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Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience

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Abstract

Objective. To investigate organizational facilitators and barriers to patient-centered care in US health care institutions renowned for improving the patient care experience.

Design. A qualitative study involving interviews of senior staff and patient representatives. Semi-structured interviews focused on organizational processes, senior leadership, work environment, measurement and feedback mechanisms, patient engagement and information technology and access.

Setting. Eight health care organizations across the USA with a reputation for successfully promoting patient-centered care.

Participants. Forty individuals, including chief executives, quality directors, chief medical officers, administrative directors and patient committee representatives.

Results. Interviewees reported that several organizational attributes and processes are key facilitators for making care more patient-centered: (i) strong, committed senior leadership, (ii) clear communication of strategic vision, (iii) active engagement of patient and families throughout the institution, (iv) sustained focus on staff satisfaction, (v) active measurement and feedback reporting of patient experiences, (vi) adequate resourcing of care delivery redesign, (vii) staff capacity building, (viii) accountability and incentives and (ix) a culture strongly supportive of change and learning. Interviewees reported that changing the organizational culture from a 'provider-focus' to a 'patient-focus' and the length of time it took to transition toward such a focus were the principal barriers against transforming delivery for patient-centered care.

Conclusions. Organizations that have succeeded in fostering patient-centered care have gone beyond mainstream frameworks for quality improvement based on clinical measurement and audit and have adopted a strategic organizational approach to patient focus.

Keywords: patient-centered care, quality improvement, patient care experience

Introduction

Health care organizations seek increasingly to improve quality by refocusing organizational policy and care delivery around the patient, bolstered by evidence for benefit in clinical outcomes, patient experiences and a business case that support movement toward 'patient-centered care' [1–7].

Focusing care delivery on patient needs and preferences is a useful way to define patient-centered care. Starting in the late 1980s, researchers worked to identify core components of such care, and in 1993 the Picker Institute identified eight domains: respect for patient preferences and values; emotional support; physical comfort; information, communication and education; continuity and transition; co-ordination

of care; involvement of the family and friends and access to care [8].

Further research has yielded similar core concepts [9–12], and the International Association of Patient Organizations identifies respect for patient needs and preferences as the most consistent element of definitions of patient-centered care [13].

Given such constructs, improving patient care experience is integral to improving the overall quality of care received by a patient, with 'patient-centeredness' included as a dimension of quality in its own right [1, 14]. While the domains of quality identified in the IOM 'Crossing the Quality Chasm' report have gained broad support within healthcare, implementing a patient focus is challenging. Shaller [10] developed a framework suggesting seven key factors for achieving patient-centered care at the organizational level: engagement of the top leadership; a strategic vision clearly and constantly communicated to every member of the organization; involvement of patients and families at multiple levels; a supportive work environment for all employees; systematic measurement and feedback; the quality of the built environment; and supportive information technology [10].

Health care organizations have devoted considerable effort to applying established strategies for quality improvement. With mixed degrees of success, they have focused on systems for risk management, incident reporting and quality assurance [15]. Despite such industry-based approaches, research suggests that current quality improvement strategies, such as clinical audit and feedback, are insufficient to ensure the widespread implementation of patient-centeredness throughout an organization [16, 17].

Organizations are struggling to involve patients and learn from their experience [16, 18, 19]. A comprehensive, organization-wide approach, fundamentally linked to organizational strategy, may be required [20]. Hypothesizing that 'exemplar' institutions might furnish particular insights, we undertook a qualitative research study to examine both facilitators and barriers within organizations renowned for improving patient care experience.

Methods

We constructed our study to select eight health care organizations across the USA that were geographically dispersed and covered a range of health care services: three acute, inpatient hospitals; three medical groups/ambulatory care; and two group/staff model health management organizations. We selected an additional pilot site for testing the interview process. Each agreed to participate in the study. The Institutional Review Board (IRB) of Beth Israel Deaconess Medical Center approved the study.

The site selection criteria focused on organizations that either had widely recognized reputation for improving the patient care experience (e.g. had won national awards for patient-centered care, or had been the subject of case studies on leading patient-centered organizations), or were high performing in the area of patient care experience data (i.e. scores well above the national average). To evaluate data trends in recent years, we reviewed both site data reports and national and state-based data collections for patient care experience (e.g. H-CAHPS, Clinician/Group-CAHPS and Health Plan-CAHPS), focusing on data items in common across surveys (such as 'global rating of care' and 'willingness to recommend').

Table 1 Outline of interview guide

Key areas
Organizational processes for improving patient care experience
Facilitators and barriers to improving patient care experience
Role of senior leadership
Communicating with staff
Involvement of patients and families
Work environment and support of staff
Measurement and feedback
Supportive technology, infrastructure and information access
Motivating and sustaining factors for the organization

The participating organizations had a proven track-record in improving patient care experience, as evidenced by awards (such as the Picker Award for Excellence in the Advancement of Patient-Centered Care, or the CHART Certificate of Excellence) or above national average performance in patient experience reports and consistent improvements in overall ratings (e.g. up to an 11% point increase over the two preceding years).

Forty individuals participated in semi-structured interviews. In each site, five key informants were invited to participate in an interview. These typically included the chief executive officer, chief medical officer, quality director, administrative director/practice manager and a patient representative with committee membership. Interviewees participated in face-to-face interviews lasting ~45–60 min during site visits held between January and May 2009. Telephone interviews took place shortly thereafter with those interviewees unavailable during site visits. One interviewer (K.L.) conducted the interviews using an interview guide (Table 1) with several modules of questions corresponding to Shaller's framework [10], and additional questions relating to other organizational factors of interest for their hypothesized relevance to improving patient care experiences. The interview guide questions were tested in interviews at the pilot site and refined (K.L., D.G.S. and T.D.).

The interviews were digitally recorded with consent and transcribed verbatim. The transcribed interviews were then imported into MAXQDA®, a software package for managing and analyzing qualitative research data. One researcher (K.L.) conducted the primary content analysis, reading the interviews and progressively developing a thematic coding framework to categorize themes raised by interviewees. Highly experienced in health care, an independent coder conducted

a coding validation on a random sample of interviews. She found a high degree of concordance for emerging themes.

Results

The results we present outline the themes that emerged from the interviews, illustrated with example quotes from interviewees—organized as key facilitators of and key barriers to advancing patient-centered care.

Key organization-level facilitators

Several organizational factors that may facilitate improved patient-centered care emerged consistently from analysis of the interviews.

Strong, committed senior leadership.

> So we try to make real the importance of the patient experience – that's why we're here. It's no longer just the dollars and cents of the institution or the mortality rates.
>
> (CEO)

Interviewees in seven out of eight organizations repeatedly identified strong CEO and governance support for achieving patient-centered care as a critical facilitator. Of potential import, the CEOs, deriving either from a business or clinical background, had an average tenure of 7 years in the eight institutions evaluated, with three having 10+ years. The mission to improve patient care experience in most organizations arose from the Board or CEO, with senior clinicians also in strong support. The Boards focused heavily on quality, including care experience, as evidenced by meeting agendas that assigned 'quality' time equal to that afforded to financial issues. Moreover, CEOs of acute inpatient facilities noted improvements in business and clinical metrics associated with their patient-focused approach.

We note also that the chief executives and senior clinicians often cited personal or family experiences with health care services (in seven out of eight organizations) that influenced strongly their support for patient-centered care delivery. And leaders in five out of eight organizations cited an internal organizational ethic ('this is just the right thing to do'), coupled with brand recognition as a 'patient-centered' service, as the dual motivating themes driving their institutions to improve.

Communication of strategic vision.

> When [the CEO] first came, he really tagged the phrase, 'Patients first.' You'll hear employees talk about that all the time. That really focused the organization – remember, that's why we here. It's not about the nurses, or the physicians. It's about the patients.'
>
> (Chief Nursing Officer)

Interviewees in five out of eight organizations identified the CEO as clearly articulating the patient-centered mission to staff, often by using an engaging personal story at orientation sessions for new employees. In addition, the acute care organizations had re-crafted their strategic goals to emphasize a more singular focus on improving patient-centered care.

Engagement of patients and families.

> We help with everything, from paint chips to policy.
>
> (Patient representative)

> Action plans for improvement are collaboratively developed with the patient advisors. (VP Patient Care)

Interviewees in five out of eight organizations cited the engagement of patients, families and carers as a critical strategy for promoting patient-centered care. Engagement ranged from involvement in organizational decisions (e.g. service redesign and staff interview panels) to engagement at point of care (e.g. 'partners in care'; inclusion in hand-offs; 24/7 family access). At an organizational level, this typically included patient and family advisory committees, along with representation on the board of trustees, quality improvement committees, employee interview panels and medical executive committees. While engagement was mentioned as a facilitator of patient-centered care at all sites, the most extensive levels were reported by acute inpatient facilities.

Sustained focus on employee satisfaction.

> We have a people's choice award where we recognize the medical staff that patients have selected as having met their needs in a very outstanding way.
>
> (VP Quality)

Interviewees in seven out of eight organizations consistently reported that a focus on improving the satisfaction of employees was viewed as a facilitator for building a patient-centered organization. Interviewees acknowledged links between employee satisfaction and patient satisfaction and noted that constantly developing and reviewing the staff culture and work environment were important processes in their organization. Employees were publicly recognized for achievements through newsletter articles and award ceremonies, and they displayed plaques on wards. 'Caring for the caregivers' was recognized as improving staff satisfaction and retention rates.

Regular measurement and feedback reporting.

> I think consistency in focus, in measurement, in feedback to the frontline .... the consistency sends a message that this is an important long-term issue.
>
> (Chief Medical Officer)

All eight organizations reported that providing front line staff, management and governance with regular reports of patient care experience data with high specificity ('from the Board to the Ward') was an enabling factor. They all cited using feedback actively to identify areas for improving patient-centered care. Interviewees noted that their organizations had a long history of systematic measurement of patient feedback (typically exceeding 10 years), using a variety of mechanisms such as surveys, focus groups, anonymous shoppers, real-time feedback and complaints databases.

Adequate resourcing for care delivery redesign.

> We are listened to, and many of the things we suggest are put into practice.
>
> (Patient representative)

Interviewees in seven out of eight organizations consistently referred to their organizations as being 'responsive' to patient feedback by resourcing systems solutions to support patient-centered care, including new patient scheduling systems, facilities for families (e.g. overnight stay beds), 24/7 access, concierge programs, service recovery systems and redesign of existing facilities. CEO interviewees noted that changes in care delivery, based on patient feedback, were often surprisingly simple and inexpensive.

Building staff capacity to support delivering patient-centered care.

> If they're not fitting into what we're looking to for our vision, we don't bring them on board.
>
> (Nurse Manager)

> There comes a point where you coach and you teach, but then you also hold accountable and if you're not comfortable doing these things, maybe you should work in another place.
>
> (VP Care services)

Interviewees in seven out of eight organizations described retraining and remodeling the workforce for 'mission commitment'. They identified as a key facilitator building the capacity of staff to support a 'patient-focus'. Workforce capacity building techniques reported included training in communication skills, patient-centered care values, customer service and leadership skills and using specific patient feedback in individual staff development.

Accountability and incentives.

> . . . if you want to have better care, you have to have people accountable for it. It's not rocket science – it's just basic management.
>
> (Chief Executive Officer)

Interviewees cited the use of accountability for patient care experience as a key enabler (six out of eight organizations). Interviewees reported that patient feedback ratings were incorporated with other metrics in employee performance reviews at all levels, and in some sites they were also linked to remuneration incentives. Board scorecards and dashboards typically included patient care experience metrics for review as a key performance indicator.

Culture strongly supportive of change and learning.

> Part of our culture is that we're never happy with the status quo. Never; . . . We ask patients, 'What would we need to do in order to be a 10/10?'.
>
> (Chief Nursing Officer)

Interviewees noted over and over that promoting a culture of learning facilitated patient-centered care (seven out of eight organizations). Interviewees articulated a shared vision of what could be possible for their organization, based both on values and how the organization collectively learned from examples of 'below standard' care.

Interviewees placed high value on narrative feedback from patients as a learning tool and reported narratives as a catalyst for change. Interviewees frequently stated that patient stories, whether from qualitative surveys or patient journals, provided important insights not captured by quantitative data.

Key barriers

> So for whatever reason, we had the attitude where the physician is king and the patient, 'well, we'll get to the patient when we have time'.
>
> (Chief Operating Officer)

Changing the mind-set of employees from a 'provider-focus' to a 'patient-focus' was the barrier to patient-centered care (reported by seven out of eight organizations) most consistently mentioned. Listening to patient stories about their experience of care and 'experiencing care yourself' were identified as particularly influential in overcoming this barrier.

> A culture shift takes three to five years, and we're in the midst of it. This isn't a sort of 'flavor of the month' type of thing.
>
> (Chief Executive Officer)

Another barrier identified by interviewees in five out of eight organizations was that the change towards a patient-focused organization took longer than anticipated, given that culture change does not happen quickly. Organizational leaders were often cited as influential in changing the culture and reassuring employees that the process was a 'journey' to transform care, rather than '. . . a six month pilot project'. Some interviewees identified insufficient resources to support improvements as a barrier.

Discussion

Our findings support the importance of an organization-wide approach for successfully advancing patient-centered care. The findings also exhibit considerable concordance with previous examinations of key organizational facilitators, including those enumerated in Shaller's framework [10]. However, a number of additional key facilitators emerged from these interviews: adequate resourcing of the redesign of care delivery, actively building staff capacity, ensuring accountability and a culture supportive of change and learning. And two factors previously identified as important to organizational effectiveness in advancing patient-centered care did not emerge as important themes: 'quality of the built environment' and 'supportive information technology (IT)' [10].

The unexpected outcome regarding the two factors that did not emerge may reflect a study sample containing non-acute health care services for which such factors may have been perceived to play a lesser role in improving patient experience. For example, in the physician-based medical practice groups, interviewees may not have seen the built

environment in which care is delivered as closely linked to advancing patient-centered care, in contrast to the acute, inpatient setting. Similarly in medical practice groups/ambulatory settings, IT may have been in place for many years and perceived by interviewees as supportive of administrative functions and clinical management, but not necessarily for improving patient-centered care delivery. Shaller [10] has also noted that experts consider supportive IT as 'generally underused' in facilitating patient-centered care.

Our insights overlap with previous findings about the impact of management perspective on key organizational attributes for promoting 'quality' in healthcare, such as senior executive management, culture, organizational design and incentive structures [21]. Other studies have highlighted similar factors promoting quality improvement in healthcare, including training, sufficient resources and a strategic focus on customer needs [22, 23]. While many health care organizations have worked to adopt some of the guiding principles of quality improvement, such as a focus on teamwork, systems, processes and measurement [24], the organizations in our study had also devoted considerable attention to the improvement tenet of 'customer-focus', translating to a focus on patients as 'customers' of the health service.

The sites in this study also exhibited many aspects of 'learning organization' theory and have characteristics described in 'learning culture' frameworks [25, 26]. While healthcare organizations often commit to continuous quality improvement, focusing on needs analysis and performance measurement, learning organizations additionally support a culture that values people, stimulates new ideas, develops teamwork and adopts staff recognition systems.

Although adaptive to external environmental forces, learning organizations are characterized by enhancing internal capacity, and by learning from past events. Such culture may have contributed to the fact that external forces, such as public reporting or pay for performance, did not emerge as key facilitators for improving patient care experience at the sites we reviewed. Our finding supports previous work indicating that such external incentives alone are insufficient drivers of improvement efforts [20]. The difficulty in carrying out a shift away from a 'provider-focus' supports the concept that culture change is integral to implementing patient-centered care.

Our findings suggest once again that both qualitative and quantitative feedback data are important for organization-wide, patient-focused improvement [27, 28]. As suggested by previous work, a focus on staff satisfaction appears also positively linked with improving patient-centered care [29].

The fact that the study site CEO's had longer than average tenures (7.0+ years, versus a national average of 5.6 years) [30] may also have supported a strategic, long-term approach to improving patient-centered care. Senior leaders within these organizations clearly played a crucial role in engaging employees in a patient focus, including using such strategies as personal storytelling [31].

This study was limited to eight organizations with a proven track-record and reputation for having successfully engaged in creating a more patient-centered care setting. While all organizations invited to participate in the study agreed to do so, these eight organizations cannot constitute the universe of organizations that have addressed and been successful in this realm. Thus, it is possible that other observations or themes might have emerged from interviews with leadership from other organizations nationally. In addition, we have no way of verifying the comments of individual interviewees. However, the internal consistency among interviewees from each organization supports the validity of the organizational experiences that were shared.

Our findings suggest that organizations that have succeeded in fostering patient-centered care have gone beyond mainstream frameworks for quality improvement based on clinical measurement and audit and have adopted a strategic organizational approach to patient focus. The findings may provide some insight into key facilitating factors and barriers for organizations aiming to improve patient-centered healthcare.

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