Person-centred care

Recommendations

Recommendation	Reference	Grade*
To optimise patient health outcomes and health-related quality of life, a person-centred communication style should be used that: • uses person-centred and strength-based language • uses active listening • elicits patient preferences and beliefs • assesses literacy, numeracy and potential barriers to care	1 American Diabetes Association, 2019	B
Care should be aligned with components of the Chronic Care Model (CCM) to ensure productive interactions between a prepared, proactive practice team and an informed, activated patient	1 American Diabetes Association, 2019	A
Care systems should support team-based care, community involvement, patient registries and embedded decision-support tools to meet patient needs	1 American Diabetes Association, 2019	B
Treatment decisions should be timely, based on evidence-based guidelines and tailored to individual patient preferences, prognoses and comorbidities	1 American Diabetes Association, 2019	B
*Refer to 'Explanation and source of recommendations' for explanations of the levels and grades of evidence.		

Background: What is person-centred care?

Person-centred care is the holistic treatment of patients based on their assessed clinical condition, considering their individual preferences, priorities and sociocultural contexts.

Studies show that people with diabetes are more likely to engage in self-management and achieve optimal health outcomes if their care plans are person-centred.[2,3]

A person-centred consultation involves assessing someone's clinical signs and symptoms, as well as their thoughts, fears, preferences, expectations and social context. This ensures a complete understanding of the individual who is living with type 2 diabetes.

From a position of mutual understanding, using a shared decision-making process (Box 1), management plans can be developed with the patient and tailored to specifically meet their needs, values and choices.

The following are important characteristics of person-centred care:

- care is personalised
- care is coordinated
- care is enabling
- the person is treated with dignity, compassion and respect.

Supporting principles include the following:

- **Partnership**: people are engaged as true partners in their healthcare
- **Compassion and empathy**: healthcare is always delivered with compassion and empathy
- **Trust**: two-way trust is established and maintained
- **Carers and family**: the support and expertise of carers, families and communities is recognised, encouraged and valued
- **Diversity**: diversity is valued, and the different needs of people are understood and provided for
- **Continuous learning**: the person and clinicians strive to continuously improve their knowledge, skills, health literacy and self-management strategies, and foster environments that support ongoing learning

The following key components of person-centred care are discussed in this chapter:

- self-management
- patient education
- health literacy
- structured multidisciplinary care.

Note that although many of the assessments discussed in this handbook are performed informally during a routine consultation, systems should be developed within the practice to allow appropriate assessment, review and management of individual patients. Some patient-related outcome measures and expectation measures are discussed in an article by Borg et al (2019) and on the International Consortium for Health Outcomes Measurement (ICHOM) website.

For a full recommended structured assessment of the patient with diabetes, refer to the section 'Assessment of the patient with type 2 diabetes'.

Box 1. Shared decision-making

Shared decision-making is a collaborative process between a patient, their doctor and other members of their care team (practice nurses, credentialled diabetes educators, etc) for making treatment decisions. It involves consideration of the evidence, including benefits and harms of treatment, and takes into account the patient's values, preferences and circumstances.[4]

Shared decision-making does not necessarily require the use of decision tools; however, these can be useful.[5] For example, the ICAN discussion aid is designed for use with chronic conditions. It helps clinicians work with patients to understand their capacity to follow a treatment plan, taking into account factors such as workload and treatment burden.[6]

Other shared decision-making resources can be found at the NSW Health Agency for Clinical Innovation.

Self-management

Self-management involves the person with diabetes working in partnership with their carers and health professionals to:

- understand their condition and various treatment options
- contribute to, review and monitor, a plan of care (eg care plan)
- engage in activities that protect and promote health
- monitor and manage symptoms and signs of the condition
- manage the impact of the condition on physical functioning, emotions and interpersonal relationships.

Identifying barriers to self-management is important when developing a management plan with the patient. Issues around cognition, physical disability, mental health, health literacy, socioeconomic constraints, location and access to services can affect the ability of the person to self-manage their diabetes.[7]

Evidence-based, structured self-management training programs are available through the National Diabetes Services Scheme (NDSS).

My Health Record

My Health Record may help people with type 2 diabetes manage their medical and therapeutic information, and can optimise both emergency and physician care of their diabetes.

Patient education

Providing education to people with diabetes about their condition and its treatment, including education to support self-management, is an integral part of diabetes care.[8,9] It is important to note that simply providing brochures and other written information is not health education, and is unlikely to change health behaviour. Patients and their carers should be offered a structured, evidence-based education program at the time of diagnosis, with an annual update and review.[10]

In addition to the team members shown in Figure 1, patients can obtain further education and support through Diabetes Australia and the NDSS, or their state or territory diabetes organisation.

Multiple online support and education programs may be available for patients unable to access face-to-face group meetings. However, there are few studies on the individual effectiveness of these programs.[11]

More information is available from:

- Diabetes Australia
- NDSS
- Australian Diabetes Educators Association (ADEA).

Health literacy

Health literacy is defined as an individual's ability to understand and use healthcare information to make decisions and follow instructions for treatment.[12]

A person's degree of health literacy significantly influences their ability to self-manage, participate in shared decision-making and benefit from patient education.

Patients with lower literacy or numeracy skills are at greater risk for poor diabetes outcomes.[13] Literacy and numeracy skills are not always obvious, but GPs may worry that attempting to evaluate them will be uncomfortable or embarrassing for patients. However, this concern is not supported by the evidence.[14] It is appropriate to ask direct questions about a patient's understanding of their medical conditions and to specifically ask what the take-home messages were from a consultation (reflective listening, or 'teach-back').

A patient's health literacy typically improves through self-education and contact with health providers.[14]

Organisations such as Diabetes Australia provide self-management education and support programs, peer support programs, mental health and diabetes programs, culturally and linguistically appropriate education, and information in several languages. They also have resources to help patients with low literacy skills.

Structured multidisciplinary care

In a structured care program, a multidisciplinary team of health practitioners provides comprehensive and holistic care to patients, helping them reach individualised health goals.

A multidisciplinary care team allows the patient to benefit from a broad perspective on their health and wellbeing (Figure 1), and can improve clinical outcomes and quality of life.[15] For example, a patient's social difficulties may be detected during a diabetes educator evaluation or by a practice nurse, rather than during a routine medical consultation.

Whatever the composition of the team, care needs to be organised and delivered systematically.

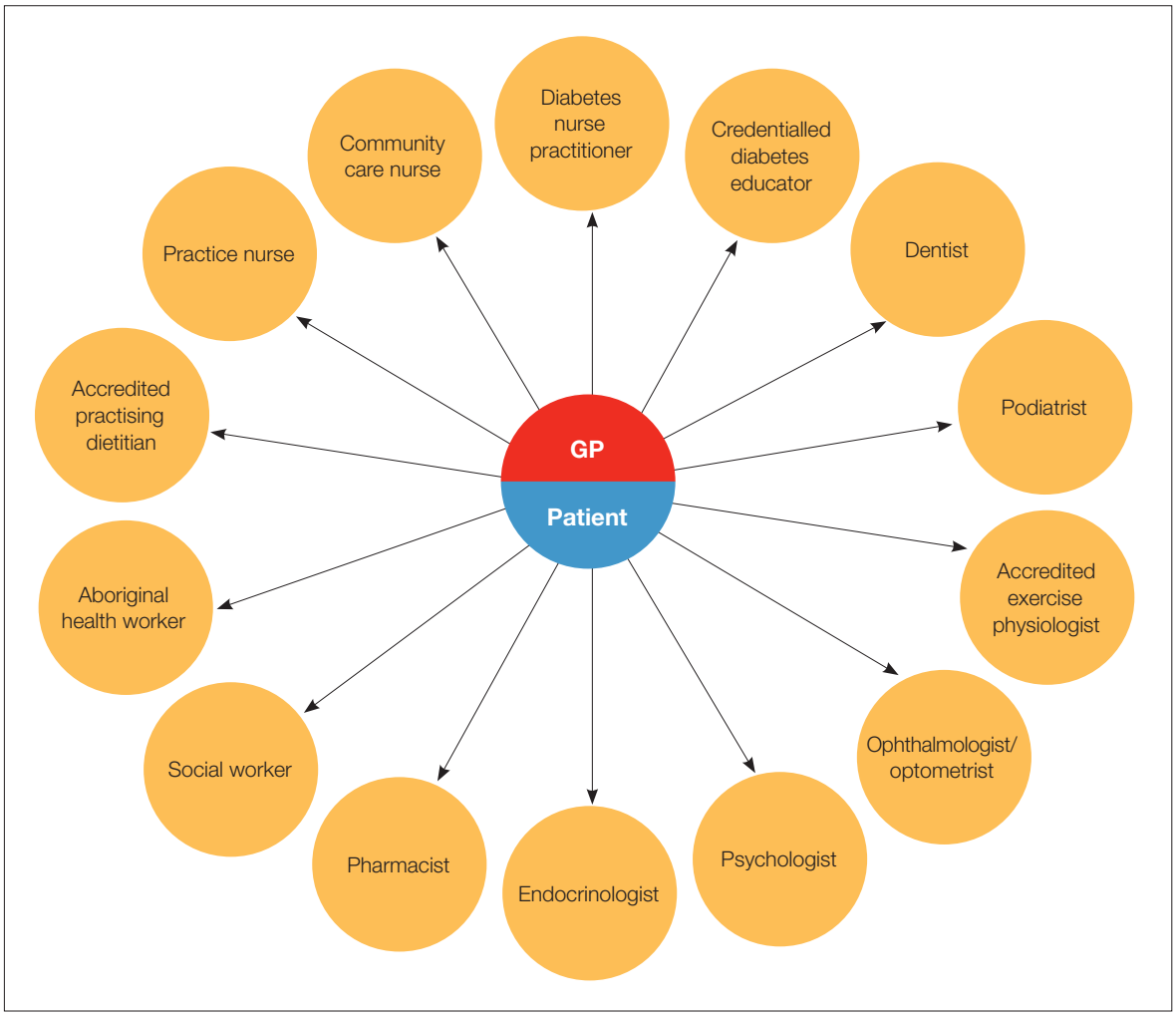
Aboriginal and Torres Strait Islander point

Involvement of an Aboriginal health worker, Aboriginal liaison officer, or Indigenous outreach worker or care coordinator is essential in the care of Aboriginal and Torres Strait Islander people.

Information about Medicare items for allied health referrals can be found on the Australian Government Department of Health website.

Refer to the section 'Assessment of the patient with type 2 diabetes' for examples of a structured, person-centred care plan.

Figure 1. Potential members of the multidisciplinary diabetes care team



Resources

The **Australian Diabetes Educators Association (ADEA)** website for person-centred care has a number of resources for healthcare professionals, including the 'Person-centred Care Toolkit'.

The Victorian Government **Better Health Channel** has information for patients about person-centred care.

Diabetes Australia has a position statement regarding language and communication with, and about, people with diabetes.

The **Minimally Disruptive Medicine** website has the ICAN discussion aid.

The **National Diabetes Services Scheme (NDSS)** has resources on more than 40 diabetes topics, many available in over 20 languages.

The **NDSS** has designed an online course specifically to support people with type 2 diabetes.

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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