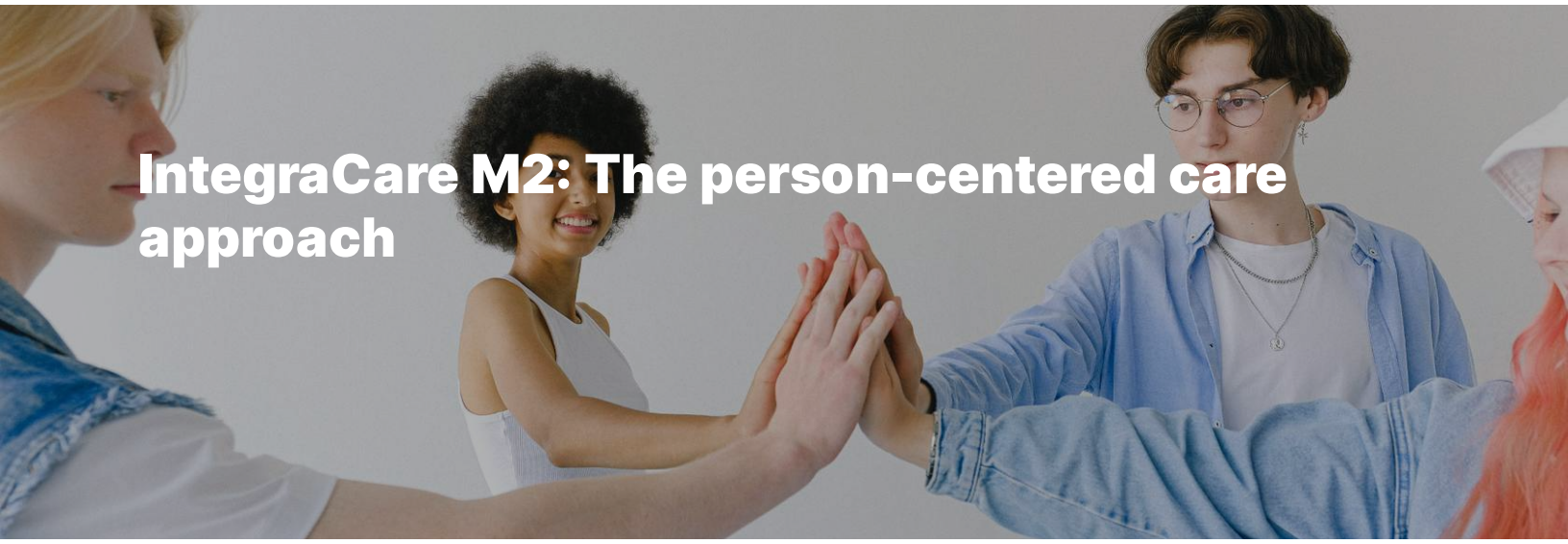

IntegraCare M2: The person-centered care approach

Co-funded by the European Union

There are growing numbers of older people and people living with long-term conditions and disabilities. At the same time, health and social care budgets are under increasing pressure. Adopting person-centered care as ‘business as usual’ requires fundamental changes to how services are delivered and to roles and the relationships between patients, health care professionals and teams. This module seeks to provide a quick overview of person-centered care approach, the history of evolution of the different models, and the benefits of choosing the person-centered care model.

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What is person centered care?

Different models of centered approach

Benefits of choosing the person-centered care model

Module summary

What is person centered care?

Abstract

There are growing numbers of older people and people living with long-term conditions and disabilities. At the same time, health and social care budgets are under increasing pressure. Adopting person-centered care as 'business as usual' requires fundamental changes to how services are delivered and to roles and the relationships between patients, health care professionals and teams. This module seeks to provide a quick overview of person-centered care approach, the history of evolution of the different models, and the benefits of choosing the person-centered care model.

Learning objectives

1. Amplify knowledge about history and definition of personal centered approach.
2. Understand differences between several model.
3. Motivate practitioners in critically apply a user centered approach.

Table of contents

2. Different models of centered approach

3. Benefits of choosing the person-centered care model

Duration 2 hours

START

History and evolution of personal centered approach

Person-centered care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the center of decisions and seeing them as experts, working alongside professionals to get the best outcome.

In the past, people were expected to fit in with the routines and practices that health and social services felt were most appropriate.

But in order to be person-centered, services need to change to be more flexible to meet people's needs in a manner that is best for them. This involves working with people and their families to find the best way to provide their care. This partnership working can occur on a one-to-one basis, where individual people take part in decisions about their health and care, or on a collective group basis whereby the public or patient groups are involved in decisions about the design and delivery of services.

The underlying philosophy is the same:

It is about doing things with people, rather than 'to' them.

There is no one definition of person-centered care. People might also use terms such as patient-centered, family-centered, user-centered, individualized or personalized. Regardless of the terms used, a lot of research has looked into what matters to patients and how to provide person-centered care to make sure people have a good experience.

There are many different aspects of person-centered care, including:

- Taking into account people's preferences and expressed needs
- Coordinating and integrating care
- Working together to make sure there is good communication, information and education
- Making sure people are physically comfortable and safe
- Emotional support
- Involving family and friends
- Making sure there is continuity between and within services
- Making sure people have access to appropriate care when they need it

Person centered care timeline

Person-Centered therapy is a humanistic approach developed by Carl Rogers in the 1950s.

Step 1

1940s

This first period is characterized by the development of two aspects of the therapist's role: that of responding to feelings, as distinct from content; and the acceptance, recognition and clarification of positive, negative and ambivalent feelings.

In 1942, Roger's articulated his own views on effective psychotherapy in his ground-breaking book *Counseling and Psychotherapy*. Here Rogers popularized the term "client" for the recipient of counseling and psychotherapy, a first step in moving away from a medical model of mental illness. In this book, Rogers also introduced his "non-directive" method, based on a core hypothesis about human growth and personality change.

Step 2

1950s

The second decade begins in the 1950s, when Rogers outlined the framework and structure of the client-centered approach.

This hypothesis focuses on the idea that the client has within himself the capacity, latent if not evident, to understand those aspects of his life and of himself which are causing him pain, and the capacity and the tendency to reorganize himself and his relationship to life in the direction of self-actualization and maturity in such a way as to bring a greater degree of internal comfort. AS a consequence, the function of the therapist is to create such a psychological atmosphere as will permit this capacity and this strength to become effective rather than latent or potential.

Step 3

1960s

Is marked by the publication of *On Becoming a Person*. Rogers' interest in the concept of congruence and emphasis on experience and experiencing, being and becoming may also be traced back to this period. For the next quarter century, Rogers and his colleagues continued to develop the applications of the client-centered approach in various fields: education, group work, business, leadership, creativity, personal relationships, cross-cultural communication, intergroup conflict resolution, even maintenance of international peace.

Step 4

1970s

In the late 1970s, American psychiatrist George Engel proposed a need for a review of the medical model and promoted the move from a medical to a biopsychosocial model of health – a model that is now commonly used to explain the shift required to deliver person-centered care. He proposed needing more than just an understanding of the determinants of disease and requiring a model with an inclusive and holistic view of the patient, social context and complimentary system of society

Step 5

1990s

These ideas began to become aligned within health care in the 1990s in the US, when the Chronic Care Model was developed to address perceived deficiencies in how people with long-term conditions were supported.

Step 6

2000s

The influence of Engel and Rogers models makes most European countries to start introducing gradually the elements of person centered model of care in the own Public Health Services.

The highly influential Institute of Medicine included ‘patient-centredness’ as one of its six aims of health care quality.

Over the following decade, ideas of person centredness began appearing with increasing regularity first in UK health policy.

Step 7

2010s

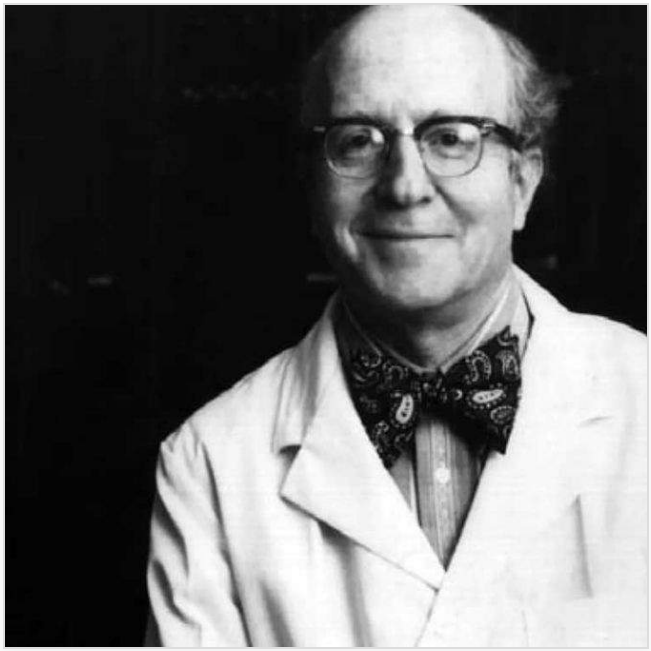
The 2010s in Europe are characterized by greater involvement of patients and their carers at every level of the health service in order to deliver safe, meaningful and appropriate health care'.

Today

Nowadays, person-centered care is central to the policies of all European countries.

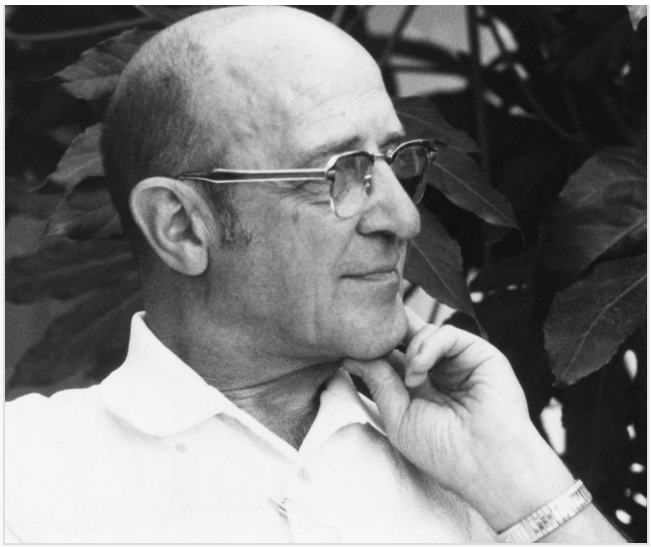
Making sure that people are involved in and central to their care is now recognized as a key component of developing high quality healthcare.

George Libman Engel



Carl Ransom Rogers

George Libman Engel (1913-1999) was born in New York City, he was an American psychiatrist and he spent most of his career at the University of Rochester Medical Center in Rochester, New York. In 1977 George Engel proposed a need for a review of the medical model.



Carl Ransom Rogers (1902-1987) was born in Illinois, was an American psychologist, he spent a number of years working in academia, holding positions at Ohio State University, the University of Chicago, and the University of Wisconsin. It was during this time that

An inspiring initiative

The first National Health Service Constitution in England

A great example is the first National Health Service (NHS) Constitution in England set out what people could expect the NHS to deliver, pulling together all of these policy statements of intent into a rights framework. It stated that 'NHS services must reflect the needs and preferences of patients, their families and their carers. Patients, with their families and carers where appropriate, will be involved in and consulted on all decisions about their care and treatment.' This has been further strengthened in subsequent versions.

Why is person-centered care important?

Making sure that people are involved in and central to their care is now recognized as a key component of developing high quality healthcare.

However, there is much work to be done to help health and social services be more person-centered and this has become more of a priority over the past decade. This is because it is hoped that putting people at the centre of their care will:

1. Improve the quality of the services available.
2. Help people get the care they need when they need it.
3. Help people be more active in looking after themselves detour. Perhaps that distraction will guide you onward.
4. Reduce some of the pressure on health and social services.

Different models of centered approach

System-centered approach vs. People-centered care

Health care used to be based on a systematic model of care: "patient-centered care". That model was an unidirectional clinical approach. Around the turn of the 21st century, health care providers started to listen to the voice of patients and families and they started to using the person-centered model.

Patient-centered care

People-centered care

- Decisions about policies, procedures, and work environment are made exclusively by management.
- Frontline staff are not involved in the decision-making process.
- Traditional medical model where care is driven by diagnosis, care tasks, and the individuals who perform the tasks.

- Care that is focused and organized around the health needs and expectations of people and communities rather than on diseases.
- People-centered care extends the concept of patient-centered care to individuals, families, communities and society.

TRADITIONAL MODEL	PERSON-CENTERED MODEL

- Care is focused on medical diagnoses, disability and deficits, using standardized assessments and treatments.
- Schedules and routines are determined by the facility.
- Professionals make major decisions about treatment; decision-making is centralized.
- Work is task-oriented, with staff rotating assignments. Staff knows how to perform tasks that can be completed for any resident in the facility.
- Services are impersonal; the facility is seen as the staff's workplace.
- Structured activities are available only when the activity director is on duty.
- Focuses on quality of treatment as defined by regulations and professional standards.
- The facility lacks a sense of home, potentially leading to a sense of isolation, loneliness and homelessness.

TRADITIONAL MODEL	PERSON-CENTERED MODEL

- The focus is on the person and his/her abilities, preferences, values and individual needs. Disability is only one of the characteristics considered, not the defining one.
- Schedules and routines are flexible to match the person's preferences and needs.
- The person and his/her support network make decisions about care, seeking advice when needed.
- Work is relationship-centered, with consistent assignments for staff. Staff brings personal knowledge of the resident into the care-giving process.
- The person is a citizen and is supported in participating in community life with fellow citizens.
- Spontaneous activities occur around the clock.
- Focuses on quality of life, as it is defined by the person. What is important to rather than for the person?
- The facility is the person's home; person and staff share a feeling of community and belonging.

Principles of person-centered model

- [ ] Know the patient/user is a person: Build a relationship with them, get to know the person beyond the diagnoses.
- [ ] Share the power and responsibility: Focus on respecting preferences; treat them as partners when setting goals, planning care and making decisions about care, treatment or outcomes.
- [ ] Accessibility and flexibility: Meeting the individual needs by being sensitive to his/her values, preferences and expressed needs. Give the choice by providing timely and complete information in a manner he/she is able to understand.

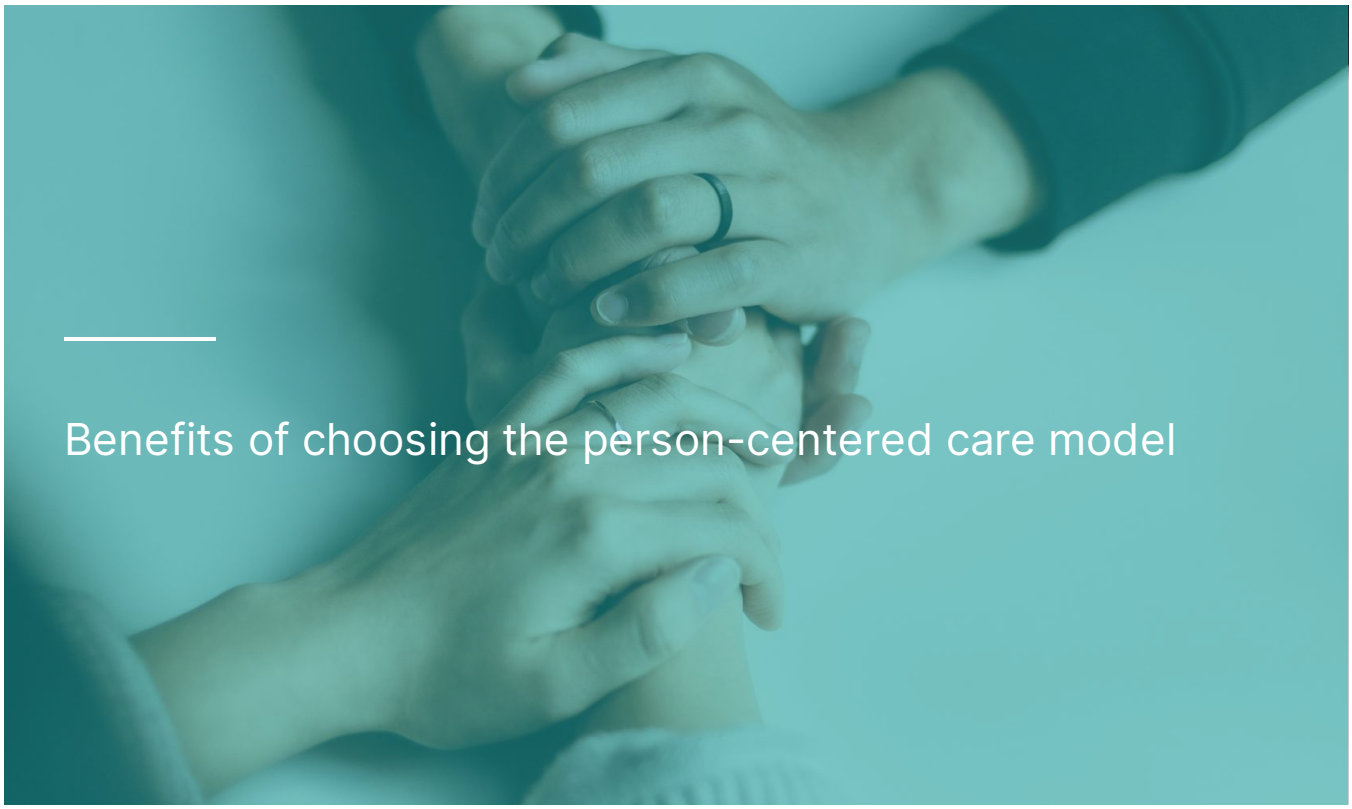
- Coordination and integration: Work together to minimize duplication and providing each resident with a key contact at the facility. This is about teamwork, with all service providers and systems working seamlessly behind the scenes to maximize resident outcomes.

- Environment: This includes the physical, organizational and cultural environments of a facility. The optimal environment is structured to optimize the staff's ability to provide person-centered care to the residents.

Compare

Person centered	Service/System centered
Talking with the person	Talking about the person
Planning with the person	Planning for the person
Focused on strengths, abilities, skills	Focused on labels/ diagnosis, deficits
Finding solutions that could work for anyone, preferably community based.	Creating supports based on what works for people with 'that diagnosis'
Things are done that way because they work for the person	Things are done that way because they work for staff or the service
Family and community members are seen as true partners	Family members & community seen as peripheral

Benefits of choosing the person-centered care model



What kind of changes are possible through person-centered care?

Person-centered care can be used to improve any aspect of health care, from making an appointment to making decisions about palliative care. Person-centered care has been used to improve quality of health care in a range of ways – for example, to:

- Reduce the number of complaints and improve the admissions process in a secure psychiatric unit.

- Negotiate a treatment plan for people with recurrent mental health problems, working with them during a well period to plan for how their treatment should look when they are less able to choose.

- Support people living with conditions such as diabetes, chronic obstructive pulmonary disease (COPD), depression and long-term pain to become more effective self-managers through structured education, training for health care professionals and improving organisational processes.

- Enable dialysis patients to carry out as many of the 13 steps to managing their own hospital treatment as they felt comfortable with.

- Support mental health service users through employing peer support workers (people with lived experience of mental health problems) as part of the health care team to provide practical, physical and emotional support to individuals, contributing to a significant reduction in inpatient stays amongst the people they worked with.

- Support women to decide whether to have a mastectomy or breast-conserving surgery, and men with enlarged prostate to decide whether to take drugs, have surgery or make lifestyle changes.

Putting person-centered care into practice: successful examples

In order to make health care more person-centred, services and practitioners **need to be open to a wide range of approaches and initiatives**. In this section, we will presents some examples of work that is being done, with the aim of providing inspiration and helping those who are looking to put person-centered care into practice.

A national campaign founded by Kate Granger, a doctor living with terminal cancer, to

Hello, my name is...

encourage all staff to introduce themselves by name and profession when meeting a new patient. Kate says, 'In my mind it is the first rung on the ladder to providing compassionate care.

Experience-based co-design

A method for improving people's experience of health care that involves gathering experiences of patients and staff and then bringing them together to develop service improvements. This evidence-based method was developed by

Person and family-centered care

A quality improvement process that focuses on two parallel aspects of health care: care processes (the way care is organised) and staff interactions with patients and their families

(human interactions). This evidence-based approach incorporates 'shadowing'

3 of 4

'What matters to me' boards

An information board placed above beds to make sure everyone can see what is most important to each patient. The magnetic boards are used to write down patients' preferences and priorities, such as whether they want friends and family close by, or

4 of 4

Does person-centered care save money?

There is evidence about cost savings and reductions in service use related to person-centered care activities. For example:

When people are better informed they may choose different treatments – often those that are less invasive and less expensive.

People who are supported to manage their own care more effectively are less likely to use emergency hospital services.

People who take part in shared decision making are more likely to stick to their treatment plan and to take their medicines correctly.

By enabling patients to make choices about what they want, person-centered care helps create better value

for money, ensuring that what we do spend goes towards those things that patients value most.

Module summary

Person-centered care is not just about giving people whatever they want or providing information. It is about considering people's desires, values, family situations, social circumstances and lifestyles; seeing the person as an

individual and working together to develop appropriate solutions.

Key words

System-centered care approach	Talking about the person. Planning for the person. Focused on labels/ diagnosis, deficits. Creating supports based on what works for people with that diagnosis. Things are done that way because they work for staff or the service. Family members & community seen as peripheral.
People-centered care approach	Talking with the person. Planning with the person. Focused on strengths, abilities, skills. Finding solutions that could work for anyone, preferably community based. Things are done that way because they work for the person. Family and community members are seen as true partners.

Traditional-cenetered model care

Care is focused on medical diagnoses, disability and deficit, using standardized assessments and treatments. Schedules and routines are determined by the facility. Professionals make major decisions about treatment. Work is task oriented. Services are impersonal.

Person-centered care into practice

Back of card
Successful examples of person-centered approaches:

- Hello, my name is...
- Experience-based co-design
- Person and family-centered care

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