Patient Satisfaction Assessment

Patients with concomitant chronic diseases managed by a primary care interdisciplinary team

Part 4 – Highlights, successful aspects to include and needs to fill – November 2013

Assessment of patient satisfaction in a context involving the structured management of the health of patients with chronic diseases who are registered with a family medicine group (FMG), and the presence of a trained and equipped interdisciplinary team around family physicians, is a first in Quebec, if not in Canada and North America.

Carried out in a showcase project*, this assessment provides improved understanding.

First, the results show a high rate of satisfaction among patients being managed using care pathways, with a rate of positive responses exceeding 95%. These scores are a credit to the interdisciplinary team that participated in this living lab carried out in an FMG for two years (2011-2013), since patients indicated that they received concrete support that respected their values.

Second, the results illustrate – with a rate of positive responses of 98.6% – that the experience of patients with chronic diseases is very positive when an interdisciplinary team is deployed around the family physician.

Third, the results confirm, with a rate of positive responses exceeding 95%, the importance for patients to receive tailored services and guidance that allows them to set realistic objectives. In this respect, the results clearly show that efforts must be made to prevent chronic diseases and to avoid complications when the disease already exists. In reality, while the system must concern itself with people with several chronic diseases, primarily people in their sixties, it must also tackle the aspect of preventing and reducing complications among patients who already present a risk of complications – patients in their forties who already have two chronic diseases.

In the general population, given that:

- **50% of people have one chronic disease;**
- **these people account for 90% of hospital admissions;**
- **the majority of people with chronic diseases have three or more concomitant diseases;**
- **the average age of these patients is in the early sixties;**

Quebec health system managers must take concrete action when it comes to chronic diseases and interdisciplinary primary care. In the light of studies conducted to date in this area, and insight from the Health and Welfare Commissioner and the committee on patient-based health care funding, the government's response is eagerly anticipated by the population and the health care community.

More specifically, and in light of the results collected, below are three successful aspects to include (rate of positive responses exceeding 95%) and three needs to fill (rate below 70%).

Three successful aspects to include (rate of positive responses exceeding 95%)

1. Provide concrete, respectful support for patients

This dimension (Problem-solving/Contextual) had the highest positive response rate among patients. The highest scores relate to the fact that they were asked:

- If they were helped to plan ahead to take care of their chronic condition in hard times (99.3%);
- If they were helped to make a treatment plan that they could do in their daily life (96.5%);
- If their values and traditions were considered when treatment was recommended (95.7%).

2. Coordinate the services offered in a medical clinic

Patients had a very positive assessment of this dimension (Delivery system design/Decision support). Concretely, patients appreciated:

- How well their care was organized at their medical clinic (98.6%).

3. Tailor the care

In this dimension (Goal-setting/Tailoring), the patients surveyed particularly liked that:

- They were asked questions about their lifestyle habits (97.9%);
- They received help to set goals to improve their eating and exercise (95.7%).

Three needs to fill (rate of positive responses below 70%)

1. Direct patients to self-help groups in the community

Few patients (55%) said that they were directed to self-help groups in the community, although literature and experience in this area show the value added by this type of support.

2. Devote more attention to patients with two chronic diseases

The number of positive responses among patients with two chronic diseases was much lower with respect to coordination (66.1%) and whole person care (68.4%). This study does not make it possible to explain these results, but it may be an invitation to set up the prevention and education activities, and the interdisciplinary follow-up required for this type of patient.

3. Take action earlier for patients in their forties

People in their forties gave lower positive responses about the coordination of services (68.3 %) than individuals in the other age groups. This study does not make it possible to explain these results, but once again, it may be an invitation to take action earlier and to prevent complications among people who already risk developing complications or other chronic diseases. The question arises whether a strategy should be developed for people in this age group.

Also read

Part 1 – Data collection and analysis methodology* – November 2013

Part 2 – Results by five assessments areas – November 2013**

Part 3 – Results by assessment area, number of pathologies and some sociodemographic data – November 2013

*As part of a showcase project carried out in two family medicine groups for two years, pursuant to a collaboration agreement between the Centre de santé et des service sociaux du Sud de Lanaudière, the Agence de la santé et des services sociaux de Lanaudière, the Ministère de la Santé et des Services sociaux and Concerto Health Group, a group of experts in medicine, nursing, and management (www.groupsanteconcerto.com). The showcase project was supported by technology partner Bell Canada, and by five pharmaceutical partners: Sanofi, Astra Zeneca, Pfizer, Bristol-Myers Squibb and Shire.

** The patient satisfaction assessment questionnaire was structured according to the dimensions and questions validated as part of two research efforts. 1. Pan-Canadian study in chronic diseases and primary health care: *Patient Assessment of Chronic Illness Care* or PACIC, Cameron N. McIntosh, Statistics Canada, 2008. 2. Measurement of the effects of the *Patient-Centered Medical Home* models (Jaén et al., 2010 & Nutting et al., 2010).