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Person-centred care after acute coronary syndrome, from hospital to primary care — A randomised controlled trial☆,★

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ABSTRACT

Aim: To evaluate if person-centred care can improve self-efficacy and facilitate return to work or prior activity level in patients after an event of acute coronary syndrome.
Method: 199 patients with acute coronary syndrome <75 years were randomly assigned to person-centred care intervention or treatment as usual and followed for 6 months. In the intervention group a person-centred care process was added to treatment as usual, emphasising the patient as a partner in care. Care was co-created in collaboration between patients, physicians, registered nurses and other health care professionals and documented in a health plan. A team-based partnership across three health care levels included transparent knowledge about the disease and medical state to achieve agreed goals during recovery. Main outcome measure was a composite score of changes in general self-efficacy ≥5 units, return to work or prior activity level and re-hospitalisation or death.
Results: The composite score showed that more patients (22.3%, n = 21) improved in the intervention group at 6 months compared to the control group (9.5%, n = 10) (odds ratio, 2.7; 95% confidence interval: 1.2–6.2; P = 0.015). The effect was driven by improved self-efficacy ≥5 units in the intervention group. Overall general self-efficacy improved significantly more in the intervention group compared with the control group (P = 0.026). There was no difference between groups on re-hospitalisation or death, return to work or prior activity level.
Conclusion: A person-centred care approach emphasising the partnership between patients and health care professionals throughout the care chain improves general self-efficacy without causing worsening clinical events.

1. Introduction

Acute coronary syndrome (ACS) is one of the most common conditions in Western countries. Mortality rates after an ACS event have declined in recent decades owing largely to reductions in incidence and case-fatality rates [1] and radically improved and refined methods for the acute treatment of people with ACS. Still the recovery period among ACS survivors remains problematic. Patients report symptoms after discharge from hospital [2] and return to work and everyday life is hampered by several factors beyond the cardiovascular condition, such as social aspects and co-morbidity [3]. In Sweden, sick-leave and re-admission rates after a myocardial infarction have declined during recent years. Nevertheless, in 2013 approximately 30% of patients with an ACS were still on sick leave up to 10 weeks after the cardiac event and 15% were readmitted to hospital during the following year [4].

Treatment during the acute event and in the recovery phase after an ACS has a focus on the medical condition with assessment of the coronary disease and pharmacological therapy driven by health care professionals. There is growing evidence that patients, who are actively involved in their own care, receive effective treatments, self-management support and regular follow-up in coordinated systems, report better outcomes and satisfaction with their care [5,6].

☆ All authors take responsibility for all aspects of the reliability and freedom from bias of the data presented and their discussed interpretation.
★ Trial registration: Swedish registry, Researchweb.org, ID NR 65 791.
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Person-centred care (PCC) has been identified as a core component for sustainable, high quality health care [7,8]. Although there is currently no consensus definition of PCC it is generally recognised that the focus of care is on the patient as a person rather than on the disease alone. An approach to PCC has been operationalised and tested by the Gothenburg Centre for Person-Centred Care (GPCC) [9,10]. In this approach (henceforth gPCC) the patient narrative is the point of departure, which forms the basis for a partnership between the patient and health care professionals, which in turn is formalised, documented and implemented in a jointly developed gPCC plan [9]. Congruent with the principles of shared decision-making, a fundamental aim of the gPCC approach is to engage and empower patients as active partners in their care. Self-efficacy, defined as a person's belief that he/she is able to successfully execute behaviours necessary to achieve desired goals [11], has been proposed as a central concept in gPCC [12]. Increasing self-efficacy and active patient involvement are decisive factors to improve outcomes [12,13]. To date, we have evaluated gPCC in in-hospital setting, showing that the approach is effective in reducing length of hospital stay [10] and uncertainty in illness [14]. The purpose of this study was therefore to assess the potential added benefits of gPCC, over conventional care, applied at all links in the chain of health care – from hospital, to outpatient and primary care – in terms of improved self-efficacy and return to work or prior activity level 6 months after an acute coronary event.

2. Methods

2.1. Study design

We conducted a multicentre randomised parallel-group, controlled intervention study which assessed six-month outcomes of treatment as usual versus gPCC added to treatment as usual performed at three health care levels (hospital, outpatient and primary care). Randomisation was based on a computer-generated list, stratified for hospital site and employment status, and performed via opaque, sealed and numbered envelopes. The Regional Ethical Review Board approved the study (DNr 275-11) and the investigation conforms to the principles outlined in the Declaration of Helsinki.

2.2. Setting

Patients were enrolled at two hospital sites within the Sahlgrenska University Hospital, Gothenburg, Sweden between June 2011 and February 2014. After hospital discharge follow-up was performed first at an outpatient cardiac clinic and subsequently at public primary care centres in the greater metropolitan area of Gothenburg (n = 43). Five of these centres had designated gPCC professionals who worked exclusively with patients as a team in the gPCC intervention group. These centres were selected to provide good geographical coverage within the area.

2.3. Patients

Patients admitted to the designated wards were screened consecutively. Patients were considered eligible if they were provisionally diagnosed with ACS (ICD = I200, I209 or I21) within a 72-hour period after hospital admission. The time interval was imposed to ensure that the intervention could be initiated as early as possible during hospital stay. Exclusion criteria were: ≥75 years, currently listed at a private primary care centre or at a primary care centre in another region, no permanent address, planned heart surgery such as coronary artery bypass grafting (CABG), cognitive impairment, alcohol and/or drug abuse, survival expectancy less than one year or participating in a conflicting study. All eligible patients willing to participate were included in the study. After randomisation, additional exclusion criteria were misdiagnosed as ACS and anticipated extended hospital stay >14 days (e.g. CABG). All patients received oral and written information about the study and gave written consent to participate.

2.4. Control group

Patients enrolled to the control group were managed according to treatment as usual which followed guideline-directed care [15]. After hospital discharge patients underwent two standard individual cardiac check-ups at an out-patient cardiac clinic, one led by a registered nurse (RN) after two-three weeks and one by a physician after four-six weeks, where they were given advice and informed about the condition. When the patients were assessed as medically stable, they were referred to their regular primary care centre where medication and rehabilitation was planned by the primary care physician and, where appropriate, with other health care professionals (e.g. RN, physiotherapist). Medical referrals and discharge notes were shared by health care professionals at the units but not necessarily with patients.

2.5. Intervention group

The intervention group was also medically managed according to guideline-directed care [15], however, care planning and decision-making were performed collaboratively by patients and health care professionals according to the gPCC approach [9]. Follow-up at an outpatient cardiac clinic was conducted after three to five weeks by specially trained gPCC professionals consisting of a physician and RN. When the patient and the gPCC professionals agreed as a team (gPCC team) that the patient's clinical situation was stable, the patient was assigned to the gPCC professionals at the designated primary care centre located closest to their homes about four weeks thereafter.

All gPCC professionals had received training in the theory and practice of gPCC [9,10] through lectures, seminars and workshops and were given practice in how to formulate and execute gPCC plans. Training emphasised the importance of seeing the patient as a person with needs as well as resources and of a person-centred dialogue as a basis for engaging patients as actively involved partners in their own care. Four three-hour booster sessions with tutoring and case examples were provided during the study period to ensure adherence to the gPCC approach. In the gPCC-intervention group the partnership (initiating, working, safeguarding and maintaining the partnership) between the patient and health care professionals [9] was emphasised at all three health care levels (i.e. hospital, outpatient and primary care) which is described in detail below and in Fig. 1.

2.5.1. Hospital stay

2.5.1.1. Initiating the partnership. The point of departure in the gPCC approach was a structured patient narrative. The narrative was derived in a meeting with an RN held within 24 h after randomisation in which patients were asked to recount their expectations, preferences and goals for treatment along with their own capabilities for and limitations to achieving those goals. The narrative was discussed in a meeting between the patient, RN and physician with the aim to co-create a preliminary gPCC plan integrating the patient's values, expectations and goals with medical expertise and to identify possibilities and barriers to recovery after ACS.

2.5.1.2. Working the partnership. Within 48 h after randomisation, the patient, physician and RN met again to review and to come to a joint agreement on the content of the gPCC plan. The plan was signed by the patient and health care professionals. In addition to patients' medical status, the gPCC plan included information on personal capacities (e.g. motivation), description of the goals and measures