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Health Policy Analysis

Patient-Centered Care for Women: Delphi Consensus on Evidence-Derived Recommendations



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ABSTRACT

Objective: Patient-centered care (PCC) could reduce gender inequities in quality of care. Little is known about how to implement patient-centered care for women (PCCW). We aimed to generate consensus recommendations for achieving PCCW.

Methods: We used a 2-round Delphi technique. Panelists included 21 women of varied age, ethnicity, education, and urban/rural residence; and 21 health professionals with PCC or women's health expertise. Panelists rated recommendations, derived from prior research and organized by a 6-domain PCC framework, on a 7-point Likert scale in an online survey. We used summary statistics to report response frequencies and defined consensus as when $\geq 85\%$ panelists chose 5 to 7.

Results: The response rate was 100%. In round 1, women and professionals retained 46 (97.9%) and 42 (89.4%) of 47 initial recommendations, respectively. The round 2 survey included 6 recommendations for women and 5 recommendations for professionals (did not achieve consensus in round 1 or were newly suggested). In round 2, women retained 2 of 6 recommendations and professionals retained 3 of 5 recommendations. Overall, 49 recommendations were generated. Both groups agreed on 44 (94.0%) recommendations (13 retained by 100% of both women and clinicians): fostering patient-physician relationship ($n = 11$), exchanging information ($n = 10$), responding to emotions ($n = 4$), managing uncertainty ($n = 5$), making decisions ($n = 8$), and enabling patient self-management ($n = 6$).

Conclusion: The recommendations represent the range of PCC domains, are based on evidence from primary research, and reflect high concordance between women and professional panelists. They can inform the development of policies, guidelines, programs, and performance measures that foster PCCW.

Keywords: consensus recommendations, Delphi technique.

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Introduction

Throughout their lifespan, women have unique biological and physiological healthcare needs, which can interact with social factors (eg, rise in labor force participation, shift to later marriage and childbearing, simultaneous roles as paid workers and caregivers) and influence their access to healthcare services and their health outcomes.^{1,2} Compared with men, women in both developed and developing countries experience a higher rate of unmet healthcare needs, even after adjustment for a range of socioeconomic and contextual factors, and as a result, have poorer health outcomes and quality of life.^{1,3,4} For example, among 214 824 patients hospitalized for acute myocardial infarction, women underwent fewer procedures and had a significantly higher risk of 30-day admission compared with men,⁵ and women were less likely than men to be referred for cardiac rehabilitation.⁶ Among all noninstitutionalized

adults in the United States, disparities between men and women remained constant between 2000 and 2013 for 83% of measures of access to care, patient safety, person-centered care, effective treatment, and healthy living.⁷ These findings illustrate an urgent need to address persistent sex inequities in healthcare quality.

Over several decades, numerous national and international organizations have issued recommendations for strategies to improve quality of care for women. These include the 2009 World Health Organization report "Women and Health"⁸ and the 2018 United Nations report "Gender Equality in the 2030 Agenda for Sustainable Development."⁹ In 1999, the Johns Hopkins University Women's and Children's Health Policy Center, with the federal Maternal and Child Health Bureau, undertook a review of the health of women in the United States and invited experts to develop recommendations for health policy, programs, practices, and research.² A similar process was undertaken in Canada based

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on insight from women's health experts, health system leaders and providers, and over 200 women.¹⁰ All of these initiatives emphasized the need for policies, strategies, guidelines, and quality measures that promote and support high-quality healthcare for women across the lifespan.

Patient-centered care (PCC) is an approach that could reduce sex inequities by tailoring care to the clinical needs, life circumstances, and individual preferences of women. In adopting this approach, clinicians personalize care by thoroughly understanding each person's context and being attentive to symptoms and concerns that may otherwise be ignored or misconstrued, leading to proven sex inequities in healthcare quality.¹⁻⁷ The Institute of Medicine defined PCC as care that establishes a partnership among practitioners, patients, and their families to ensure that providers and systems deliver care that is attentive to the needs, values, and preferences of patients.^{11,12} Since then, through considerable research, the concept has evolved and expanded: there are at least 25 unique frameworks or models of PCC.¹³ Important dimensions of PCC include the consideration of each patient as a unique person, patient involvement in care, and patient-clinician communication.^{14,15} A variety of informational, educational, and supportive interventions targeted at patients, family members, or providers can be employed to foster PCC.¹⁶ Patient-centered care is now considered a fundamental component of high-quality healthcare because it has been associated with numerous beneficial outcomes for patients (ie, increased knowledge, skill, satisfaction, quality of life; decreased admissions, readmissions, and length of hospital stay), family members (increased satisfaction; decreased stress and anxiety), and providers (improved job satisfaction, confidence, and quality of care; reduced stress and burnout) across multiple settings including primary, emergency, acute, and intensive care.¹⁶⁻¹⁸

Although much is known about PCC, a review of published research identified a paucity of studies, interventions, or measures focused on women.¹⁹ Another review revealed no PCC frameworks or models specific to women.²⁰ Similarly, a content analysis of practice guidelines on various clinical topics identified little guidance on how to achieve PCC or tailor care for women.²¹ Hence, we lack knowledge about how to achieve patient-centered care for women (PCCW). Such knowledge is needed to inform the development of policies, guidelines, programs, and quality measures that, in turn, would promote and support PCCW. The purpose of this study was to engage women and healthcare professionals in generating consensus recommendations to achieve PCCW.

Methods

Approach

Given limited evidence on what constitutes PCCW and how to achieve it, we employed a consensus research design. More specifically, we used the Delphi technique, which is a widely applied method for generating consensus on strategies, recommendations, or quality measures.²²⁻²⁴ This technique is based on 1 or more rounds of survey in which expert panelists independently rate recommendations until consensus is achieved. We did not employ the modified Delphi technique, necessitating an in-person meeting or teleconference to finalize consensus. It can be challenging to schedule a time when all panelists can participate. Instead, we chose to employ a stringent process and rules for consensus and to wait and see if consensus could be achieved by Delphi only before determining if additional steps were needed. The conduct and reporting of this research complied with recommendations for conducting online surveys,²⁵ and the Conducting and Reporting of Delphi Studies criteria to enhance rigor.²⁶ The research team—

composed of health services researchers; physicians of various specialties; experts in women's health or PCC; representatives of professional societies, charitable foundations, and quality improvement agencies; and patient research partners—provided input at all stages, further enhancing rigor. The University Health Network Research Ethics Board approved the study.

Expert Panel Sampling and Recruitment

We assembled an expert panel composed of 42 members from across Canada: 21 professionals (researchers, clinicians, managers with expertise in women's health research or policy) and 21 women aged 18 or greater who had experienced care for any health condition or issue for themselves or a female family member. A systematic review on 80 Delphi studies found the median number of panelists was 17 (range 3 to 418).²⁷ Other research showed an increase in Delphi reliability with increasing panel size.²⁸ and we wished to ensure that professionals and women represented the diversity of the Canadian population and a variety of characteristics that might influence their rating. We recruited women from among 50 members of our Women's Advisory Group, which was established in 2018 to assist in our PCCW research. The advisory group includes women who vary in age, healthcare issue, ethnicity/culture, and urban or rural setting who volunteered to assist with our research program, of which this study was one part, by providing input as needed for study planning and data collection, analysis, and interpretation. They were identified through a 600+-member patient and family advisory committee maintained by Health Quality Ontario based in Canada's largest province. We identified professionals through publicly available university websites and the Canadian Research Information System (http://webapps.cihr-irsc.gc.ca/cris/Search?p_language=E&p_version=CRIS), a directory of research funded by various Canadian agencies, and selected them for expertise in women's health or PCC. The research team and recruited panelists recommended additional participants.

Survey Development

We derived recommendations to be rated by panelists from various sources including a review of research published between 2008 and 2018 that investigated PCC and included at least 50% women or reported subanalyses for women,¹⁹ and interviews we conducted with 34 women representing various characteristics and 37 clinicians of multiple specialties to explore what constitutes PCCW and how to achieve it (under review). From these sources, T.F. and A.R.G. extracted data on all unique facilitators and barriers of PCCW and suggested strategies for promoting or support PCCW, and worded the concepts underlying those facilitators, barriers and strategies as recommendations. We organized recommendations in a table by 6 PCC domains (fostering patient-physician relationship, exchanging information, responding to emotions, managing uncertainty, making decisions, enabling patient self-management) based on a conceptual framework developed by McCormack et al.²⁹ We chose this framework from among others because it was comprehensive and rigorously developed.^{13,29} The table also included the source of each recommendation (review, women interviews, clinician interviews). The research team (including patient research partners) reviewed recommendations for construct, content, and face validity, and clarity of wording. We used this feedback to merge, expand, or reword recommendations, resulting in 47 recommendations.

Data Collection and Analysis

We transformed the 47 recommendations into a round 1 online survey using Google Forms. Each recommendations was to be

Table 1. Female panelist characteristics.

Characteristics	No. (% of 21)
Age (years)	
<40	3 (14.3)
40-60	11 (52.4)
>60	7 (33.3)
Ethnic background	
White	13 (61.9)
African American	1 (4.8)
Caribbean	1 (4.8)
Chinese	3 (14.3)
South Asian	3 (14.3)
Location	
Urban	15 (71.4)
Rural	6 (28.6)
Education	
High school	2 (9.5)
College	5 (23.8)
University	7 (33.3)
Postgraduate	7 (33.3)

rated on a 7-point Likert scale (1 strongly disagree, 7 strongly agree). We included a free-text option for comments about the recommendations and for additional recommendations not included in the survey. The research team (including patient research partners) reviewed the survey and accompanying instructions for clarity, spelling, and functionality. Standard Delphi protocol suggests that 2 rounds of rating with agreement by two-thirds of panelists to either retain or discard items will prevent respondent fatigue and drop-out.²²⁻²⁴ We conducted 2 rounds of rating; however, to yield unequivocal recommendations, we applied stringent consensus criteria. Instructions, a link to the survey, and the table showing the source of each recommendation were sent to women and professionals by email between April 24 and May 1, 2019, with email reminders at 1 and 2 weeks. We developed a round 1 summary report that included Likert scale response frequencies and comments for each recommendation, which were organized by those retained (rated by at least 85% of panelists as 5 to 7), discarded (rated by at least 80% of panelists as 1 to 4), or no consensus (all others), along with newly suggested recommendations. On May 29, 2019, we emailed panelists the round 1 summary report with a link to the round 2 survey, formatted similarly to the round 1 survey, to prompt a rating of recommendations that did not achieve consensus for inclusion or exclusion in round 1. We emailed a reminder at 1 and 2 weeks. We analyzed and summarized round 2 responses in a manner similar to round 1. To thoroughly gauge consensus, we purposefully surveyed women and professionals separately and sent summary reports only for their group to compare PCC recommendations between groups without influence on rating from the results of the other group. If women and professional consensus diverged considerably, that would warrant further investigation beyond what a single joint meeting could accomplish. If instead women and professional consensus were similar without influence from the other group, that would truly signify strong consensus and provide clear support for implementing the recommendations.

Results

Panelists

Of 45 women and 53 professionals invited to participate, 27 women and 21 professionals (including 2 men) consented. From

Table 2. Professional panelist characteristics.

Characteristics	No. (% of 21)
Occupation	
Clinician investigator	10 (47.6)
Scientist	8 (38.1)
Manager/director	3 (14.3)
Expertise	
Women's health disparities/determinants	10 (47.6)
Women's cardiovascular health	3 (14.3)
Chair, women's health research	3 (14.3)
Patient engagement/patient-centered care	3 (14.3)
Women's mental health	2 (9.5)
Province (ie, region of Canada)	
Ontario	11 (52.4)
Alberta	6 (28.6)
British Columbia	3 (14.3)
Quebec	1 (4.8)

among the 27 women, 21 were chosen to match the number of professionals while maximizing variability in characteristics. All women and professionals completed the round 1 and round 2 surveys. Panelist characteristics are summarized in Table 1 (women) and Table 2 (professionals). Most women were between 40 and 60 years of age, white, based in urban settings, and with post-high school education. Most professionals were clinicians including 2 nurses, 2 obstetric internists, 2 obstetrician gynecologists (1 also a psychiatrist), and 1 each for social worker, psychologist, nephrologist, and geriatrician. All professionals focused on some aspect of women's health research or policy.

Initial Recommendations

We derived initial recommendations in non-mutually exclusive fashion from a review of published research (28, 59.6%) and interviews with women (28, 59.6%) and clinicians (44, 93.6%). A total of 22 (46.8%) recommendations were common to all 3 sources, and 30 (63.8%) were common to both women and clinician interviews. Appendix 1 (in Supplemental Materials found at <https://doi.org/10.1016/j.jval.2020.03.017>) presents all 47 recommendations included in the round 1 survey and their sources, organized by PCC domain: fostering patient-physician relationship (n = 12), exchanging information (n = 11), responding to emotions (n = 5), managing uncertainty (n = 5), making decisions (n = 8), and enabling patient self-management (n = 6).

Delphi Results

Appendix 2 (in Supplemental Materials found at <https://doi.org/10.1016/j.jval.2020.03.017>) presents the rating results of round 1 and round 2. Figure 1 shows the number of recommendations retained and discarded in each round for women and professionals. In round 1, women retained 46 (97.9%) and professionals retained 42 (89.4%) of the initial 47 recommendations; 41 (87.2%) were retained by both women and professionals. The round 2 survey included 6 recommendations for women (1 did not achieve consensus in round 1; 5 were newly suggested) and 5 recommendations for professionals (none achieved consensus in round 1). In round 2, women retained 2 of 6 recommendations and professionals retained 3 of 5 recommendations.

Table 3 shows the final results. Ultimately, 49 recommendations were generated, of which 13 could be considered highest priority because they were retained by 100% of both women and clinicians (bolded in Table 3). At least 80% of women and professionals agreed on 44 (93.6%) of 47 initial recommendations, demonstrating a high degree of consensus overall and between

Table 3. Final PCCW recommendations.

PCC domain	PCCW recommendations*
Fostering patient-physician relationship Establishing a friendly, courteous, and comfortable relationship	<ul style="list-style-type: none"> • Clinicians should listen, acknowledge, and convey that they do listen to women's concerns. • Clinicians should establish rapport with women (ie, engage in friendly conversation) to facilitate trust and openness. • Clinicians should exhibit behavior that shows respect and eliminates power differentials (ie, maintain eye contact, be seated at the same level when feasible, be respectful of cultural beliefs and practices). • Clinicians should ensure that waiting areas, offices, and clinics are pleasant, clean, safe, and comfortable. • Family/care partners should be included in appointments if desired by women. • Appointments should be scheduled to ensure that there is sufficient time to address all concerns so that women do not feel rushed. • Time spent with patients during appointments should be optimized as needed through use of a multidisciplinary team (ie, various nursing roles, physiotherapists, psychologists) in addition to time spent with physicians. • Appointment times should be flexible and convenient (ie, offered at various hours including evenings and weekends or by video) to accommodate women's schedules (ie, employment, family responsibilities). • Clinics and health services should provide women who desire it with a safe and private environment (ie, appointments or clinic hours with women clinicians, separate waiting areas for women, spaces for children). • All staff (ie, clinicians, allied professionals, administrative personnel) must be welcoming and friendly. • Clinician offices and clinics should accommodate women's caretaking needs (ie, allowing them to be accompanied by children, providing child-friendly waiting areas/facilities). • Clinicians should attend a training course/workshop on how to achieve patient-centered care for women [women only]. • Women should be given the opportunity to provide feedback to their healthcare provider about their experience to strengthen further interactions [newly suggested by women only]. • Clinicians should ask patients if they have any accessibility issues requiring assistance (ie, cognitive, visual, or physical impairments/disabilities) [newly suggested by women only].
Exchanging information Learning about the patient; words or language used to discuss healthcare	<ul style="list-style-type: none"> • Clinicians should adopt an open and nonjudgmental manner (ie, tone, facial expression, language) so that women feel comfortable about stating treatment preferences, concerns, or sensitive information. • Clinicians should explore women's healthcare goals and priorities upon initial consultation, express that they recognize those goals, help to set realistic expectations, and continually revisit them over time. • Clinicians should explore factors such as age, gender (ie, trans women), social pressures, negative or traumatic experiences, socioeconomic status, cultural background, and lifestyle to fully understand their healthcare needs, experiences, and preferences. • Clinicians should involve a translator, community facilitator, or family member/caregiver in consultations with women who may have language barriers, with the women's consent. • Clinicians should ask questions to assess women's baseline knowledge regarding their condition/treatment before offering treatment suggestions. • Based on an assessment of baseline knowledge, clinicians should communicate with women using language and information that is relevant, practical, and accessible. • Clinicians should confirm and facilitate recall and understanding (ie, open questioning, asking women if they need clarification or more information). • Clinicians should use diagrams, handouts, and visual aids during appointments with women to help explain concepts and conditions, if requested. • Clinicians should ensure that women have an opportunity to ask questions during appointments. • Clinicians should recognize and respond to women's symptoms by acknowledging them and expressing empathy. • Clinicians should offer a "question prompt" list or encouragement to ask about their primary concerns before or at the outset of appointments so that women are prepared for what to ask their clinician [women only].

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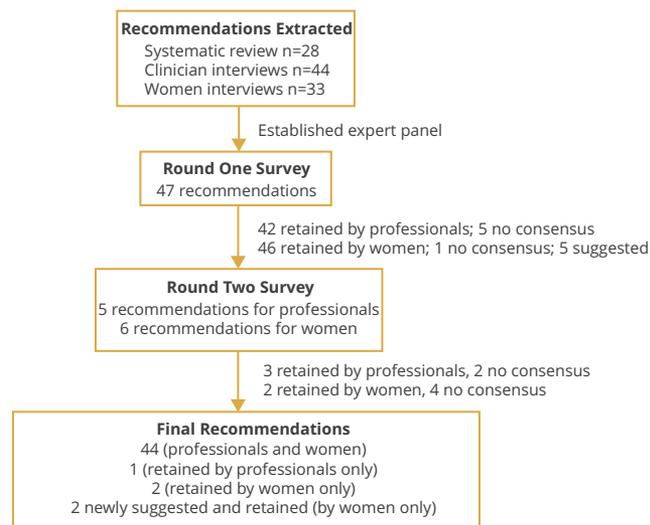
Table 3. Continued

PCC domain	PCCW recommendations*
Responding to patient emotions Response to or management of emotional reactions	<ul style="list-style-type: none"> • Clinicians should explore, identify, and encourage expression of women's feelings or concerns (ie, asking patients about their feelings, providing time for patients to express their thoughts or feelings). • Clinicians should validate women's emotions or concerns (ie, acknowledge emotions or concerns, provide reassurance when reasonable, express empathy, and remind women that they are not alone). • Clinicians should provide or refer women to/with available resources and services to support overall well-being (ie, social worker, peer support group, nurse, psychologist, psychiatrist, depending on need/severity). • Clinicians should maintain and seek support for their own well-being to reduce burnout and optimize their capacity to effectively respond to women's concerns. • Clinicians should allow women to take breaks if/when overcome by emotions or concerns if appropriate, or revisit topics at a later date if needed [professionals only].
Managing uncertainty Addressing uncertainties about prognosis or outcomes	<ul style="list-style-type: none"> • During consultations, clinicians should inform women of what to expect during the appointment and in follow-up appointments. • Clinicians should recognize and address women's uncertainties about risks, benefits, and outcomes (ie, recovery expectations, prognosis) by asking if they have questions or probing for understanding. • Clinicians should discuss the likely effectiveness of medication/treatment to ensure that women have realistic expectations about risks, benefits, and outcomes. • Clinicians should discuss treatment risks, side effects, and impacts on health and lifestyle with women during the appointment (ie, verbally, and with diagrams/posters). • Clinicians should offer or refer women to sources of informational material (ie, pamphlets, websites) on their condition; treatment options; and treatment risks, benefits, and outcomes that they can refer to after the appointment.
Making decisions Engaging women in discussion and decision making	<ul style="list-style-type: none"> • Clinicians and women should together discuss the merits of treatment options. • Clinicians should engage women in the decision-making process. • Clinicians should offer or refer women to informational material and education about all relevant treatment options so that they can participate in discussions and decisions as desired. • Clinicians should provide and rationalize recommendations but make it clear that women have the final choice, if desired, an approach that is likely to optimize adherence to treatment plans and improve health outcomes. • Clinicians should refer to contextual information they elicited from women (ie, lifestyle, cultural background, socioeconomic status, personal preferences) to match treatment options to women's holistic needs. • Clinicians should give women time to think about treatment options before making a decision (ie, time to reflect on options during the appointment and/or schedule a follow-up appointment acuity permitting). • Clinicians should involve women's family members/care partners in the decision-making process if desired by the woman. • Clinicians should convey understanding and support for women's choices, regardless of whether it was the clinician's recommendation, or engage in careful discussion if choices are counter to medical advice.
Enabling patient self-management Setting expectations for follow-up; preparing for self-managing health and well-being	<ul style="list-style-type: none"> • Follow-up appointments should be scheduled to reevaluate treatment plans and address women's questions or concerns. • If clinically feasible, women should be given the option to have follow-up appointments online or at home to accommodate physical or lifestyle. • Clinicians should offer women who desire it with specific instructions on how to self-monitor and self-manage their condition or lifestyle behavior (ie, verbal guidance, pamphlets, websites). • Clinicians and women should jointly identify potential challenges of treatment adherence or behavior modification, and discuss strategies or resources/services to overcome those challenges. • Clinicians, women, and family members/care partners (if desired) should jointly create a plan on how to deal with adverse effects of treatments and/or condition complications, including how to identify and manage them. • Clinicians should give women information on who to contact with treatment concerns or follow-up questions depending on availability (ie, 24-hour hotline, primary care physician, nurse practitioner, emergency department).

Note. Bolded recommendations were retained by all women and clinician panelists.

PCC indicates patient-centered care; PCCW, patient-centered care for women.

*Retained by both women and professionals unless otherwise noted

Figure 1. Delphi process and results.

the 2 groups. Recommendations reflected all PCC domains. By PCC domain, the number of recommendations retained by both groups were fostering patient-physician relationship ($n = 11$), exchanging information ($n = 10$), responding to emotions ($n = 4$), managing uncertainty ($n = 5$), making decisions ($n = 8$), and enabling patient self-management ($n = 6$). Four additional recommendations were retained by women only: 3 in the domain of fostering the patient-physician relationship (clinicians should attend PCC training, women should be given the opportunity to provide feedback on the experience, and clinicians should inquire about accessibility issues requiring assistance) and 1 in the domain of exchanging information (clinicians should offer encouragement or “question prompt” lists to help women ask about or convey their primary concerns). One additional recommendation was retained by professionals only in the domain of responding to patient emotions (clinicians should allow women to take breaks or revisit topics at a later date if overcome by emotions or concerns).

Discussion

These findings provide unique insight into how to achieve PCCW because a review of prior research identified little study of what constitutes PCC, specifically for women, as an approach for reducing persistent gendered inequities in the quality of healthcare and associated outcomes.¹⁻¹⁰ A review by Park et al of 28 reviews published from 2011 to 2017 of patient- or family-centered care identified a variety of informational, educational, and supportive interventions targeted at patients, family members, or providers that can be employed to foster PCC.¹⁶ Nevertheless, that review did not analyze data according to known PCC domains to assess the extent to which the interventions addressed PCC, and did not identify which interventions were tested in or suitable for patients with different characteristics, in particular women. Similarly, other reviews of PCC did not employ an established PCC framework (80 articles 2000-2017)³⁰ or focus on the perspective of acute inpatients (50 articles 2001-2009)³¹ or nurses (13 articles, 2001-2010)³² and thus did not examine PCCW. Although guidelines have been published that recognize considerations for the prevention, diagnosis, and treatment of disease among women,^{33,34} they offer clinical recommendations, and not

recommendations specific to patient-clinician communication and partnership. Therefore, this research offers novel findings that can be used by clinicians, managers, and policy makers to plan, deliver, evaluate, and improve PCCW. In particular, recommendations span all domains of a framework of PCC elements considered ideal by the patients and health professionals who contributed to its development.²⁹ By applying the recommendations, clinicians can better address the multiple dimensions of PCC that were prioritized by and for women. In doing so, clinicians can tailor care to the clinical needs, life circumstances, and personal preferences of women, leading to improved healthcare experiences for women and associated beneficial health outcomes.

We found a high degree of consensus between women and professionals and with the initial proposed evidence-based recommendations and recommendations that reflect the range of PCC domains. As a result, a large number of recommendations were generated, most of which emphasize clinician processes or behaviors. The ever-increasing number of guidelines places pressure on clinicians that can adversely affect job satisfaction and clinical performance.³⁵ There may be several ways to address this regarding these PCCW recommendations. For example, 13 recommendations across 5 of 6 PCC domains were retained by 100% of both women and clinicians and could be considered priorities. Nevertheless, despite stringent rules, we applied for consensus; most recommendations were retained by 80% or more of panelists. In future research, recommendations could be prioritized through ranking by women and professionals. This could identify a core set of recommendations that should be widely adopted. Such prioritization could also occur locally so that healthcare organizations choose and apply recommendations that address specific needs, perhaps revealed through needs assessment.

Four recommendations that achieved consensus only among women identify additional approaches that could help clinicians adopt PCCW. Women recommended that clinicians undergo PCCW training. Research shows that idealism about PCC declined as students progressed through medical school unless PCC was explicitly taught and modeled, underscoring that clinicians would benefit from PCC training.³⁶ Thus, academic and professional organizations could develop and offer continuing professional development opportunities to their constituents that focus on PCC and women's health. Research may also be needed to examine medical curriculum for the presence of content related to PCCW, and if absent, then medical schools may wish to include such content in the education of medical trainees. Women also recommended that clinicians encourage women to discuss their concerns and ask questions through use of a communication aid. Question prompt lists, composed of a list of questions that patients can ask their clinician, have been shown to improve patient question-asking, knowledge, satisfaction, discussion of sensitive issues, comfort, participation, and recall of information, and reduce perceived unmet needs and anxiety.³⁷⁻³⁹ Previous research has suggested that question prompt lists are especially effective for culturally and linguistically diverse patients in improving health service delivery and care.⁴⁰ Importantly, question prompt lists may be readily adopted: physicians who employed question prompt lists said they were feasible to implement, did not strain resources, and encouraged them to provide more information during consultations.³⁷⁻³⁹ Therefore, in ongoing research, we plan to develop and evaluate the impact of a question prompt list informed by these PCCW recommendations. Given that professionals did not achieve consensus on these recommendations, further study may be needed to explore clinician views about PCCW education and the use of question prompt lists. Two additional recommendations were retained only by women. The first, feedback to their provider regarding their experience to further

strengthen interactions, does seem to be a useful approach in keeping with the PCC domain of fostering a healing relationship and exchanging information, but could result in unintended consequences such as tension or resentment on the part of clinicians, and thus warrants further study on how to optimize this recommendation. The second, clinicians should inquire about and accommodate accessibility needs based on cognitive or physical disabilities, is a recommendation that reflects the need for equitable access to care and also warrants further study to establish the extent of the problem and identify corresponding solutions.

One recommendation, take breaks or revisit topics at a later date when women are overcome by emotions or concerns, was retained only by professionals. This may warrant additional probing to understand acceptability among women and feasibility among clinicians. Future research should also explore the feasibility of implementing PCCW recommendations via guidelines, programs, and performance measures among healthcare managers and policy makers. Another interesting option would be mapping the recommendations to other frameworks or models of PCC to further illustrate what constitutes PCC specifically for women.¹³ Given that other PCC frameworks emphasize general principles, such as consideration of each patient as a unique person, patient involvement in care, and patient-clinician communication,¹³⁻¹⁵ we hypothesize that the recommendations generated by our Delphi study are likely unique from and more comprehensive than existing PCC frameworks.

This study featured several strengths. Recommendations reflect the perspectives of both women and clinicians and a variety of characteristics within both groups. Although the recommendations were generated through a consensus process, they were derived from primary research and therefore evidence based. We optimized the Delphi process by using a large panel size to enhance reliability and 2 rounds to minimize respondent fatigue,^{22-24,27,28} and in so doing, achieved a 100% response rate in both rounds. We also imposed a strong definition of consensus to ensure that recommendations were unequivocal. To optimize rigor, we complied with research and reporting standards for online surveys²⁵ and for Delphi studies,²⁶ and involved our multidisciplinary research team that included patient research partners in planning and undertaking data collection, analysis, and interpretation. A few limitations should also be noted. Panelists were volunteers, thus their views about what constitutes PCCW and how to achieve it may differ from the women and health professional populations they represent. Their views may not be generalizable to women or health professionals in countries outside of Canada with differing cultural and health system contexts. Also, most of the female panelists had postsecondary education and were older than 40 years, thus their views may not represent what constitutes PCCW for women with high school education or less, or younger women. Although women and professionals rated the same initial recommendations, we provided summary reports specific to their group. A Delphi process typically shares ratings with all panelists, but we did this to avoid potential influence on ratings and to compare consensus between women and health professionals. Despite lack of exposure to results from the other group, this approach revealed a high degree of consensus between the 2 groups so subsequent additional processes were not needed to finalize consensus, and clear support for implementing the recommendations, which in fact could be considered a strength of this research. Although many of the recommendations appear to also be relevant for men, they were based on evidence from prior research¹⁹ and from interviews with women and clinicians about what specifically constitutes PCCW.^{41,42}

Conclusions

This research provides unique, much-needed insight on how to reduce persistent gendered inequities in healthcare quality by employing a PCC approach. A 42-member multidisciplinary panel including women and health professionals with diverse characteristics generated 49 recommendations to support or achieve PCCW. The recommendations reflect the full range of PCC domains (fostering patient-physician relationship, exchanging information, responding to emotions, managing uncertainty, making decisions, and enabling self-management). The recommendations were based on evidence from primary research, and strong consensus was achieved: at least 80% of women and health professional panelists agreed upon 44 (93.6%) of 47 initial recommendations, and 13 recommendations were agreed upon by 100% of both women and clinicians. Therefore, these recommendations can be used to inform the development of policies, guidelines, programs, and performance measures that promote and support PCCW.

Supplemental Material

Supplementary data associated with this article can be found in the online version at <https://doi.org/10.1016/j.jval.2020.03.017>.

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