Special Article

Enhancing Patient and Family-Centered Care: A Three-Step Strengths-Based Model

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Abstract

Background: Persons are best understood within their families; therefore examining the whole family as opposed to each individual could form a strong base for fostering different aspects of patient and family-centered care. Despite the enthusiasm for the patient and family-centered care, there are scanty of practical models that aid in the achievement of this approach.
Objective: Our aim here is to translate existing conceptual descriptions of family strength and the domains of Patient and Family-Centered Care into a three-step model that is practical, easy to remember and can act as a guide to skill development. In short to integrate family strengths in yet a novel highly appreciated model of Patient and Family-Centered Care.
Results: The three-step model for enhancing different dimensions of Patient and Family-Centered Care based on family strengths succinctly portrays the key steps of how to foster patient and family collaboration in healthcare promotion. We describe the three key steps of the model namely: (1) *Strength assessment*, (2) *Feedback session*, (3) *Developing strengths to achieve goals.* The feedback session is involved in every step of the model. Strength assessment involves assessment of family strengths by healthcare providers. Developing strengths to achieve goals involves focusing on the identified strengths and areas of growth so that specific goals can be achieved.

Keywords: Patient-Centered Care, family strengths, collaborative goal setting, decision making, family engagement, family-centered care

Background

The Biomedical model provided novel advances in curative options and novel potent drugs (Barry & Edgman-Levitan, 2012; Mitchell et al., 2016) that on the other hand, inadvertently distanced Healthcare Providers (HCPs) from the patient and their family (Barry & Edgman-Levitan, 2012). This created an environment in which patients and their families are oftentimes sidelined from important discussions and at times left in the grey zone, wondering how their needs are being managed and how to navigate the overwhelming array of diagnostic, economic and treatment options (Barry & Edgman-Levitan, 2012). Consequently, this exclusion in care led to a call for healthcare systems that consider the needs, preferences, and participation of patients and their

family in policy and decision making (Barry & Edgman-Levitan, 2012; Goldfarb, Bibas, Bartlett, Jones, & Khan, 2017; Kogan, Wilber, & Mosqueda, 2016; Mitchell et al., 2016). This is embedded in the Patient and Family-Centered Care model (PFCC).

The potential for patients and families to partner with HCPs and become involved in care is significant (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993). However aligning patient and family contribution to healthcare is complex. PFCC comprises of individualized care and empowerment of patients and their family to be active participants in their disease management (Epstein, Fiscella, Lesser, & Stange, 2010; Wolfe, 2001).

HCPs listen, educate, and respect patient and family beliefs and incorporate their preferences into the care plan (Ciufo, Hader, & Holly, 2011). Studies have reported better outcomes and satisfaction and reduction in the per capita costs of healthcare with PFCC (Tzelepis et al., 2014, 2015). Indeed, it has been endorsed internationally by various professional healthcare organizations (Goldfarb et al., 2017; Mackie, Mitchell, & Marshall, 2017).

Albeit the enthusiasm for PFCC, there is a practical gap on how to accomplish the different domains in the PFCC approach. Most models fostering the clinical application of PFCC have centered on shared decision making (Barry & Edgman-Levitan, 2012) which hardly any models that can foster the other aspects of PFCC. Henceforth, we posit that the family strengths model could afford to enhance PFCC. Indeed, McAllister (2007) argues that the family strengths framework is a solution-based approach to health care (McAllister & Thomas, 2007).

Defrain opined that the family strengths approach seeks to identify and encourage positive attributes in the family system. With this approach, HCPs help families identify their visions and goals for the future albeit capitalizing on what factors contribute to family problems (DeFrain & Asay, 2007a).

The driving question in practice is how family strengths could be used to enhance PFCC. The visual perspective of this model based on how family strengths and healthcare environment fit to mutually influence each other. PFCC is both a goal in its own perspective and a tool for enhancing health outcomes (Cheraghi, Esmaeili, & Salsali, 2017). This interrelationship between the metaphorical dimensions of PFCC and the metaparadigm concepts that portray family strengths represents the unique opportunity for developing on family strengths to achieve PFCC as a goal.

Building on family strength offers family support also helps overcome feelings of vulnerability in hospitalized patients (Lolaty, Bagheri-Nesami, Shorofi, Golzarodi, & Charati, 2014; Mitchell & Chaboyer, 2010) who transition more efficiently through the health care system when their families are involved (Berube, Fothergill-Bourbonnais, Thomas, & Moreau, 2014; Mackie et al., 2017) We propose that family strengths approach can be used in routine clinical community practice to enhance patient and family centered care.

Guiding Principles: The three-step model depicts statements, explanations, and prescribes actions towards achieving goals. It provides a coherent set of propositions and statements that describe (factor-isolating), explain (factor-relating), and predict (situation-relating) phenomena as well as prescribe (situation-producing) actions toward goals (Dickoff, James, & Wiedenbach, 1968).

Based on the fact that the PFCC model considers the needs, preferences, and involvement of patients and their families where healthcare professionals make optimal contributions (Ciufo et al., 2011). Families could function best through their operational strengths that afford positive outcomes, (Moore, Whitney, Kinukawa, & Scarupa, 2009) owing to the fact that the family environment has an impact on individuals based on the family's values, needs, beliefs and ability to cope to a crisis (DeFrain & Asay, 2007b).

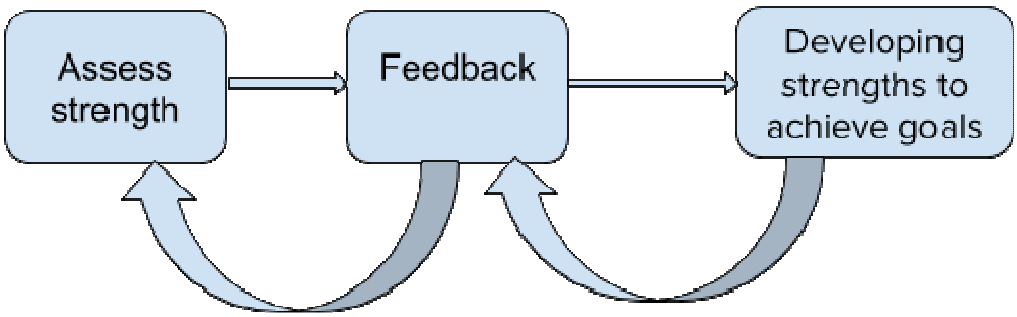
Therefore, through assessment and identification of family strengths, HCPs identify strengths and focus is given to strengthening families (L. Smith, 2008). Based on the identified family strengths, the healthcare provider enhances the ability to cope by developing on the strengths and setting goals with the family (Sittner, Hudson, & Defrain, 2007). The

family strengths form a set of interrelations and processes that consequently satisfy, support and protect family members, this, in turn, could potentiate the family's ability to actively participate in decision making, collaboration in care, increase physical and emotional comfort, satisfaction with care, improve access to care and enhance continuity and transition of care. Family strengths also form a positive unifying conceptual framework for understanding families (DeFrain & Asay, 2007a, 2007b).

Borrowing from Bronfenbrenner's ecological model, of the mesosystem represents face to face interactions with the inner environment and relationships with healthcare providers (Bronfenbrenner, 1977). The mesosystem and exosystem involve different types of connections and belonging. This creates a family network in which the network is detrimental to social, emotional and economic roles. The microsystem deals with how the family members are interconnected whilst the macrosystem encompasses the outside influences (Bronfenbrenner, 1977). The response to admission to hospital is embedded in the macrosystem. For example members of the family may not have learned how to respond to the Intensive Care Unit (ICU) crisis from within the family but it could be found to permeate society as a whole. The interaction between human beings and the environment in terms of calm and crisis determine the wellness and functioning of human beings during times of health and illness (Donaldson & Crowley, 1978). Therefore identifying strengths could afford to enhance PFCC.

As with ecological model (Bronfenbrenner, 1977), the influence between the patient, family, and healthcare environment is reciprocal, in that influence of the family on the ICU environment can be more or in equilibrium with the influence of ICU environment on the family. Therefore identifying family strengths in this crisis, supporting these strengths could enhance and express family and patients' preferences during the crisis and in the continuum of care (DeFrain & Asay, 2007b). The three-step model for enhancing different dimensions of PFCC based on family strengths (*see Figure. I*) succinctly portrays the key steps of how to foster patient and family collaboration in healthcare promotion. We describe the three key steps of the model namely: (1) *Strength assessment*, (2) *Feedback session*, (3) *Developing strengths to achieve goals.* The *feedback sessions* are involved in every step of the model. Strength assessment involves the HCPs assessment of family strengths. Developing goals and strengths involves focusing on the identified strengths and areas of growth. The existence of family strengths signifies its importance in deciphering the relationship between that strengths and dimensions of PFCC, while the development of the identified strengths is essential to the establishment and achievement of goals in the continuum of care.

Figure 1. A three-step strength based Model



Key to the figure

Assess strength	Identify qualities that capture the family's ability to withstand, rebound from crisis and adversity. Place an "S" for a quality they perceive to have achieved and a "G" for areas that need growth.
Feedback	Give feedback to the family about your finding and encourage more dialogue to elicit their preferences and values. This is an ongoing process.
Developing strength to achieve goals	Promote optimal support with emphasis on the development and growth of strengths and resources of the family. Help families develop positive attitudes towards their capabilities and build trust in the care relationship.

Doing family strengths assessment: Various tools have been developed to assess family strength. These tools are used to initiate conversations with any family member that look for support and encourage family strengths. These include the American Family Strength Inventory (AFSI) (DeFrain & Asay, 2007a) and a replica of the AFSI known as the Australian Family Strengths Nursing Assessment (AFSNA) based on the Australian research findings (L. M. Smith & Ford, 2013). An "S" is placed for a quality they perceive to have achieved and a "G" for areas that need growth. Conducting a comprehensive family assessment helps to create a good relationship, understand the family's experience of a health crisis, needs and preferences, understanding a family as a unit (Wright & Bell, 2009).

Developing strengths to achieve goals: From a conversation with families, you can begin to walk away more closely with the family in their effect to promote optimal developmental health, collaboration and other domains of patient and family centered care. Different interventions can be integrated into this step depending on the strengths that need development and the preferred goals. For instance decision support, referral to a counselor or appropriate spiritual providers.

Discussion

We have proposed a model of enhancing patient and family centered care in clinical practice, medical and nursing education and everyday life. The model is a construct from the family strengths model (DeFrain & Asay, 2007a), the PFCC Model (Epstein et al., 2010) and the ecological model (Bronfenbrenner, 1977). The model is based on three key steps: *family strengths assessment*, *feedback* and *developing strengths and goals* (*Figure I*). Metaphorical insights into using family strengths model to enhance PFCC driven the conception of this model. There is seminal evidence about the importance of helping families develop strengths to promote health outcomes and increase resilience (McTavish & Phillips, 2014; Moore et al., 2009). This approach focuses on competencies, resources, capacities and actively seeks to identify, strengths and create a context for change (Wright & Leahey, 2012). Nonetheless, we proposed the three-step model based on the metaphorical insights.

Case example one: To assist families with the ability to cope with stress and crisis effectively in health-related circumstances, HCPs could identify strengths through assessment.

This assessment identifies strengths in areas such as communication, togetherness, sharing activities, affection, support, acceptance, commitment, and resilience, disclose spirituality, family's own beliefs, values and rituals. In the Developing on strength step, it is vital for the health care provider to build on spirituality as strength into the plan of care. This could assist the family in coping with health and psychosocial adversities as they arise (Wright & Bell, 2009) hence achieving emotional support and alleviation of fear and anxiety as a component of PFCC. Spiritual well-being may be organized religion or may be a purely personal spirituality that reflects the family's own beliefs, values, and rituals (Tanyi, 2002).

HCPs could also foster growth in togetherness as strength to foster relationships in sickness and in health by first assessing the family's commitments to long-term relationships, which are built on honesty, dependability, and physical and emotional presence. If that commitment exists or is desired, it is more likely that families will cope successfully.

Furthermore, instructing families that enjoyable time together during an illness is also an important attribute in maintaining healthy relationships, involvement and transition and physical support to the family. In the developing strength to achieve goals, the healthcare provider can encourage families to be physically close, celebrate occasions, and remember special occasions of the past. Encouraging individuals and families to express appreciation and affection for assistance during an illness is respectful and promotes a caring relationship based on mutual trust and support (Sittner et al., 2007).

Information obtained from the patient assessment can also be used to formulate nursing interventions that focus on incorporating family strengths into the plan of care. For example, a family might identify their strength as spiritual well-being, and the nurse might then include a referral to pastoral care during the patient's hospitalization.

Case example two: Another patient might state that at home her family had an enjoyable time together because they participated in family activities; this family strength could then translates into family coping as the nursing diagnosis. Planned interventions could then be tailored at providing privacy during family visits and including the family in the plan of care, which would promote patient's values, preferences, physical comfort, emotional support and alleviation of fear and anxiety.

Albeit the infancy of this model, many HCPs may push back with opinions on improving the model. We acknowledge this concern and opin that further research will be required to appropriately reward the model in enhancing PFCC. Consistent family strengths across studies conducted (DeFrain & Asay, 2007a), gives a mark to this model that considers family strengths in enhancing PFCC.

To effectively appreciate this model, HCPs need to be effectively equipped with comprehensive competency on family assessment and upraise the interconnection of health, family, community, and environment. This could be achieved through simulations on family assessment tools and the model. In the academic environment, it is important for medical students to be taught the family strengths framework through incorporating family strengths assessment into the curriculum thus helping to reinforce the importance of family strengths in illness and health.

We hope to build on this model by carrying out different studies in a different setting in an attempt to assess the applicability of the model in enhancing different aspects of PFCC such shared decision making, collaborative care and others. Further studies and development of this model are required in theory, practice, and research.

This paper describes the three-step strengths-based model which may not be generalized to all environments. The model might be tedious to implement without competent HCPs in family strengths assessment. On-going research and implementation are needed to explore barriers and facilitators necessary for success as well as local context-related factors.

Conclusion

This article describes the three-step strength model that could be used to foster different dimensions of patient and family centered care. We illustrate an advanced, practical, easy to remember yet novel pragmatic model applying family strengths in a highly appreciated model of Patient and Family-

Centered Care. We further emphasize that this model will go a long way in simplification of yet complex and demanding patient and family centered care. That was our objective.

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