthcare services. The second report from the Ontario Premier’s Council on *Improving Healthcare and Ending Hallway Medicine* [6] embraced the Quadruple Aim Framework in designing and delivering an effective healthcare system and its four objectives [7]:

- improving the patient and caregiver experience;
- improving the health of populations;
- reducing the per capita cost of healthcare, and
- improving the work life of providers.

This report noted that effective, integrated quality healthcare puts patients (and their caregivers) at the center of the healthcare system. The province identified the impact of sustainable change on the patient and caregiver experience:

*‘patients have access to their own personal health information and are making healthy choices by accessing preventive services in the community after talking with their primary care provider, supported by healthcare professionals, about their health needs; they are confident that they are receiving ‘wrap-around care’ that will keep them out of hospital; patients and their caregivers have access to a comprehensive care plan linked to appropriate and flexible community services to support transitions between hospital and home or community service.’*

The aim is to support patients and providers at every step of the healthcare delivery journey by ensuring effective primary care is the foundation of an integrated healthcare system by:

- working with healthcare professionals to ensure all patients – especially those with complex needs – are well-connected to a comprehensive range of health services in the community;
- working with primary care providers to ensure they have information sharing and referral tools to link with all appropriate community providers, enabling seamless transitions for patients;
- ensuring Ontario Health Teams facilitate clinician leadership and support strong and meaningful partnerships with the primary care sector.

The role and involvement of caregivers as valuable contributors to the healthcare team will be supported and respected. Caregivers will be connected to learn and share best practices.

As part of the proposed approach to moving Ontario Health Teams from Readiness to Maturity, three criteria were identified [8].

	Readiness	Expectations at Year 1	Expectation at Maturing
<b>Patient Care and Experience</b>	Plans are in place to improve access, transitions and coordination. Key features of integration, patient-self-management and health literacy and digital access to health information are identified. Existing capacity to coordinate care is assessed. Commitment to measure and improve the patient experience and offer 24/7 coordination and navigation services and virtual care is defined.	Care has been redesigned. Access, transitions and coordination and integration have been improved. 24/7 coordination and navigation services, self-management plans, health literacy supports and public information about the Team's services are in place. Expanded virtual care offerings and availability of digital access to health information is in place	Teams will offer patients, families and caregivers the highest quality care and best experience possible. 24/7 coordination and system navigation services will be available to patients who need them. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions will be seamless.
<b>Patient Partnership and Community Engagement</b>	Demonstrate history of meaningful patient, family and caregiver engagement. Plan in place to include governance structure(s) and put in place patient/family/caregiver leadership. Commitment to develop an integrated patient engagement framework and patient relations process.	Patient Declaration of Values is in place, and patients/families/caregivers are included in governance structure(s) and patient leadership is established. Patient engagement framework, patient relationship process and community engagement plan are in place	Teams will uphold the principles of patient partnership, community engagement and system co-design. They will meaningfully engage and partner with – and be driven by the needs of patients, families, caregivers and the communities they serve.
<b>Defined Patient Population</b>	Identify population and geography at maturity and target population for year 1. Put processes in place for building sustained care relationships with patients.	Patient success and service delivery targets are met. Number of patients with sustained care relationship are reported. Plan in place to expand target population.	Teams will be responsible for the health outcomes of a population within a geographic area that is defined based on local factors and how patients typically access care.

In the context of patient care and experience, at maturity, Ontario Health Teams would reengineer the care they deliver according to the best evidence and available standards, with attention to inclusive approaches to care and a relentless focus on quality improvement and rapid learning at all levels of operation. This would occur through access to care when and where needed; coordination and transition to provide planned, seamless care at each step of the care journey; and communications and information through digital access to health records (and associated information) to support patients as active partners in managing individual health by understanding what services are available and how to access them as part of a self-managed care plan. In the context of patient partnership and community engagement, Ontario Health Teams would meaningfully engage and partner with patients, families and caregivers, in communities (where they reside), based on a robust patient partnership model and community engagement strategy.

In the context of defined patient populations, Ontario Health Teams would have identified a critical mass of people in order to integrate funding and accountability structures to function well and optimize value. The identified population (in need) would be sufficient to fully optimize clinical and financial outcomes and would account for unique regional variations and approaches across rural, urban and northern communities to optimize value. Regardless of size, care delivery would be tailored to the needs of patients and communities served. Such information would demonstrate effective access to care when and as needed. It would ensure that planned, seamless communications and information through access to digital data would be tailored to respond to diverse population size and health care needs.

In summary, the focus would be on enhancing and measuring the perception and experience of a quality *patient experience*. This would require developing the capacity to collect and use information to change practices, policies and rules. It would require feedback loops that enabled improvement conversations about the breadth and depth of patient involvement. All three concepts – patient-centered care, patient engagement and patient experience, represented the principles of good relationships: partnership, equality, communication, trust and respect which are crucial levers for change [9].

## Section 3: The Health Care Environment

### The COVID-19 Pandemic

#### Inter-connectedness Processes/Programs/Services



Many health care delivery challenges have and will continue to surface as the Pandemic continues to move through its full cycle. Governments have and will continue to respond to critical healthcare challenges by sustaining the inter-connectedness of processes, programs and services. There will be an increasing need to define equitable and timely access processes to various healthcare delivery systems that support a person's safety, mental, and physical health and overall well-being. These initiatives will have to include an acceleration in the investment of new resources and creation of new process-management structures and related programs that address the wellness and mental health of

front-line caregivers [10]. New collaborations and partnership structures that emerge during the Pandemic will continue to focus on the need to bring together different levels of government, various parts of the healthcare system and private and public partnerships to define new innovative approaches to care [11] that will be needed to respond to the transition needs of the healthcare continuum.

### Health Care Delivery

Today, the healthcare delivery system is facing three key challenges – responding to the health and personal care needs of an aging population; responding to demands for equitable and timely quality healthcare and supporting the move to self-managed health care that support making the right decisions, in the right places, at the right times.

#### Key Demands Associated with the Pandemic



The Ontario Government, for example, is modernizing home and community services to enable the introduction of integrated and innovative models of care. The *Connecting People to Home and Community Care Act* is focusing on care coordination in conjunction with frontline care; care integration with primary and hospital care; flexible care plans, and provision of virtual care networks and tools. Particular attention is being given to frail older adults who rely on publicly funded home care.

These and other strategies will have to build on improvements in **integrated care** by breaking down long-established silos among home care, primary care, public health, hospital and long-term care, all supported by new partnerships for service delivery. They will have to focus on the inequities that exist in healthcare with respect to the needs of marginalized populations and populations at high risk in the Canadian society [11]. In addition, the success of a *Team Managed Approach* that has integrated the work of care providers from each of the healthcare delivery sectors will evolve as the best way to address the Pandemic and beyond.

## Home Care



Canada has one of the highest rates of institutional care and one of the lowest rates of home care among developing countries. Shirlee Sharkey, Chief Executive, SE Health says, “Two of the key lessons of the Pandemic are: the home is a safe place to be, and home is where people want to be”. The right care, at the right place and at the right time needs to be the mantra of a patient- and family-centered care system.

To fulfill that mission, one priority has to be the allowance of people to age in place, to give them the choice of living at home and dying at home with the proper supports. The Pandemic has impacted home care support. A survey of three large Canadian home-care providers – SE Health, Bayshore and VON Canada – found that in the weeks after lockdown, health nursing dropped by 22%; personal support workers’ services were reduced by 31% and home-based therapy, i.e. physio/occupational therapies plummeted by 65% [12].

Dr. Clare Liddy provides a number of principles that can also help ground the discussion of the use of virtual care that responds to the needs, (and capabilities) of seniors at home, namely:

- virtual advances can enhance physician visits in the ‘form of a virtual house call’ and expand communications with nursing staff in the community, often described as *community coordination*;
- they can bring (patients) and caregivers into the *care conversation*;
- technology can maximize (future) access to a small number of specialized geriatricians, perhaps supported by a virtual National Centre of Excellence for Elder Care, to support teaching, learning and sharing knowledge [13].

In tandem with appropriate policy measures, the promise of technology can truly have a positive effect on patients, caregivers, personal support workers and society by fostering compassionate care. Digital health technologies can be stress-free and easy-to-use, especially when users become educated. Telemedicine increases the quality of sharing health data. It can be used to reduce the physical interactions between patients and their health care providers. It can extend care within urban and rural areas through the utilization of remote patient monitoring. Telemedicine platforms can ensure the elderly receive the support they need – from prescriptions and groceries to mental health support. Additionally, emergency health monitors can give patients a sense of autonomy, allowing them to stay at home while feeling safe [14].

## Long-Term Care



The number of elderly people in Ontario and Canada is increasing and they must be provided with appropriate care that helps them transition into new stages of life without having their well-being compromised. COVID-19 has struck long-term care homes with a vengeance. Their residents, almost universally, have underlying health conditions that can complicate coronavirus infections. More than 60% of residents suffer from Alzheimer’s disease or other forms of dementia [15]. With ever more baby boomers entering their twilight years, the number of Canadian seniors requiring 24-hour care has been growing rapidly [16].

Family caregivers are constantly faced with supporting the multiple personal and healthcare needs of their loved ones. This has and can continue to be increasingly more difficult in light of the current COVID-19 Pandemic and its demands and consequences on healthcare delivery, specifically in long-term care. Public observers are focusing attention on the virus's impact on the relationship between residents/caregivers and primary care providers that can decrease both the number of and approaches to face-to-face consultations. Government policies, programs and practices are and will continue to respond to new, never thought of pressures on caregiving created by, inter alia, social distancing measures and restrictive visiting. Observers see the increasing importance of supporting residents/caregivers in the use of virtual information through 'digital information management and sharing'. This allows them continuous access to the information they need to support decisions about the personal and medical care of the resident and the health of their loved ones.

The creation of monitoring protocols to track and respond to risk management strategies will be influenced by the needs of increasing senior populations in long-term care with increased levels of frailty and associated underlying conditions. Residents in long-term care homes will continue to face barriers to accessing specialist advice. Electronic consultation (eConsult) has the potential to improve access for these residents. Primary care providers, through eConsult, can support their timely and easy access to specialist opinion [17].

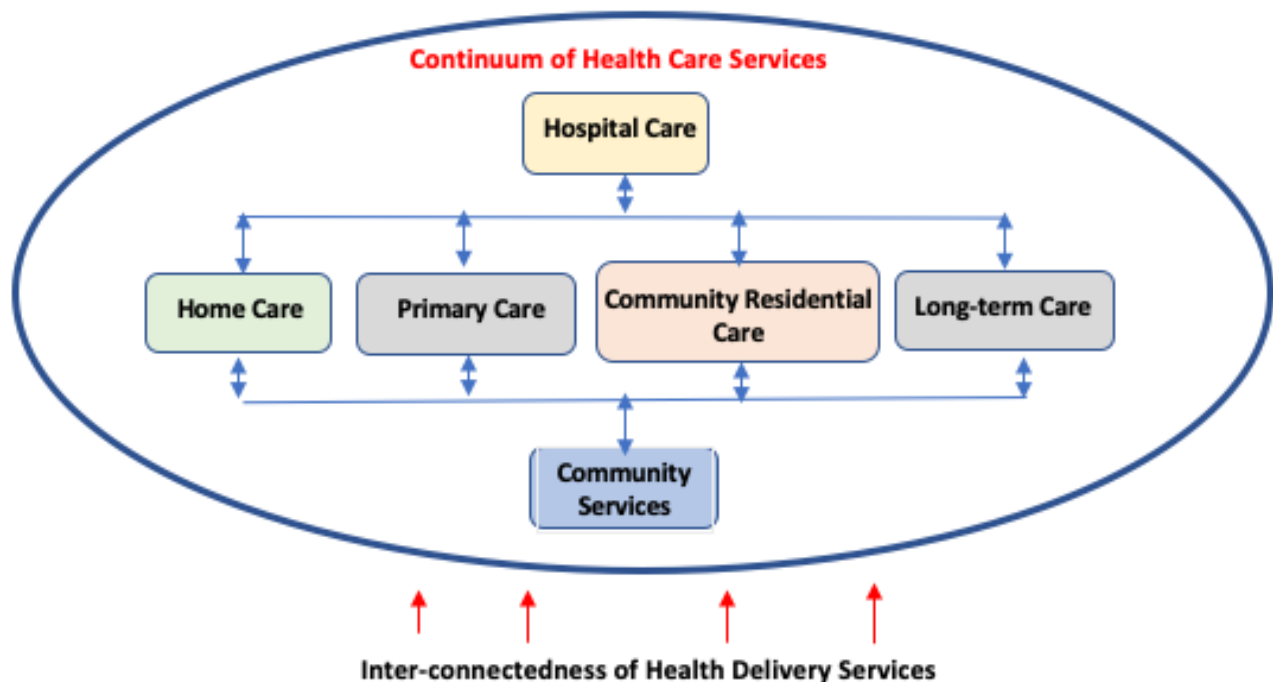
### ***Other Influencing Factors***

As early as 2010, the Ontario Medical Association focused on the issue of patient-centered care from both a system and practitioner standpoint [18]. It provided useful insights to understanding two factors that were stressing the health care environment at the time, namely integration and access.

These two stressors emerged to test the responses of healthcare delivery systems to respond to the current COVID-19 Pandemic. The lack of *integration* or inter-connectiveness continues to be recognized as one of the most difficult challenges facing the Ontario healthcare system. When a patient moves from one part of the healthcare system to another – from home to specialized community-based accommodations, from these patient-support environments to long-term care, to hospital interventions along the way in the journey, from primary care provider to primary care provider, and from specialist to specialist – the healthcare system can often fail the patient.

Over the past decade, the focus has often been solely on individual health system pathway components often failing to include the patient as an important center of attention. The lack of *effective access* to healthcare delivery services can occur when capacity fails to respond to demand. When demand exceeds capacity at any point in the system, there can be delays.





Some populations have more difficulty accessing the system than others, as noted in the OMA Policy Paper [18]. It identified the most vulnerable populations with care needs and access problems as, inter alia, those with medical co-morbidities, those with mental health illness, those with substance abuse problems, those living in remote areas, the Indigenous, those with high-risk conditions, and the frail elderly. The composition of this population cohort holds true today.

The eConsultBASE™ Service places a priority focus on such populations and others characterized as having complex circumstances.

A parallel issue, at the practitioner level, identifies many physicians as over-worked with continuing demands to increase their availability to take on new patients and address increasingly more complex medical and mental health needs, often resulting in increased burn-out. These factors can result in healthcare system access inefficiencies due to an inability to predict and absorb demand through matching supply. Research has identified a framework of options to support effective and healthy healthcare delivery by healthcare professionals [19].

Many important lessons for consideration are surfacing in the current discussion about next steps needed to respond to the Pandemic. They suggest that governments will have to respond to critical health challenges by defining equitable and timely *integration of* and access to various healthcare delivery systems that support a person’s safety, mental and physical health and overall well-being. Such initiatives will have to include an acceleration in the investment of new resources and creation of new process management structures and related healthcare delivery programs.

New collaborations and partnership structures are emerging. These include different levels of government, various parts of the healthcare system, private and public partnerships and others. We need to maintain these relationships and partnership structures to continue addressing the Pandemic and help solve other healthcare challenges [11].

## Section 4: Review of the eConsultBASE™ Service in Ontario

### ***The eConsultBASE™ Service's Contribution to HealthCare***

The Service recognizes the need to enhance access to specialist opinion to respond to care needs of complex populations, including, inter alia, patients with medical co-morbidities, mental health illnesses, substance abuse issues, those living in remote areas, the Indigenous, those with high-risk conditions and the frail elderly. The Service further recognizes the need to support patient care co-ordination to ensure the results of these consults prepare patients to move to other parts of the healthcare system.

The Service continuously demonstrates its ability to reduce wait-times for specialist opinion; increase primary care providers' ability to deliver care that aligns with patient personal and health care goals. It provides reassurances of available quality care provided to patients and their caregivers by reducing a significant disparity caused by fragmentation in the delivery of diagnostic healthcare services. The approach to sharing specialist opinion is more responsive, in a timely and equitable manner, to the specialized and localized needs of complex populations noted above. As such, the knowledge of patients and caregivers results in their meaningful involvement in a decision-making process that is closer to home and at the right time. Overall, this secure, digitally enabled solution to data exchange contributes to the enhancement of universal public healthcare services by supporting decisions based on value and quality.

Research and evaluation initiatives continuously effect improved practices that support the Service and identify and help bring into creation enhanced quality care improvement. Research is supported by the Bruyère Research Institute, that is dedicated to improving the care of aging Canadians and vulnerable populations. Its focus is on research that contributes to relevant and practical knowledge to build a more responsive healthcare system that delivers the best care to persons/patients and their families. The Institute is fully affiliated with, inter alia, the University of Ottawa and Carleton University and supports researchers who contribute to the relevant and practical knowledge needed to improve continuing care to foster quality of life through programs of research related to primary care, care of the elderly and palliative care.

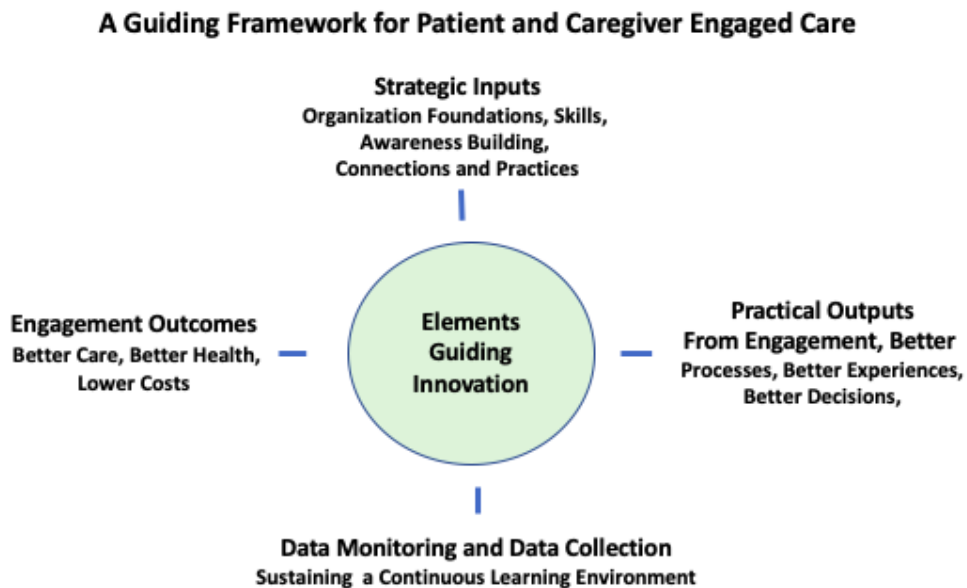
### ***Commitment to Person-Centered Care in eConsultBASE™ Service Strategies***

An innovation agenda is supported by the eConsultBASE™ Service environment and is grounded in the following commitment to the delivery of eConsult services:

*“A successful Service must be grounded in patient priorities, including access and safety, without ignoring provider satisfaction and system efficiencies. Patients (and their caregivers) and front-line providers should be empowered to influence the design, implementation and evaluation of the strategies of eConsultBASE™ Service related eReferral Services to ensure they are implemented in a way that serves them optimally. Without this critical engagement, there is a risk of causing increased fragmentation, restricted access when failing to meet referral requirements, reduced portability across geographic boundaries, inequality based on patients' access to technology and computer literacy, and provider burnout from additional administrative work. (These services) need a robust evaluation and quality improvement strategy that is shared with others to improve the understanding of the benefits, risks and potential unintended consequences of (its) innovative service-delivery model” [20].*

### ***Recognition of Elements Guiding Innovation***

The National Academy of Medicine [4] also considered in its guiding framework for patient and family engaged care the key elements for guiding innovation in the transitional stages of healthcare practice and engagement.



- (1) **Organizational Foundations** include leadership and levers for change focusing on such factors, inter alia, as an accurate assessment of the organization’s current culture, a commitment to defined change, leadership, vision and behaviors aligned with patient and family caregiver engaged care.
- (2) **Strategic Inputs** guide the evolution of interventions and tactics for creating desired outcomes. They include **structures** that focus on organizational systems and norms and break-down barriers, both literal and figurative, between care teams and patients and family caregivers and create infrastructure to bring them back into the fold, formally enlisting them as partners in creating better health care experiences, systems and outcomes.
- (3) **Skills and awareness-building** focus on making (patients) and their care partners take more active and participatory roles in care requiring, inter alia, training for healthcare personnel to help them build the skills necessary to interact in ways that facilitate shared decision-making, family caregiver involvement and the delivery of care with compassion and empathy, and skill-building opportunities to expand patient and family caregiver capabilities to be full partners (reciprocal relationships) in care and quality improvement.
- (4) **Connections** focus on building teams with common expectations, language and tools supporting what it means to work collaboratively.
- (5) **Practices** focus on methods, processes and behaviors adopted by teams to guide healthcare interactions.
- (6) **Practical Outputs** focus on a range of intermediate outcomes to gain a more immediate understanding of and support for various tactics and approaches to allow for better patient experiences in decision-making.

**(7) Engagement Outcomes** lead to better care, better health and lower costs.

**(8) Monitoring and Data Collection** focus on the need to create a continuous learning environment where implementation activities are guided by an ongoing process of discovering needs and opportunities, applying new knowledge, and assessing and adapting approaches to implement structures, practices, skills and connection-building activities that build on each other to create a culture of patient and family engaged care.

The Service recognizes the importance of these factors in considering strategic inputs to its virtual platform. The exchange of information arising from continuous monitoring and data collection among all participants occurs in an environment where the personal and health care interests of patients are recognized through respect and in response to individual patient values, needs and preferences that guide clinical support.

The Service constantly strives to enhance patient/caregiver and primary care provider/specialist engagement and shared decision-making. This occurs in a culture that recognizes that the delivery of compassionate and effective care for patients yields better health, delivered at lower costs – factors that are crucial for sustained change through practical outputs from engagement.

The Service focuses on supporting a culture of healthcare that balances a ‘disease-centered and provider-focused model’, with a model of care where patients and their caregivers are active partners in making care decisions through engagement outcomes. The Service recognizes and is sensitive to balancing the realities of these two groups by recognizing and harmonizing the needs and pressures faced by them.

The Service continuously monitors the initiatives being undertaken by provinces to improve the quality of their patient experience policies, programs and practices. As an example, in the Province of Ontario, the creation of Health Teams provides an ‘entry-point’ for the integration of the Service in the healthcare service delivery model. The Service, as it seeks opportunities to partner in healthcare innovations, will ensure that evidence against accepted standards of success is collected.

### ***Practices Supporting the Patient/Person Experience***

The Service is continuously sustaining a positive patient/person experience by recognizing the benefits of person and caregiver engagement. The involvement of patient/persons, caregivers, advisors and primary care providers and specialists can differ across the country. The Service supports their proactive engagement by building meaningful relationships that lead to the improved quality of healthcare. The elements of the frameworks and checklists that have been identified (and others that are available) can be used to assist the Service as it engages partners through a spectrum of continuous quality improvement and access to easy-to-understand health information supported by rigorous research and evaluation data.

The Service involves *Patient Advisors and Care Partners* in the consultation process to promote an understanding of its contribution to the *patient/person and caregiver experience*. They are active members of the Service’s committees which bring together patient/persons, caregivers, physicians, nurse practitioners, and service delivery administrators in the community and long-term care, supported by researchers from recognized organizations and agencies.

The Service will continue to recognize the importance of patient/person engagement by supporting relationships between patients/persons and healthcare providers as they work together to promote and support active patient/person and public involvement in healthcare and strengthen their influence on healthcare decisions at both the individual and collective levels.

The key to the successful collaboration between patients/persons/caregivers and healthcare providers is establishing a mutual understanding and acceptance of the roles and responsibilities of each group. An ongoing concern often expressed by patients/persons/caregivers is the lack of timely two-way information-sharing. They want to be better informed in order to be better prepared to participate in meaningful decision-making, rather than simply being used as a source of comment, usually after decisions have been taken. Healthcare providers must find the ways and means of welcoming patients/persons/caregivers as partners in care. The Service is continuously sustaining a positive patient/person experience by recognizing the benefits of patient/person and caregiver engagement in care plans.

The Service creates a positive working environment through the *proper coordination and integration of clinical care* with ancillary support services in the community. A timely dialogue about specialist opinion allows patients/persons and their caregivers to engage in *continuous care and transition* options, i.e. access to information, inter alia, about medical treatment, medications, pain management and assistance coupled with activities of daily living, dietary needs and access to clinical and social support services in the community. The Service ensures that the needs of caregivers are recognized in the care planning mix. This allows caregivers to address the debilitating effects of fear and anxiety and facilitate a refocused attention to addressing their own and their loved one's needs.

The Service provides a comprehensive set of information resources and technical support documents. They are available on the Service's website. They ensure patients/persons and their caregivers, and providers and specialists fully understand what the tool looks like, how it is used and who can be contacted for assistance. New and ongoing providers/specialists are provided with online training and information to develop and sustain their skills and build reciprocal relationships in developing and sharing the diagnostics.

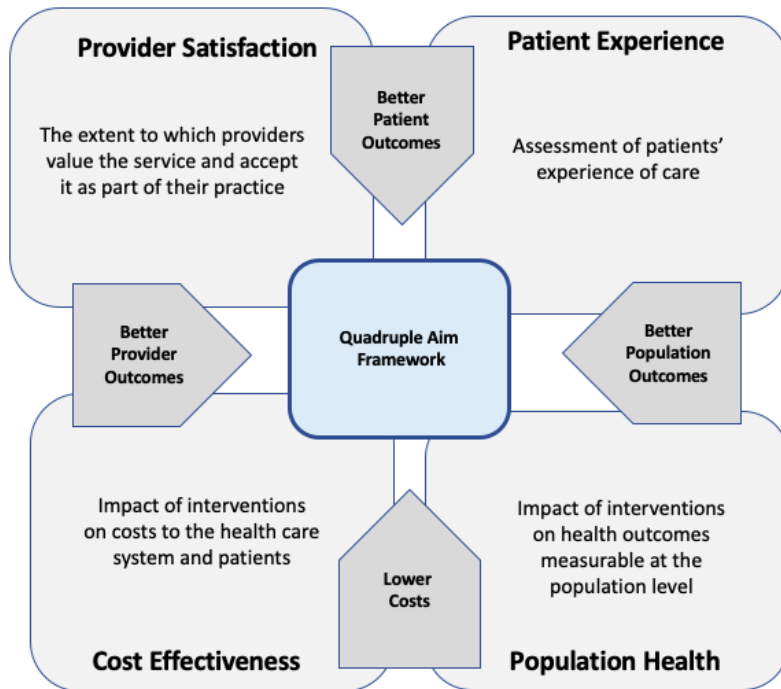
Standards of practice are based on policies, programs and practices that support the management of the Service and focus on the patient/person experience. At the same time, implementation is responsive to a hierarchy of patient/person and caregiver needs provincially, regionally, locally and at the core of health care delivery in primary and long-term care.

The Service strives for continuous harmonization with the principles of person-centered care being adopted by all provinces.

### ***Monitoring and Measuring Results***

These observations focus on measurement proposals related to the implementation of person-centered care. They are framed in the context of the *Quadruple Aim Framework* which has been adopted by the Service as the preferred approach for evaluation [7]. The Service also recognizes the importance of defining the positive impact of sustainable change on the patient/person and caregiver experience by identifying how the Service can do a better job of monitoring and evaluating what's working and what's not working.

In order to use the Framework effectively in evaluation, it will be important to harness the determinants of health; empower patients/persons and their caregivers; substantially integrate the role and impact of levels of primary care in homes, community-based accommodations and long-term care to fully understand the seamless patient journey through the whole system of care throughout a person’s life.



The Framework can guide the evaluation of the Service’s results to provide a comprehensive, in-depth approach to support the pursuit of value for health care delivery and health system optimization.

The core elements [7] of the framework are based on the following principles that complement the quadruple aim itself – optimizing holistic patient/person and population health; harnessing the quadruple aim as a dynamic whole; applying measurements as tools for, not outcomes of quality, and prioritizing therapeutic relationships.

The framework model focuses on three patient/person-centric aspects and a fourth that focuses on the clinical experience in terms of ‘joy of work’.

It works like a compass in that it guides the direction that the healthcare system – including both patients/persons and providers – need to follow.

An **improved patient/person experience** aims to enhance the quality of care that patients/persons receive with a greater focus on individuals and families. With an improved patient/person experience comes more educated patients/persons who understand their condition(s) and are prepared with the tools to better manage their own care and improve outcomes. **Better outcomes** aim to improve the health of the overall population. With the increase in chronic diseases, improving the patient/person experience for all individuals will ultimately lead to a decrease in prevalence and/or severity of chronic diseases and better chronic care management. **Lower costs** pose a significant funding challenge to spending and is generally seen to increase. The first two aspect of the initiative are targeted for achievement while simultaneously reducing the per capita cost of healthcare. While costs are driven down, the quality of care isn’t compromised. Access to and integration of healthcare remains affordable. **Improved clinical experience (Joy of Work)** focuses on the pressures that increased prevalence in ‘value-based care’ put on the care providers themselves. The pressure that is put on patients/persons and caregivers can be immense leading to unwanted outcomes that can negatively affect the quality of care provided. Primary care practitioner ‘burn-out’ can be caused by such factors as the increase in paperwork and administrative tasks and feelings of not providing quality care to patients/persons requiring continuous medical education. The *Institute for Healthcare Improvement* believes that if the framework is to work effectively it is important to harness a range of community determinants of health; empower individuals and families

(caregivers); substantially broaden the role and impact of primary care and other community-based services and ensure a seamless journey through the whole system of care throughout a person's life.

eConsultBASE™ Service research [21], references the Quadruple Aim Framework, to demonstrate its positive impact on the patient/person experience, provider satisfaction, high quality health-related information and reduction in costs. Several themes continue to influence the focus on patient/person access and patient/person/provider acceptance of the technology by linking diagnostic results to integrated care coordination in the community. Other research has suggested that the spread of *digital referral systems* can have an incremental positive impact on patient/person and caregiver involvement in care delivery.

Qualitative research [22] successfully demonstrates the Service's impact on the patient/person experience. Primary care providers are seen less as gatekeepers than as navigators and advocates in reducing frustrations and anxiety associated with seeking specialist care. Research has focused on the actual experiences of patients/persons receiving care via the Service and their views on the advantages and disadvantages associated with the use of this technology and explored patient/person attitudes towards eConsult and their experiences with the Service as a means of receiving care.

The participants discussed their attitudes towards the Service in terms of its use in their care, any benefits or drawbacks they perceived, and its potential effectiveness as an alternative to traditional face-to-face specialist referrals. Three themes emerged – access, acceptability of the service and strengthening the role of primary care providers, and the desire for greater continuity of care among care providers. The Service will continue to focus on the development of key common transition questions across all care settings, particularly for patients/persons with complex needs and their caregivers, i.e. the home, primary care, community-based accommodation settings and long-term care.

This approach acknowledges the need to link results data to survey results from other partners, i.e. The Change Foundation, the Ontario Medical Association, Bruyère Research Institute.

The success of the Service relies on how patients/persons and their caregivers perceive the quality of their care experiences. By focusing on the need to create a continuous learning environment, implementation initiatives continue to be guided by applying new knowledge, assessing and applying 'best practice' approaches and introducing new skills and connection-building activities that inter-connect to create a culture of quality patient/person care.

The Service has and will continue to use the four core elements of the Quadruple Aim Framework, the patient/person experience, provider satisfaction, population health and cost effectiveness, for evaluation, continuous learning, and quality improvement. Focus will be placed on core framework principles, noted above, including optimizing holistic patient/person and population health; harnessing the four key elements of the Framework into a dynamic whole; applying measurements as tools, not outcomes of quality, and prioritizing therapeutic relationships.

## Section 5: Future Considerations

Discussions about the content of the paper suggested referencing other sources of information focusing on person-centered care, including - eServices Evaluation Working Group, Ontario eServices Program, eConsult Centre of Excellence; Nursing Professional Practice and Patient Relations Group; hospitals in the Champlain Region, i.e. Ottawa Hospital, Winchester District Memorial Hospital; the Pioneer Network; Behavioural Supports Ontario; Person-centered Language eLearning Module, Ontario Centres for Learning, Research and Innovation in Long-term Care; LTC+ Essential Together (full documentation package supported by Healthcare Excellence Canada and focusing on, inter alia, Family Presence initiatives, Reintegrating Essential Care Partners in Long-term Care Homes); the Patient Medical Home; the work of AdvantAge Ontario, Family Councils Ontario and the Ontario Long-term Care Association. Reference all sources is outside the scope of this initial review, but they are recognized as valuable sources for future work in this area.

The following proposals are identified for future consideration of extensions to this Discussion Paper to support informed discussions about spread and scale, communications, and evaluation and research related to eConsultBASE™ Service in the context of person-centered care.

This paper was completed in October 2020 and reviewed at the beginning of 2021. The evolving Pandemic over the last several months has and will continue to pose new and continuing challenges for high quality health service delivery to meet person-centered needs in primary care, generally, in the medical home, community service delivery, long-term care and other congregate settings. Emphasis on sharing ‘best practices’ associated with virtual care in these jurisdictions and the role of eConsult in provincial eHealth Services should continue to be at the center of discussion.

It would be useful to return to Healthy Debate, Opinions, July 9, 2020, *Dealing with COVID-19: An Open Letter to Canada’s Prime Minister and Provincial and Territorial Premiers, an important healthcare delivery goal was put forward - “minimize the impact of COVID-19 using methods that are practical, effective and compatible with our values and sense of social justice and focus on preventing serious illness and death by protecting the vulnerable while allowing society to function”* - an immense challenge to transitions in healthcare, and the report of the Virtual Care Task Force, *Virtual Care, February 2020*, that concluded “consumer demand and drive will likely make virtual care more common in the Canadian Healthcare System and called for a framework to establish excellence in virtual care that upholds quality health service and supports continuity of care among healthcare teams”.

Discussions with eConsultBASE™ Service researchers, staff and care partners identified the following proposals for future consideration as extensions to the Discussion Paper.

1. All provincial initiatives could be revisited in order to provide an up-to-date summary of the use of person-centered care values, principles, and goals that continue to guide eConsultBASE™ Service initiatives, where and when possible, that respond to the sharing of diagnostic information to respond to the medical and personal needs of individuals associated with an aging population and the healthcare delivery demands posed by the Pandemic.
2. With regard to approaches to Team-based Healthcare Management, focus could be placed on giving attention to the ways and means of sustaining high quality person-centered care outcomes through



the co-creation and co-production of inputs by healthcare professionals and services, individuals and their caregivers and other care partners at the federal, provincial and local levels through health teams that are crossing these jurisdictions.

3. The eConsultBASE™ Service should continue to focus on supporting a culture of healthcare where individuals, their caregivers and healthcare providers are active partners in making care decisions through engagement and information-sharing. In such a team-based approach, consideration could be given to exploring the role the Service is playing, provincially and locally, to respond to the complex ‘access-to-care’ needs of an aging population.
4. Any extended review could focus on provincial initiatives that are being undertaken to develop effective communication strategies and structures; support the focus on delegation to the local level; develop and support project management training and development initiatives, and ensure resources are in place to support and share ‘best practices’.
5. Consideration could be given to focusing discussion on the contribution of person-centered care to eConsultBASE™ Service’s role as an important partner in the transition to virtual healthcare by balancing ‘face-to-face’ with digital consultation. The need for such discussion is supported by the College of Family Physicians of Canada in their *Virtual Care Playbook* that identifies key factors that allow for virtual care to be delivered in a safe, effective and efficient manner by fitting virtual care into the physician’s practice, being mindful of patient/person capacity and preferences, the need to address technological requirements, the need to understand what problems can be assessed and treated safely and ensuring safety and efficiency for the virtual visit, from start to finish.
6. Finally, consideration could be given to linking the introduction of eConsultBASE™ Service into the initiatives being undertaken by long-term care homes to focus on ‘digital preparedness’ or ‘digital readiness’, as they prepare for the selection and implementation and/or continuing use of virtual care platforms, while seeking provincial assistance to support the use of eHealth Services. Such discussions could be launched from a review of the Webinar hosted by Ontario Health, *Virtual Care Supports for Long-term Care, April 29, 2021*, and the Evidence Brief, *Identifying and Harnessing the Potential of Technology in Long-term Care Settings in Canada February 2021, McMaster University, Health Forum*.

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## Annex A – Afterword on the Impact of the Discussion Paper

The eConsultBASE™ Service recognizes that the values and principles of person-centered care are fundamental to generating meaningful research that could lead to quality health care delivery and outcomes and can be used to validate the adoption of the Service through a diverse set current and future research projects.

*Note: The following poster was presented at the Canadian Association of Health Services and Policy Research's 2021 Annual Conference, May 19 – 21, 2021.*

### Ensuring Person-Centered Care Principles in eConsultBASE™ Research and Service Delivery through Collaborative Engagement and Partnerships with Patient Partners

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#### Background

- Person-centered care principles are fundamental to generating meaningful research and improving care delivery.
- eConsult is a secure web-based tool that allows primary care providers to access specialist advice on behalf of their patients.
- Collaboration with patient partners facilitates integrated knowledge translation (IKT) of their lived experience to guide decision-making and ensure research and service delivery are person-centered.
- A patient partner led an initiative to describe person-centered care in relation to the eConsultBASE™ Service.

#### Figure 1. Development of Discussion Paper

#### Results and Impact

- 1) Produced a **useful document to ground our work** in principles of person-centered care.
- 2) **IKT was facilitated** through Committee discussions about the paper and person-centered care.
- 3) **Verified that person-centered values, principles, and practices are upheld** by eConsultBASE™ Service at all levels of governance and decision making.
- 4) **Revised language** in manuscripts, agreements, terms of reference, and other documents under development.

#### Approach

- Brief review of provincial and other policies, programs and practices that place person-centered care at the forefront of healthcare delivery and the eConsultBASE™ Service in Ontario (Fall 2020).
- A patient partner led development of an internal discussion paper to inform ongoing service delivery and evaluation (Figure 1).
- Paper reviewed and discussed by eConsultBASE™ Service committees: Long-Term Care Advisory Committee, Steering Committee, and Patient Partners (6 provinces).
- Committee members include patient partners, clinicians, researchers, and policy-makers.
- Paper revised based on Committee insights and feedback.

#### Components of Discussion Paper

- Nuanced definition of person-centered care
- Snapshot of selected policy/practice frameworks for person-centered care
- Common values, principles, and practices of patient/caregiver engagement and partnership
- Information on supporting high quality health care delivery
- A detailed review of the eConsultBASE™ Service's commitment to person-centered care

#### Conclusion

- A patient partner led the eConsultBASE™ Service team to re-evaluate and better understand their approach to and role within person-centered care.
- IKT, facilitated through collaborative engagement and partnerships with patient partners, proved to be an essential way to ensure person-centered care principles continue to guide all aspects of eConsultBASE™ research and service delivery.

#### Want to Know More?

- For more information contact [eConsultCOE@toh.ca](mailto:eConsultCOE@toh.ca)

Acknowledgement: Icons on this poster are from Visme, an online content creation tool.

The poster provides an overview of the approach that was used to validate the contents of the Discussion Paper, vis-à-vis person-centered care as an important component of research and service delivery through collaborative engagement and partnerships with patient partners. Collaboration occurred with experienced researchers from the Bruyère Research Institute in Ottawa and Patient Partners from six Provinces, active in the eConsultBASE™ Service process, who referenced their 'lived experiences' with health care delivery. They helped guide the development of the Discussion Paper and its internal dissemination.

The Integrated Knowledge Translation (IKT) co-production approach was employed to focus discussions on validating the content of the Discussion Paper and 'moving its use to action'.

Participants verified how person-centered care definitions, values, principles and practices were being upheld by the Service. This collaborative partnership leveraged the review of person-centered care in the Service's governance structure and decision-making processes as well as its policies, programs and practices. It resulted in revisions to language in manuscripts, research development agreements, terms of reference for research initiatives and support documents under development such as the Team's *Research Handbook for Patient Partners*.