



PATIENT-CENTERED CARE: WHAT DOES IT TAKE?

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ABSTRACT: Patient-centered care has become a central aim for the nation's health system, yet patient experience surveys indicate that the system is far from achieving it. Based on interviews with leaders of patient-centered organizations and initiatives, this report identifies seven key factors for achieving patient-centered care at the organization level: 1) top leadership engagement, 2) a strategic vision clearly and constantly communicated to every member of the organization, 3) involvement of patients and families at multiple levels, 4) a supportive work environment for all employees, 5) systematic measurement and feedback, 6) the quality of the built environment, and 7) supportive information technology. The report illustrates how these factors can be successfully implemented through case examples of two organizations, MCG Health System in Georgia and Bronson Methodist Hospital in Michigan. The report concludes with a discussion of strategies at the organization and system level that can help leverage widespread implementation of patient-centered care.

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CONTENTS

About the Author	iv
Acknowledgments	iv
Executive Summary	v
Introduction	1
Key Attributes of Patient-Centered Care.....	2
How Close Are We?.....	5
Factors Contributing to Patient-Centered Care	8
Models of Success	13
Strategies for Leveraging Change	17
Conclusion	21
Appendix A. List of Interviews	22
Appendix B. Interview Guide.....	23
Notes.....	24

LIST OF FIGURES

Figure 1	Doctor–Patient Communication: Doctor Listened Carefully, Explained Things, Showed Respect, and Spent Enough Time, National and Managed Care Plan Type	6
Figure 2	Patient-Centered Hospital Care: Staff Managed Pain, Responded When Help Was Needed, and Explained Medicines, by Hospitals, 2005.....	8

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EXECUTIVE SUMMARY

The concept of patient-centered care has gained increasing prominence in recent years as a key aim of the U.S. health care system. Yet despite growing recognition of the importance of patient-centered care, as well as evidence of its effectiveness in contributing to other system goals such as efficiency and effectiveness, the nation's health care system falls short of achieving it. Data from national and international studies indicate that patients often rate hospitals and medical care providers highly, but report significant problems in gaining access to critical information, understanding treatment options, getting explanations regarding medications, and receiving responsive, compassionate service from their caregivers.

This paper was commissioned by The Picker Institute to explore what it will take to achieve more rapid and widespread implementation of patient-centered care in both inpatient and ambulatory health care settings. The findings and recommendations of this paper are based largely on a series of interviews with opinion leaders selected for their experience and expertise in either designing or implementing strategies for achieving excellence in patient-centered care.

Key Attributes of Patient-Centered Care

A high degree of consensus exists regarding the key attributes of patient-centered care. In a systematic review of nine models and frameworks for defining patient-centered care, the following six core elements were identified most frequently:

- Education and shared knowledge
- Involvement of family and friends
- Collaboration and team management
- Sensitivity to nonmedical and spiritual dimensions of care
- Respect for patient needs and preferences
- Free flow and accessibility of information

Factors Contributing to Patient-Centered Care

The interviews and literature reviewed for this project identified seven key factors that contribute to achieving patient-centered care at the organizational level:

- **Leadership**, at the level of the CEO and board of directors, sufficiently committed and engaged to unify and sustain the organization in a common mission.
- **A strategic vision clearly and constantly communicated** to every member of the organization.
- **Involvement of patients and families** at multiple levels, not only in the care process but as full participants in key committees throughout the organization.
- **Care for the caregivers through a supportive work environment** that engages employees in all aspects of process design and treats them with the same dignity and respect that they are expected to show patients and families.
- **Systematic measurement and feedback** to continuously monitor the impact of specific interventions and change strategies.
- **Quality of the built environment** that provides a supportive and nurturing physical space and design for patients, families, and employees alike.
- **Supportive technology** that engages patients and families directly in the process of care by facilitating information access and communication with their caregivers.

These factors can be found at work in a small but growing number of hospitals and medical groups across the country. Among the examples identified through the project interviews, a few were mentioned repeatedly as outstanding illustrations of organizations that have focused on these factors to achieve measurable excellence in performance. Two specific cases highlighted in this paper are the MCG Health System in Augusta, Georgia, and Bronson Methodist Hospital in Kalamazoo, Michigan. These two organizations demonstrate how most or all of the factors identified can be addressed in an integrated, comprehensive way to achieve high levels of patient-centered care, as measured through independently collected patient survey data as well as through other important health care outcomes and organization objectives.

Strategies for Leveraging Change

Key strategies identified as necessary to overcome barriers and to help leverage widespread implementation of patient-centered care can be divided into the following two groups.

- **Organization Level.** Strategies designed primarily to strengthen the capacity to achieve patient-centered care at the organization level include:
 - Leadership development and training

- Internal rewards and incentives
- Training in quality improvement
- Practical tools derived from an expanded evidence base
- **System Level.** Strategies aimed at changing external incentives in the health care system as a whole, to positively influence and reward organizations striving to achieve high levels of patient-centered care, include:
 - Public education and patient engagement
 - Public reporting of standardized patient-centered measures
 - Accreditation and certification requirements

The findings from this project indicate that, while there are many promising examples of organizations achieving excellence in patient-centered care, these innovators are not yet the norm. The challenge lies in elevating the norm through strategies at both the organization and system level that leverage the experience of these innovators to motivate large-scale implementation of patient-centered care.

PATIENT-CENTERED CARE: WHAT DOES IT TAKE?

INTRODUCTION

In its landmark 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) named patient-centered care as one of the six fundamental aims of the U.S. health care system.¹ The IOM defines patient-centered care as:

Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.²

Studies show that orienting health care around the preferences and needs of patients has the potential to improve patients' satisfaction with their care, as well as their clinical outcomes. Patient-centered care also has been shown to reduce both underuse and overuse of medical services.³

Despite the recent prominence given to patient-centered care, and the growing evidence of its importance, the nation's health care system appears to fall short of achieving it. For example, according to a recent Commonwealth Fund survey of patients in five countries (Australia, Canada, New Zealand, the United Kingdom, and the U.S.), one-third of sick patients in the U.S. leave the doctor's office without getting answers to important questions.⁴ And across all countries in the study, one-third to one-half of respondents said their doctors sometimes, rarely, or never tell them about treatment options or involve them in making decisions about their care.⁵

This paper was commissioned by The Picker Institute to explore what it will take to achieve more rapid and widespread implementation of patient-centered care in both inpatient and ambulatory health care settings. The Picker Institute was an early leader in developing surveys designed to measure patients' experience with their care. Since the late 1980s, the Picker surveys and those modeled after them, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, have been used to gather information from millions of patients in hospitals and physician practices in the U.S., Canada, the United Kingdom, Germany, and other European countries. After all this investment in measurement, a clear need remains to determine how such information can be used to actually make and sustain improvements in the patient's experience with care.

The aim of this paper is to summarize a consensus of opinions and perspectives from key health care leaders regarding what it will take to achieve high levels of patient-centered care in the U.S. These opinions and perspectives were gleaned from a series of telephone interviews conducted by the author from June through September 2006. Leaders were identified on the basis of their recognized expertise, either as leaders of organizations that have demonstrated measurable excellence in patient-centered care or as experts working to design and implement tools and strategies for implementing patient-centered care. A total of 17 interviews were conducted, with the list of individuals included in Appendix A. The core questions that were probed in the semi-structured interviews are included in Appendix B. Throughout the interview process, the published and unpublished literature on patient-centered care, as well as relevant Web sites identified in the course of the interviews, were consulted as additional background and supporting information to the views expressed by the individuals interviewed.

KEY ATTRIBUTES OF PATIENT-CENTERED CARE

Increasingly, patients are asking to be partners in their care. A patient-centered health care system can help achieve that partnership in a variety of ways. Multiple models and frameworks have been developed for describing patient-centered care, with many overlapping elements. This section briefly summarizes three of the most influential models that form the foundation of approaches to patient-centered care in the U.S. today: (1) the Picker/Commonwealth dimensions, (2) the Institute for Family-Centered Care focus on collaborative partnerships, and (3) the Planetree model. It then presents results of a synthesis of key concepts cutting across these and other models.

Picker/Commonwealth Dimensions

The term “patient-centered care” was originally coined by the Picker Commonwealth Program for Patient-Centered Care, which later became The Picker Institute.⁶ This program conducted focus groups and national telephone interviews with patients and families to create the Picker survey instruments that measure the patient’s experience of care across the following eight dimensions:⁷

- **Respect for patient-centered values, preferences, and expressed needs**, including an awareness of quality-of-life issues, involvement in decision-making, dignity, and attention to patient needs and autonomy.
- **Coordination and integration** of care across clinical, ancillary, and support services and in the context of receiving “frontline” care.

- **Information, communication, and education** on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care, and health promotion.
- **Physical comfort**, including pain management, help with activities of daily living, and clean and comfortable surroundings.
- **Emotional support and alleviation of fear and anxiety** about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances.
- **Involvement of family and friends** in decision-making and awareness and accommodation of their needs as caregivers.
- **Transition and continuity** as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions.
- **Access to care**, with attention to time spent waiting for admission or time between admission and placement in a room in the inpatient setting, and waiting time for an appointment or visit in the outpatient setting.

Institute for Family-Centered Care Model

The Institute for Family-Centered Care was founded in 1992 to ensure that principles of patient- and family-centered care are reflected in all systems providing care and support to individuals and families, including health, education, mental health, and social services. According to the Institute, patient- and family-centered care is an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, their families, and health care providers.⁸ The core concepts of patient- and family-centered care include:

- **Dignity and respect.** Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information-sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

- **Collaboration.** Patients and families are also included on an institutionwide basis. Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in health care facility design; in professional education; and in the delivery of care.

The Planetree Model

The mission of Planetree, founded in 1978, is to serve as a catalyst in the development and implementation of new models of health care that cultivate the healing of mind, body, and spirit; that are patient-centered, value-based, and holistic; and that integrate the best of Western scientific medicine with time-honored healing practices.⁹ The nine elements of the Planetree patient-centered care model are:

- Explicitly recognizing the importance of human interaction in terms of personalized care, kindness, and being “present” with patients.
- Informing and empowering diverse patient populations through consumer-oriented health libraries and patient education.
- Integrating health partnerships with family and friends in all aspects of care.
- Attending to the nurturing aspects of food and nutrition.
- Incorporating spirituality and inner resources for healing into care of patients.
- Incorporating massage and human touch.
- Incorporating the arts (music, visual art forms) into the healing process.
- Integrating complementary and alternative practices into conventional care.
- Creating healing environments through architecture and design.

Synthesis of Key Attributes

In order to identify similarities and differences across the varying definitions and descriptions of patient-centered care, Carol Cronin, an independent consultant under contract with the National Health Council in 2004, reviewed nine models of patient-centered care (including the three described above) to arrive at 45 concepts embedded in the definitions.¹⁰ The following six elements appeared in three or more of the definitions or descriptions:

- Education and shared knowledge (in five of the definitions)
- Involvement of family and friends (in five of the definitions)
- Collaboration and team management (in four of the definitions)

- Sensitivity to nonmedical and spiritual dimensions (in four of the definitions)
- Respect for patient needs and preferences (in three of the definitions)
- Free flow and accessibility of information (in three of the definitions)

Clearly, there is no lack of definitions of patient-centered care, and there is substantial convergence and commonality across at least half a dozen key attributes. According to one of the experts interviewed for this project, “We’ve gathered tons of data, done many focus groups: We know what patients want. The hard part is delivering it.” The next section will explore how close we are to getting there.

HOW CLOSE ARE WE?

How close are we in the U.S. to achieving a health care system that delivers on the patient-centered aim called for by the IOM and so many others? This section briefly examines the range of perspectives offered by the various leaders interviewed for this project, and reviews some of the available empirical evidence based on national patient experience surveys.

Leader Perspectives

Opinions of leaders interviewed ranged from a mildly optimistic assessment of the progress that has been made toward patient-centered care to a conviction that the system is utterly failing to deliver on this key aim. For example, one expert suggested that “we’ve made a lot of progress...a lot has been mainstreamed since the first national Picker Commonwealth study in 1989.” But most others were less optimistic about the system as a whole, offering comments such as:

How close are we? Not even close. There are a few promising innovators and early adopters out there, others on the way. Many are way behind. About 80 percent to 95 percent are someplace in between.

We’re not even close to a tipping point. I’ve never seen us so far from our customers.

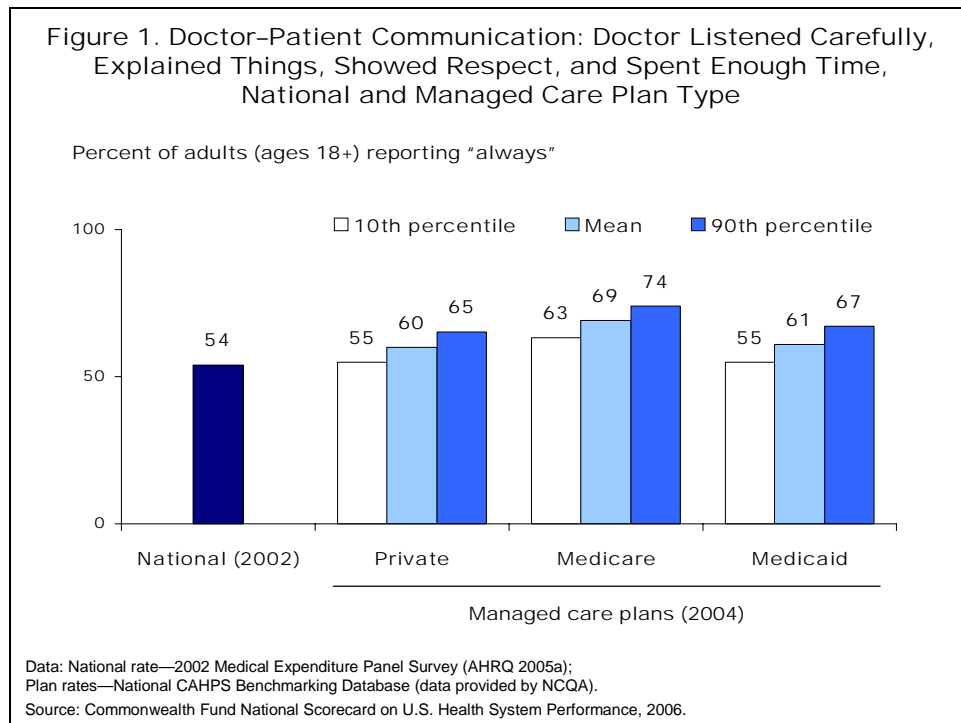
The most consistent perspective that emerged among the leaders interviewed is that remarkable progress has been made in a relatively small number of organizations, but that the vast majority of hospitals and medical practices fall far short of achieving high levels of patient-centered care. A large number of the most innovative organizations mentioned include children’s hospitals or other programs with an emphasis on pediatric care. A few specific examples are described in the section “Models of Success” ([see page 13](#)).

Empirical Evidence

Empirical evidence based on surveys of patients' health care experiences provides another, more quantitative assessment of progress. As noted earlier, rigorous and standardized evaluations of patients' experiences are now gaining increasing traction in the U.S., stimulated in large part by the early Picker surveys.

In the ambulatory sector, the CAHPS Health Plan Survey is now administered annually by health plans enrolling more than 130 million Americans. Reports of national results based on this survey show the majority of survey respondents rate their medical care providers and overall health care highly.¹¹ For example, in 2006, well over 50 percent of all respondents across all sectors (commercial, Medicare, and Medicaid) rated their personal doctors and specialists either "9" or "10" on a 10-point scale where "0" is the worst possible and "10" is the best possible. Over half of all respondents also rated their overall health care highly.

However, in contrast to overall ratings, actual consumer reports of experiences with health care providers show substantial room for improvement. For example, Figure 1, compiled by The Commonwealth Fund, shows that just over 50 percent of U.S. adults report that their health providers always listened carefully, explained things clearly, respected what they had to say, and spent enough time with them.¹²

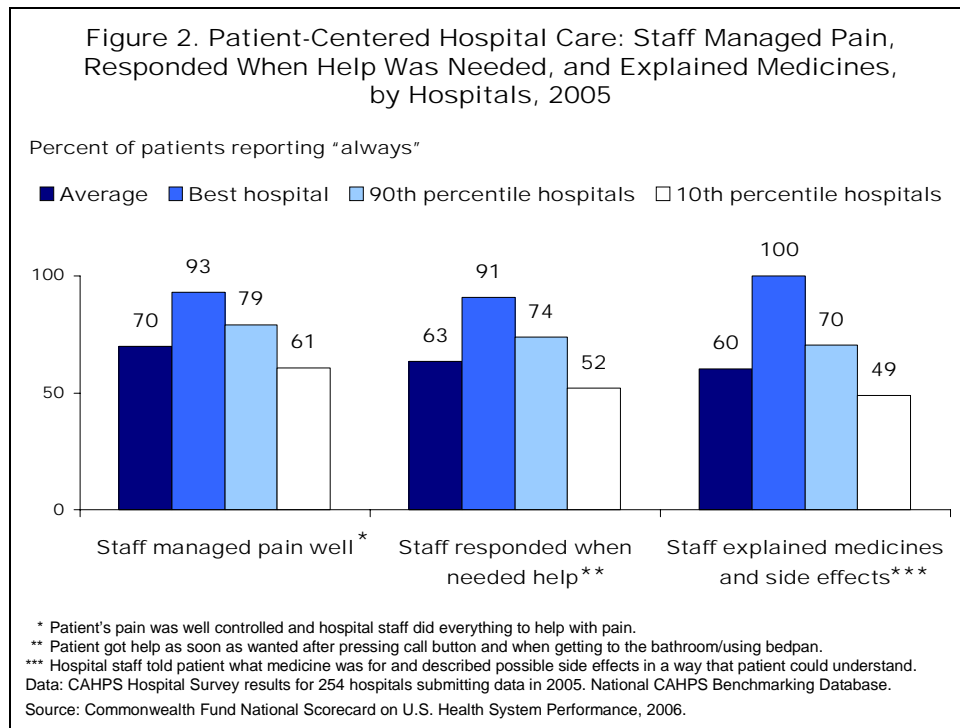


Recent international surveys indicate other significant problem areas in ambulatory care. The previously mentioned Commonwealth Fund survey of patients in five countries revealed substantial gaps in doctor-patient communication related to treatment options and other health care management plans.¹³ An international survey of primary care physicians shows that only 40 percent of physician practices in the U.S. have arrangements for after-hours care, compared to over 80 percent in the U.K., Australia, and the Netherlands.¹⁴ Over 60 percent of sicker adults in the U.S. report difficulty getting needed care on nights, weekends, and holidays without going to the emergency room.¹⁵

Similar national standardized survey measures of inpatient care are more difficult to come by. The CAHPS Hospital Survey, recently endorsed as the national standard for assessing inpatient care from the patient's perspective by the National Quality Forum, is now only in the initial stages of national implementation. Based on national test data submitted in 2005 by 254 hospitals to the National CAHPS Benchmarking Database, overall ratings of hospital care by discharged patients are high.¹⁶ For example, over 55 percent of survey respondents rated their hospitals either "9" or "10" on a 10-point scale where "0" is the "worst possible hospital" and "10" is the "best possible hospital." Furthermore, over 94 percent of respondents would either "definitely" (71%) or "probably" (23%) recommend their hospital to their friends and family.

Compared to the national CAHPS Health Plan Survey results noted above, patients' reports of doctor and nurse communication in the hospital setting are significantly better. For example, nearly nine out of 10 respondents (86%) reported that doctors always treated them with courtesy and respect (compared to 81% saying nurses did so), and 79 percent reported that doctors always listened carefully (nurses, 71%).

However, several significant problem areas remain. Figure 2, compiled by The Commonwealth Fund and based on the 2005 CAHPS Hospital Survey data, shows that on average only 60 percent of respondents reported that hospital staff always described possible side effects of new medications in a way they could understand. Moreover, large differences exist in pain management, staff responsiveness, and communication about medications between the highest and the lowest performing hospitals.



Clearly, even though comprehensive national measures are not yet available for hospital care and ambulatory practices, the existing preliminary evidence shows there is substantial room for improvement in patient-centered care across a number of important dimensions. National implementation of the CAHPS Hospital Survey, spurred largely by the Centers for Medicare & Medicaid Services, will provide a source of continuing data for monitoring hospital performance.

FACTORS CONTRIBUTING TO PATIENT-CENTERED CARE

The previous sections have defined what patient-centered care is and reviewed some of the evidence regarding how close we are to achieving it in the nation as a whole. This section summarizes seven key factors identified through the project interviews and literature review that contribute to patient-centered care at the organization level. These factors are: (1) leadership, (2) a strategic vision clearly and constantly communicated to every member of the organization, (3) involvement of patients and families at multiple levels, (4) care for the caregivers through a supportive work environment, (5) systematic measurement and feedback, (6) the quality of the built or physical environment, and (7) supportive technology.

Leadership

According to the majority of individuals interviewed for this project, the single most important factor contributing to patient-centered care, whether in the hospital or in the

ambulatory care setting, is the commitment and engagement of senior leadership at the level of the CEO and board of directors. The organizational transformation required to actually achieve the sustained delivery of patient-centered care will not happen without top leadership support and participation. In the words of one observer, “There is no chance to succeed without it, and maybe not even with it.”

The importance of leadership has been well documented in the literature on organizational development.¹⁷ The noted organizational theorist Edgar Schein has identified the close connection between leadership and culture in an organization, suggesting that:

Organizational cultures are created by leaders, and one of the most decisive functions of leadership may well be the creation, the management, and if and when that may become necessary, the destruction of culture. Culture and leadership, when one examines them closely, are two sides of the same coin and neither can really be understood by itself.¹⁸

Jack Silversin and his colleague, Mary Jane Kornacki, nationally recognized experts on physician culture, have applied these concepts specifically to health care organizations through a model of organizational change that focuses on the elements of leadership, shared vision, culture, and the concept of an explicit “compact” between management and the medical and supervisory staff.¹⁹ According to Gary Kaplan, MD, CEO of Virginia Mason Medical Center in Seattle, Washington, leaders must become “change managers” that help transform the traditional, implicit compact between physicians and the organization from one based on “entitlement, protection, and autonomy” to one focused entirely on “putting the patient first.” In the case of Virginia Mason, Dr. Kaplan applied Silversin’s framework to the creation of both a leadership compact and a physician compact that clearly delineate mutual responsibilities and expectations regarding patient-centered care. These compacts became the cornerstone of a wholesale transformation of the medical center from a culture focused on accommodating physicians to one directed toward placing the patient at the center. While organizational change of such magnitude cannot be attributed to a single individual alone, Dr. Kaplan’s leadership was instrumental in guiding board members, senior executives, and medical staff to embrace a new vision.

A Strategic Vision Clearly Communicated

With exceptional, committed leadership in place, the organization needs to develop a clear vision and strategic plan for how patient-centered care will fit into its priorities and processes on a daily operational basis. Experts interviewed for this project emphasized the

importance of articulating a vision and mission statement with clear, simple elements that can be easily repeated and embedded in routine activities that all staff members carry out. Management consultant Kathleen Jennison Goonan, MD, Executive Director of the Center for Performance Excellence, describes the importance of achieving a “line of sight” that is always visible from “the boardroom to the bedside,” meaning an ability to communicate the leadership’s strategic goals systematically throughout all levels of the organization. Goonan cites SSM Health Care, 2002 winner of the distinguished Baldrige Award in health care, as a “practice leader” in this area. For example, SSM has standardized all of its meetings so that all sites follow the same protocols that include constant reminders of the organization’s mission and values. According to Goonan, who bases her consulting work on the Baldrige model, such standardization of processes helps “translate vision into ways people behave. . . . All successful organizations do this.”

Involvement of Patients and Families

In patient-centered care, if patients are to be truly involved, so must their families. These are broadly conceived as close friends and significant others, not just family relatives, who can provide vital support and information throughout the care process. According to Bev Johnson, president of the Institute for Patient- and Family-Centered Care, patients and families should be involved in care at several levels, consistent with the IOM’s recommendations in the *Crossing the Quality Chasm* report. The first level is the point of care delivery, where patients and families can contribute to the process of gathering information about perceptions of care and assist in analyzing and responding to treatment strategies. The second level is the clinical microsystem, where patients and family advisers should participate as full members of quality improvement and redesign teams, participating from the beginning in planning, implementing, and evaluating change.

The third level is the organization leadership, where the perspectives and voices of patients and families are vital to quality improvement, planning, and policy and programmatic development. Patients and families should participate on key committees dealing with issues such as patient safety, facility design, quality improvement, patient/family education, ethics, and research. One example of patient and family involvement at this level is the patient and family advisory council. Such a council creates an opportunity for patients and families who represent the constituents served by the organization to become members of a permanent group that meets regularly with senior leaders.²⁰ While they do not function as boards, patient and family advisory councils can play a vital role in problem-solving, since they often identify opportunities or solutions that professional managers may overlook. Finally, at the fourth level, the perspectives of patients and families are critical to the development of local, state, and national policies

affecting the finance and delivery of care, and should inform accreditation and licensing bodies, the design of reimbursement policies, and medical education curricula.

Supportive Work Environment: Care for the Caregivers

If health care organizations want to become patient-centered, they must create and nurture an environment in which their most important asset—their workforce—is valued and treated with the same level of dignity and respect that the organization expects its employees to provide to patients and families. The relationship between employee satisfaction and patient or customer satisfaction has been well documented.²¹ Experts interviewed for this project stressed the importance of hiring, training, evaluating, compensating, and supporting a workforce committed to patient-centered care. An important way to achieve this commitment and engagement is to involve employees directly in the design and implementation of patient-centered processes. According to Peter Coughlan, transformation practice leader at IDEO, one of the world’s most sought-after design consulting firms, health care organizations should strive to be “human-centered”, not just patient-centered, meaning that all stakeholders (including managers, medical staff, nurses, and other frontline staff) should be engaged in creating effective, responsive systems of care.

In a similar vein, Erie Chapman, president and CEO of the Nashville-based Baptist Healing Trust, suggests that the “single biggest responsibility of caregivers is to take care of people that take care of people.” He describes a “wave theory” of behavior that can contribute to a positive work culture, based on the premise that the majority of people in an organization or on a team model their own behavior in accordance with those around them.²² Positive behavior modeled by team leaders will encourage similar behavior in other team members, which will in turn contribute to the ability of the entire team to provide responsive, service-oriented care to patients and their families.

Systematic Measurement and Feedback

A frequently used axiom in health care quality improvement is, “You cannot manage what you cannot measure.” A major factor contributing to patient-centered care is the presence of a robust customer-listening capacity that enables an organization to systematically measure and monitor its performance. According to Kate Goonan, such a listening capacity should comprise a “balanced scorecard” that includes multiple measurements of performance, such as patient experience surveys, complaints, and “patient loyalty” assessments based on rates of voluntary disenrollment from a practice. Other important “listening posts” include walk-throughs, a process in which staff members play the role of patients and experience a service or procedure in the same way that

patients and families do.²³ The implementation of patient and family advisory councils, described above, provides another way to gather systematic feedback from patients.

The value of such measurement and feedback lies in using them to design and implement specific interventions or processes to improve the patient experience. Whether the intervention is large (for example, redesigning the appointment process in an office practice) or small (adding signs to help patients and families find their way through the building), it is vital to continuously measure the effect of the change to determine whether it is working and, if not, how to modify the process for a better result. The systematic use of measurement in planning an intervention, implementing it, reviewing its effects, and modifying it as needed constitutes the cycle of quality improvement often referred to as PDSA, for “plan, do, study, act.” According to Peter Coughlan, the success of this process depends on having real-time feedback, in order to be able to trace results back to specific actions or processes that can be studied, altered if necessary, and spread throughout the organization if successful.

Quality of the Built Environment

One of the most important factors contributing to patient-centered care is the quality of the physical environment in which care is provided. Since its founding in 1978, Planetree has pioneered new approaches to architecture and design that recognize the vital link between physical space and the healing process. The Planetree approach to health facility design encourages settings that:

- Welcome the patient’s family and friends.
- Value human beings over technology.
- Enable patients to fully participate as partners in their care.
- Provide flexibility to personalize the care of each patient.
- Encourage caregivers to be responsive to patients.
- Foster a connection to nature and beauty.

Over the past several decades, these design principles have been incorporated into a variety of health care settings, and have been shown to correlate highly with improved measures of patient experience and other important health and business outcomes.²⁴ In 2000, the Center for Health Care Design launched the Pebble Project as a research effort to systematically document the evidence that supportive and nurturing physical environments are therapeutic for patients, conducive to family involvement, promotive of

staff efficiency, and restorative for workers under stress.²⁵ By carefully documenting examples of health care facilities whose design has made a difference in the quality of care and financial performance of the organization, the Pebble Project intends to create a “ripple effect in the health care community” that will lead to more widespread adoption of such evidence-based design. Currently, more than 40 organizations are participating, and each is committed to systematic documentation of the results of its design innovations. Preliminary data from these projects have shown demonstrable improvements in clinical outcomes, economic performance, productivity, and customer satisfaction.

Supportive Technology

A final contributing factor permeating virtually all of the above elements is supportive technology, especially health information technology (HIT) that engages patients and families directly in the care process by facilitating communication with their caregivers and by providing adequate access to needed information and decision support tools. Numerous applications of health information technology have emerged in recent years, from simple e-mail communication between patients and clinicians to more sophisticated patient Web portals that enable patients to interact with their physicians’ electronic medical records. Such applications range widely in complexity as well as in cost. Most of the experts interviewed for this project agreed that supportive information technology is generally underused and that organizations at the forefront of developing patient-centered HIT applications are demonstrating that they can enhance physician-patient partnerships in care. The key to success is to make adoption easy for both patients and clinicians, and to implement applications gradually in order to avoid fears that new technology will abruptly undermine the quality of the patient-caregiver interaction.

MODELS OF SUCCESS

The factors contributing to patient-centered care outlined in the previous section can be found at work in a small but growing number of hospitals and medical groups across the country. This section briefly highlights several examples to illustrate how most or all of the factors identified can be applied in an integrated, comprehensive way to achieve high levels of patient-centered care, as well as other important health care and business outcomes.

MCG Health System

The MCG Health System (MCG), in Augusta, Georgia, provides a remarkable example of what can be achieved in a large academic health system over a relatively short period of time. MCG includes an adult and a children’s medical center, both of which are affiliated with the Medical College of Georgia. In 1993, MCG began a process of transforming its

organizational culture, starting with the development of its new children's hospital. An internal assessment revealed that the care delivered addressed primarily the needs of providers and did not adequately respond to patients' and families' needs and concerns.²⁶ Senior leaders at MCG made a commitment to improving patient-centered care in its new pediatric inpatient units. The ensuing transformation, which evolved to include adult health care services and medical education as well, comprised the following key elements:

- **Leadership.** According to Pat Sodomka, senior vice president for patient- and family-centered care at MCG, “Leaders are the guardians of the ideals related to the patient experience of care.”²⁷ The commitment and participation of senior leadership were instrumental in initiating and sustaining the organization's commitment to patient-centered care.
- **Strategic Vision.** In 1993, hospital leaders convened a visioning retreat, where participants developed a philosophy and values statement for the new MCG Children's Medical Center and built a consensus for patient- and family-centered concepts and priorities. Attendees included hospital- and community-based physicians, other clinical staff, administrators, and families.
- **Involvement of Patients and Families.** A focus on involving patients and families has been the cornerstone of the MCG transformation. MCG began by establishing the Family-Centered Care Steering Committee, which included staff, faculty, and families. Training sessions were held to help committee members learn how to work collaboratively. The original committee evolved into the Family Advisory Council, which continues to provide guidance for policy and program development. More than 125 patient and family advisers are currently involved in collaborative endeavors at MCG. Another example of including patients and families is the MCG policy of inviting families to stay with their loved ones 24/7, especially in the intensive care unit.
- **Supportive Work Environment.** Patient-centered behaviors among the MCG workforce are both modeled and rewarded. Staff members are integrally involved in all aspects of organization planning and process design. The MCG human resources department ensures that new employees possess attitudes and skills consistent with patient- and family-centered care. Behaviors for customer service and for patient- and family-centered care have been defined, and both sets of behaviors are included in position descriptions and MCG's performance-review system.
- **Systematic Measurement and Feedback.** MCG's efforts to advance patient- and family-centered care have been closely monitored through several measurement activities. Through the patient and family councils, the efforts of the director of Family Services Development, and a program called “Speak Up!”, leaders regularly receive

patient and family input on the experience of care. Patient feedback is also obtained through independent surveys, and the results are compelling: MCG Children's Medical Center has consistently ranked in the 90th percentile or higher among more than 50 children's hospitals in a national survey of patient satisfaction.

- **Quality of the Built Environment.** Patients and family members were integrally involved in the architectural design of the new Children's Medical Center, collaborating with architects, physicians, nurses, and others. Patient perspectives also were incorporated in the redesign of several areas in the adult hospital, including the mammography area of MCG Breast Health Services, a PET/CT unit and the Neuroscience Intensive Care Unit. The redesign of these units created warm and welcoming spaces to help increase patient comfort, privacy, and convenience.

Since the transformation process began in 1993, patient- and family-centered care has become the core business model for the entire organization, leading to positive results on each one of MCG's fundamental business metrics: finances, quality, safety, satisfaction, and market share. MCG has been recognized as a pioneer in patient- and family-centered care by the American Hospital Association and the Institute for Family-Centered Care, and was recently featured in the PBS series *Remaking American Medicine*.²⁸

Bronson Methodist Hospital

Bronson Methodist Hospital (BMH) is the flagship organization of Bronson Healthcare Group, a large community health system serving the nine-county region surrounding Kalamazoo, Michigan. As a result of its commitment to patient-centered care, BMH has been the recipient of numerous awards, including the Malcolm Baldrige National Quality Award in 2005. Factors contributing to the success of BMH include:

- **Leadership.** Frank Sardone, President and CEO of Bronson Healthcare Group, exemplifies the qualities of senior leadership required to articulate a strong vision that places patients at the central focus of the organization, and that engages a collaborative management team to carry the vision forward. Sardone describes a “three-legged stool” of leadership excellence, consisting of the board of directors, senior management, and the medical and nursing staffs. Leaders at the management level meet for a two-day retreat three times each year for planning and strategy development. Board members actively participate and are consulted throughout the process. Medical and nursing staff leaders work on “goal-sharing” and align strategic objectives to foster collaboration.
- **Strategic Vision.** According to Sardone, excellence is embedded in BMH's culture and is the thread running through its mission. Three strategic goals, known as the

“Three Cs,” comprise the vision—Clinical Excellence, Corporate Effectiveness, and Customer and Service Excellence. The one-page *Plan for Excellence*, distributed to all employees, captures the mission and Three C vision, and outlines the personal accountability that “every staff member has every day, with every interaction, with every customer.”²⁹ The plan serves as a constant “line of sight” reminder of the principles critical to BMH in delivering high-quality care and excellent service.

- **Supportive Work Environment.** Since the mid-1990s, BMH has focused on becoming the employer of choice in the region. The hospital’s Workforce Development Plan includes the strategies needed to develop and retain the current workforce as well as those needed to address future staff recruitment, retention, development, and diversity. For example, to meet a critical need for respiratory therapists, BMH provides interested staff members with financial assistance, including benefits and payment for tuition and books, while they are attending classes. Evaluation of individual performance is aligned with the organization’s Three Cs, annual objectives, and action plans; reward and recognition are directly related to the results achieved. For several years running, BMH has been included in *Fortune* magazine’s “100 Best Companies to Work For.”³⁰
- **Quality of the Built Environment.** A major redevelopment of the BMH physical space initiated in 1993 has resulted in a state-of-the-art, all-private-room facility on a 28-acre, easily accessible health care campus. The facility includes a medical office pavilion, an outpatient pavilion, and an inpatient pavilion that come together around a central garden atrium. BMH is currently using evidence-based design to develop a new birthing center and neonatal intensive care unit. As a participant in the Pebble Project, described earlier, BMH is measuring employee turnover, outcomes, length of stay, cost per unit of service, waiting times, patient satisfaction levels, nosocomial infection rates, and organizational behaviors in the new versus the old facilities.
- **Systematic Measurement and Feedback.** BMH employs multiple measures to achieve a “balanced scorecard” of its patient-centered care results, including patient surveys, post-discharge telephone calls, focus groups, and community surveys. In addition, BMH leaders and patient relations staff conduct “rounds” to talk to and learn from patients and visitors. According to results from a national patient survey vendor, patient satisfaction at BMH has improved from approximately 95 percent in 2002 to almost 97 percent in 2004.
- **Supportive Technology.** On the wireless campus, all visitors, patients, and staff can access the Internet via workstations. While on site, patients and visitors have access to maps, service directories, and other information through interactive kiosks and the public Web site. All BMH employees have access to e-mail and to the BMH intranet

as well. In addition, the system allows physicians to provide patient care from off-site locations by accessing patient information through a secure Internet connection.

Other Successful Models

Other important models of successful implementation of patient-centered care exist in both the ambulatory and inpatient care settings. Some of the more prominent examples identified through the project interviews include the following:

- **Virginia Mason Medical Center**, where top leadership support guided a strategic planning process that led to a total redefinition of the organization’s mission to put the patient first, utilizing a set of “compacts” with medical staff and senior management to specify roles and responsibilities, and incorporating concepts of “lean production” as developed by world-class manufacturers such as Toyota.³¹
- **Cincinnati Children’s Hospital Medical Center**, where partnering with patients and families takes place on multiple levels (such as through the Family Advisory Committee, on quality-improvement teams, on hospitalwide teams, and on unit-based committees and task forces), creating an environment where families are no longer viewed as visitors, units are open 24/7, and families are encouraged to be present for rounds and given choices about how they would like to participate.³²
- **Henry Ford Health System**, where senior leadership cultivated collaboration across organizational lines and within divisions to create a team approach to cancer care, increasing patient satisfaction levels to 99 percent, and employed e-prescribing technology to improve access, information, safety, and efficiency.³³
- **Weill Cornell Medical College, New York, NY**, where innovations in the built environment for a new ambulatory care complex have led to documented reductions in errors, improved workflow, alleviation of patient anxiety, and increased staff productivity.³⁴

These and other examples demonstrate how innovative organizations have successfully applied the concepts and principles of patient-centered care to achieve dramatic improvements in a wide range of measurable outcomes.

STRATEGIES FOR LEVERAGING CHANGE

As shown in the previous sections, multiple factors contribute to patient-centered care, and there are a growing number of examples demonstrating how these factors can be integrated into successful programs. Yet, also as noted earlier, the evidence suggests that most organizations are far from achieving what is possible.

This section reviews some of the key strategies identified in the project interviews as necessary to overcome barriers and to help leverage widespread implementation of patient-centered care. These strategies are divided into two groups: (1) those designed primarily to strengthen the capacity to achieve patient-centered care at the organization level, and (2) those aimed at changing external incentives in the health care system as a whole, to positively influence and reward organizations striving to achieve high levels of patient-centered care.

Organization-Level Strategies

Leadership Development and Training. An overwhelming conclusion emerging from this project is that senior leadership at the level of the CEO and board of directors is essential to achieving patient-centered care. The importance of leadership suggests the need to focus substantial resources on the development of capable, committed individuals to fill these critical roles. To be successful, an overall strategy for leadership education and development must encompass the entire pipeline of health care leaders, from graduate education and entry level to mid-career, and finally to the senior level. It must also cross disciplines, from administration to nursing to medicine, and span multiple sectors, including health care delivery organizations, suppliers, and insurers.

Internal Rewards and Incentives. As capable, committed leaders are trained and recruited, an equally important strategy will be to assure that they are retained and rewarded for desired levels of performance. Experts interviewed for this project expressed considerable dismay that hospital executives turn over far too frequently, sometimes as often as every two or three years. Executive compensation is oriented primarily to achieving bottom-line financial results based on quarterly earnings and market share; currently less than 5 percent of hospital CEO compensation is tied to patient experience scores.³⁵ Clearly, compensation and incentives for CEOs and senior management must shift to focus on measurements of patient-centered care as part of an overall performance scorecard. Such a shift will require new levels of engagement and support by boards of directors. Similar shifts in compensation and rewards must take place at all levels of the organization, from the medical staff to frontline employees.

Training in Quality Improvement. Despite all of the emphasis on various quality-improvement approaches in recent years, experts interviewed expressed concern that there is still not a widespread, ingrained capacity for process improvement in most health care organizations. While managers may possess some knowledge of clinical guidelines and the PDSA cycle of quality improvement, few of these skills have been systematically applied to improving the patient care experience. Staff members at multiple levels in the organization

need training in quality-improvement concepts and methods that will enable them to effectively make, measure, and manage change. Physicians may be the ones most in need of such training, since most do not receive such instruction in medical school. Historically, physicians have been trained largely to succeed as individuals but not as members of a team. Yet team approaches are central to quality improvement, since almost everything needed to achieve patient-centered care is dependent on successful relationships among staff as well as among patients and their families.

Practical Tools Derived from an Expanded Evidence Base. For change to occur, evidence regarding specific interventions that work to improve patient-centered care must be documented and made available to managers and change leaders. Important progress has been made in this direction, but more is needed, particularly in a form that is readily accessible to staff in busy office practices and other care settings. For example, the Picker Institute Europe makes available a set of improvement guides on various topics, aimed at supporting managers responsible for interpreting and using patient survey results to improve scores.³⁶ Through its Quality Enhancing Interventions (QEI) project, researchers at Picker Europe also have compiled evidence on the effectiveness of a broad spectrum of patient-centered interventions.³⁷ A similar effort is under way to update *The CAHPS Improvement Guide* and to make it accessible to health plans and ambulatory care practices as a Web-based tool. The Pebble Project, described earlier, is attempting to document the evidence with respect to architectural and interior design strategies. Such practical guidance, based on rigorous evaluations of effectiveness, is needed to support the efforts of well-trained staff in supportive work environments.

System-Level Strategies

Public Education and Patient Engagement. According to Nancy Schlichting, president and CEO of the Henry Ford Health System, consumers are the single most important drivers of change in health care organizations. Strategies for educating and engaging patients to take a more active role in the care process will provide an important complement to the efforts of health care organizations to become more patient-centered. Recent national polls indicate that most Americans want to become more involved in their care and be active partners with their health care providers in making decisions.³⁸ Information and tools to support patients in this expanded decision-making role are becoming increasingly available through the Internet and other media. The evidence suggests that decision-making approaches shared between patients and providers can lead to improved patient knowledge, more realistic perceptions of potential benefits and harms, and greater ease in reaching decisions that reflect patient values and preferences.³⁹ Yet the availability of these tools is still quite limited in the population as a whole, and many

Americans are not aware of their features and benefits. Strategies for promoting awareness of tools are needed to stimulate their demand and use. Involving patients and families at the various levels described earlier will also lead to increased pressure for organizational responsiveness to the need for patient-centered care.

Public Reporting of Standardized Measures. The importance of systematic measurement and feedback to achieving patient-centered care was noted earlier. Such measures are useful not only for monitoring and guiding improvement within organizations, but for holding organizations accountable for their results through public reporting. Ideally, such measurement and reporting should be based on the best available scientific evidence and standardized to enable fair and accurate comparisons within and across organizations and practitioners. Building on the foundation established by the original Picker surveys, the evolving CAHPS suite of standardized instruments for assessing the patient experience now spans the continuum of care, including health plans, medical groups, individual physicians, in-center hemodialysis centers, hospitals, nursing homes, home care services, and assisted living facilities.⁴⁰

The Centers for Medicare and Medicaid Services (CMS) publicly reports data from many of the CAHPS surveys on its Web site, and is planning to report results from national implementation of the CAHPS Hospital Survey in March of 2008. A number of regional initiatives, such as the Massachusetts Health Quality Partners and the Pacific Business Group on Health, are also publicly reporting patient experience survey data to help consumers make informed choices about providers. A limited but growing body of evidence suggests that public reporting of quality measurements creates strong incentives for organizations to improve their performance.⁴¹ The effectiveness of these data for supporting consumer choice of health care providers is less clear.⁴² However, the experts interviewed for this project agree that the public reporting of patient-centered care measurements will play an increasingly powerful role in stimulating organizational change, especially as they are incorporated into various pay-for-performance schemes designed to link either cash payments or market share to comparative levels of performance.

Accreditation and Certification Requirements. Accreditation and certification programs have historically provided significant external incentives for health care organizations to improve. Increasingly, these programs are building measurements of patient-centered care into their process. For example, the National Committee for Quality Assurance (NCQA) is exploring how measurements of patient-centered care might be built into a physician quality recognition program, in which physicians or physician groups interested in seeking recognition submit the required data to NCQA for scoring against predefined standards.⁴³

NCQA currently gives accreditation points to health plans that conduct and apply ambulatory patient surveys for physicians or groups in their network. As another example, the American Board of Medical Specialties (ABMS) is working with its Member Boards to develop revised maintenance-of-certification requirements that would include measurements of patient-centered care. Although the data would not be publicly reported, physicians would be required to use them to complete specific quality improvement modules to obtain certification. The American Board of Internal Medicine, the largest of the certifying boards, is currently using a tailored version of the new CAHPS Clinician & Group Survey in its system for certifying specialists in internal medicine.

CONCLUSION

The findings and evidence presented in this paper demonstrate that considerable consensus exists regarding the attributes of patient-centered care and the key organizational factors required for attaining them. Although patient-centered care can be defined, measured, and achieved with great success in some organizations, national data suggest that the system as a whole can do much better. While there are many promising examples of organizations achieving excellence in patient-centered care, these innovators are not yet the norm. The challenge lies in elevating the norm through strategies at both the organization and the system level that can leverage the experience of these innovators to motivate large-scale implementation of patient-centered care.

APPENDIX A. LIST OF INTERVIEWS

Leaders of Organizations Demonstrating Excellence in Patient-Centered Care

Gary Kaplan, M.D.
Chairman and CEO
Virginia Mason Medical Center

Frank Sardone
President and CEO
Bronson Methodist Hospital

Katharine Luther, R.N., M.P.M., C.P.H.Q.
Director, Performance Improvement
Memorial Hermann Hospital

Nancy Schlichting
President and CEO
Henry Ford Health System

Julie Morath
Chief Operating Officer
Children's Hospitals and Clinics of
Minnesota

Patricia Sodomka, FACHE
Executive Vice President, CEO, Hospital
Operations
MCG Health, Inc.

Experts in Design and Implementation of Patient-Centered Care Strategies

Rosalyn Cama
President and Principal Interior Designer,
CAMA, Inc.
Chair, Center for Health Design

Kathleen Jennison Goonan, MD
Executive Director
Center for Performance Excellence

Erie Chapman
President and CEO
Baptist Healing Trust

Beverly Johnson
President and CEO
Institute for Family-Centered Care

Peter Coughlan
Lead, Transformation Practice
IDEO

Heather J. Kopecky, PhD, MBA
Partner
Heidrick & Struggles

Susan Edgman-Levitan, PA
Executive Director
John D. Stoeckle Center for Primary Care
Innovation

Wendy Leebov
Wendy Leebov, Inc.

Susan Frampton, PhD
President
Planetree, Inc.

Marie Siniotis
President and CEO
National Center for Healthcare Leadership

Gail Warden
President Emeritus
Henry Ford Health System

APPENDIX B. INTERVIEW GUIDE

- What are the key attributes of patient-centered care?
- What are the most important factors that contribute to patient-centered care?
Are there differences in these factors for inpatient and ambulatory care settings?
- What are the major barriers that stand in the way of achieving patient-centered care?
- Can you describe one or two examples or success stories that illustrate what it takes to achieve patient-centered care?
- Are there important lessons from these examples or success stories that can be applied more broadly?
- What is it going to take to achieve widespread implementation of patient-centered care?
- Where will the leadership and/or leverage come from to drive this transformation?

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Patient-centered care (PCC) seems to be a popular buzzword among policymakers and administrators in recent years. Indeed, many physicians see our health care system as payer-centric, many patients see it as physician-centric, and no one seems to see it as patient-centric. PCC does not mean that full decision-making autonomy is given to the patient, just as routine care does not demand that the physician provide full decision making. It has been shown that many patients who demand certain care, such as antibiotics when not warranted, do respond to proper communication and explanations of why it is not merited. It's quicker to write a prescription than to take time to explain to a patient why the prescription isn't necessary. Patient-centered care is the practice of caring for patients (and their families) in ways that are meaningful and valuable to the individual patient. It includes listening to, informing and involving patients in their care. The IOM (Institute of Medicine) defines patient-centered care as: "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions." 1.

Overview of Picker's Eight Principles of Patient Centered Care. Does person-centred care take longer? Person-centred care comprises not only a whole range of tools and activities, but a mindset that values and supports patients to be partners in their care. Taking a simple approach such as "Hello, my name is" (see page 21) "introducing oneself by name to a patient" would not take any longer, but might make a big difference. Because person-centred care comprises a combination of activities that depend on the patient and situation in question, measuring the degree to which it is happening can be challenging. What is person centred for one person may not be for someone else. A person-centred approach means focusing on the elements of care, support and treatment that matter most to the patient, their family and carers.