

British Columbia Ministry of Health

Patients as Partners Initiative

Primary Care Engagement Tip Sheet

Our health system works well, but there are challenges – such as an aging population, more chronic diseases and an over-reliance on hospitals. As the health care system develops initiatives to address these challenges, the need to engage patients, families and caregivers in specific population groups can be anticipated. With this in mind, we have developed a series of tip sheets on engagement processes and for engaging patient population groups including: people who receive primary care services, caregivers, older adults that have complex medical conditions or are frail, people experiencing mental health or substance use, people who will receive surgical services, people in rural or remote locations, and multicultural populations. These tips apply to all three domains of health-system engagement: individual care; program and community services; and system redesign.

The purpose of the tip sheets is to provide guidance and support to health-care organizations in their patient, family and community engagement activities. The tip sheets are intended for use by engagement staff, health service practitioners, program managers, community development officers, and any health-care staff across the B.C. health system who works on engagement projects related to co-design of health care.

Engaging patients, families and caregivers for the Primary Care population

What is the rationale?

Primary care is typically a patient's first contact with the health-care system. Primary care includes most basic health-care services provided by general practitioners, nurse practitioners, and nurses in an office, primary care centre or a patient's home. It also includes services from health professionals such as support from a counsellor, advice from a dietitian or prenatal care from a midwife. Primary care helps keep people healthy and is the entry point into a broader system of care when British Columbians need more services.

A community-based, team approach to primary care can help improve access for patients to receive the comprehensive primary care services they need. Improving access close to home can reduce the use of hospital and emergency services. Supportive interdisciplinary teams in enhanced family practices and primary care clinics, working as part of an integrated network with health authority primary care services, is the cornerstone of this approach to better access to care.

Who are the stakeholders?*

- ✓ All B.C. residents, with particular focus on:
 - Those who do not currently have a primary care practitioner
 - People who are currently receiving services
 - Frequent users of hospital emergency rooms
 - Frequent users of walk-in clinics
- ✓ Health-related community organizations and groups, and health authorities
- ✓ Primary and community care service providers, including family doctors, nurses and other practitioners

*Each of these stakeholder groups includes multiple sub-groups that need to be considered as you design and undertake engagement activities related to this population. Broad sub-groups to consider include: ethnicity, socio-economic status, language, geography and demographic profile.

While other stakeholder groups are identified, the barriers, tips and techniques below are specific to engaging the patient and family/informal caregiver populations related to primary care.

Barriers to engagement

- Culture of physician-led practice decision-making and approach to practice redesign.
- Lack of patient- and community-centred planning, system transformation/redesign and policy development at health care practice/clinic level.
- Lack of internal capacity for patient and community engagement in health-care clinics.
- Lack of time, resources and support required to plan and deliver engagement processes.
- Attitudes/beliefs that patient and family perspectives are already understood/known. For example, “We know what’s best for patients. We are all patients.”
- Other attitudinal barriers, such as fears that engagement could compromise confidentiality, lead to a less-than-best course of treatment, and beliefs that patients do not have the capacity and skills to engage effectively.
- Lack of incentives for patient engagement within physician compensation models, and limitations of negotiated agreements and practitioner union agreements.
- Lack of education, training and skills for partnerships with patients at family practice level.
- Lack of understanding of benefits of patient and family engagement at practice level, and organizational barriers such as lack of incentives for partnering/engaging with patients.
- Potential for patient, family and community member burnout due to high time spent and/or ongoing participation.
- Potential for engagement fatigue, especially if input is not used or patient partners do not see the impact of their participation.
- Mistrust.

Tips and tools for effective engagement

- Engage patients, family and community members as equal partners in all stages of the planning cycle.
- Engage early, and follow through with commitments such as reporting back.
- Allow time and resources to ensure engagement processes are inclusive, and seldom-heard stakeholder groups are involved.
- Communication with participants should be timely, clear, straightforward and free from jargon (use plain language). Use a variety of methods and ask participants about their communications preferences.
- Engage patients, family, community stakeholders and clinicians/practitioners to build relationships, trust and equal partnerships. Build and maintain relationships over time.
- Provide capacity building and support programs for both patients and practitioners, including engagement training, orientation and skill development.
- Provide staff, physicians and patients with ongoing support and mentoring.
- Design engagement processes that best fit the purpose, and with input from stakeholders – rather than taking a one-size-fits-all approach.

- Include patients and family in engagement planning and delivery. For example, seek patient support in recruitment of participants, facilitation, etc.
- Local context, priorities, capacity/capabilities, and desired outcomes should all be considered when planning and designing engagement.
- Evaluate engagement activities in an ongoing way and make adjustments as necessary.
- Provide a variety of opportunities and levels of effort/time commitment for patients, families and community members to participate.
- Engagement should be authentic and meaningful – avoid tokenism. Input should influence the decision, and how input was used and the outcomes should be reported back to participants.
- Measure outcomes.
- Acknowledge and celebrate accomplishments.

Recommended engagement techniques

- Surveys (intercept surveys, for example, in family practice waiting rooms; online surveys and polls)
- Focus groups
- Interviews
- Coffee klatches (small-group dialogue over coffee)
- Workshops (charrette, future search and appreciative inquiry)
- Patient and family membership on clinic redesign teams (multiple patients, participating as full members)
- Patient and family advisory councils

