Patient centredness and quality improvement efforts in hospitals: rationale, measurement, implementation

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Abstract

Quality Problem. Patient-centred care is increasingly being acknowledged as an integral part of evaluating health care. Yet, from a quality improvement perspective the rationale, measurement and implementation of strategies to improve patient-centred care is often subject to debate.

Objective. The aim of this paper is to review why quality improvement efforts should embrace patient-centredness, to examine some of the measurement issues and to assess conceptual underpinnings that should inform both measurement and actions to improve patient-centred care.

Lessons. The causal pathway through which quality improvement affects and/or is associated with patient centredness is complex and goes beyond patients’ rights and assessing patient views. Interventions to improve patient-centred care should reflect on key rationale, measurement strategy and underlying theory.

Keywords: patient-centred care, quality improvement, hospitals

Introduction

Patient-centred care is defined as ‘health care that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients’ wants, needs and the preferences and that patients have the education and support they need to make decisions and participate in their own care’ [1]. This is increasingly being acknowledged as an integral part of evaluating health care; in fact, improving patient centredness is one of the six aims of the Institute’s of Medicines (IOM) Health Care Quality Initiative according to which health care should be safe, effective, patient-centred, timely, efficient and equitable. This focus is not entirely new and numerous contributions to the scientific and the grey literature have stressed the need to improve patient-centred care.

Yet, firstly, the reasons for a patient-centred approach from a quality improvement perspective are not always clear to all stakeholders. As such it might be difficult to realize working towards a common goal. Furthermore, quality improvement projects may put a focus on a particular aspect of patient centredness, say humanity of care; an important albeit not the exclusive rationale. Secondly, it appears that many quality improvement initiatives imply that adding a patient survey to existing performance measures will be sufficient to realize patient-centred care. While this may be informative, it may not be very effective. Moreover, there appears to be a selection bias towards a few established instruments capturing generic patient experience or satisfaction and thus ignoring some of the broader challenges in assessing patient centredness. Thirdly, there are some important concerns with regard to common strategies to improve patient centredness. These will be illustrated to avoid that well-intentioned strategies may in fact contribute towards widening existing gaps in patient centredness.

Patient-centred care: a requirement for quality improvement?

The origins of patient centredness in health care can be traced back to the Hippocratic oath; however, it was not until the 1950s that the concept of patient-centred care gained importance in medicine and health services research. At that
time the excessive focus of medical care on disease processes as compared with illness experience raised a lot of concerns and Engel and Balint opposed the predominant biomedical model [2, 3]. Since then, the focus on patient-centredness has continuously evolved in the literature and in recent years has been greatly emphasized in policy initiatives. The literature on strategies to improve patient-centred care is overwhelming and a review prepared by the Cochrane Collaboration highlighted that ‘patient-centred care is a widely used phrase but a complex and contested concept’ [4]. Therefore, I will give three simple arguments for a patient-centred approach from a quality improvement perspective: improving patients’ rights, improving health gain and contributing to organizational learning.

**Improving patients’ rights**

Patients’ rights embrace arguments of democratization (according to which a paternalistic relationship between patient and professional would contradict the notions of democratic societies), operationalized in hospital settings in terms of policies to ensure confidentiality, informed consent, information about treatment and care and issues related to professional-patient interaction [5, 6]. It is not a question whether such issues always lead to better empowerment, participation in health care or even contribute to outcomes—there are ends in themselves [7]. Frequently, these ends are not met. For example, Schoen et al. [8] assessed the experiences of patients with health problems and found that a considerable proportion of patients reported problems with lack of respect for patients’ preferences and involvement of family and friends, and more than a third of patients assert that risks of treatments or procedures were not or were only partly explained. Similar results were found by Coulter and Jenkinson [9] in a cross-European study of patients’ views on the responsiveness of health systems and health-care providers. Since patients’ rights have become an integral part of definitions of quality of care, quality improvement efforts should strengthen these rights.

**Improving health gain**

In contrast to the argument above, the health gain perspective addresses the implications of patient-centred care on patient behaviour, recovery and outcomes. The evidence-base concerning health gain and outcomes spans from sociology, over psychology to medicine, nursing and rehabilitation sciences. Research suggests that patient centredness is associated with better compliance, patient satisfaction, better recovery and health outcomes, augmentation of tolerance for stress and pain levels, reduced readmission rates and better seeking of follow-up care [10–13]. In a review of systematic reviews on three topics central to patient-centred care (interventions to improve health literacy; interventions to improve clinical decision-making and interventions to improve self-management of chronic diseases) Coulter and Ellins [14] report that a majority of reviews yielded positive effects in terms of improving knowledge, better experience of care, decreased use of resources and improved health behaviour and health status. The evidence for the effectiveness of informing, educating and involving patients in their care is substantial.

**Organizational learning**

Another rationale for patient-centred care is less prominent in the health-care literature, alas; it is an important focus from a quality improvement perspective. In short, in order for organizations to learn, personal context-specific knowledge needs to be transferred into codified systematic and formal knowledge. Knowledge-dependent organizations constantly revise knowledge at all organizational levels in order to inform process alignment, innovation, product development and service provision [15]. In hospitals, the patients’ knowledge has traditionally been ignored as a ‘production factor’, ignoring the potential contributions to assessing, improving and implementing work processes.

Research suggests that patients can contribute significantly to health-care improvements, in particular through their assessment of non-clinical aspects of care, their assessment of the care environment and their observations and experience with the care process [7, 11, 16, 17]. However, this information is not always gathered systematically, thus hospitals are missing relevant information for improvement projects. For example, while many hospitals carry out patient surveys, little is known to what extent professionals are aware of the results of patient surveys in their ward, or whether this information is used at all for quality improvement work [4, 18]. There are a number of reasons why patient survey data are not systematically used in quality improvement efforts, such as organizational barriers (lack of priority or supporting infrastructures), professional barriers (scepticism, resistance to change) or data-related barriers (lack of timely feedback or lack of specificity and discrimination) [19]. Notwithstanding, quality improvement efforts are well advised to overcome these barriers in order to include patients’ contributions in processes of organizational learning [20].

**Assessing patient-centred care: one measure is not enough**

A key to quality improvement is measurement: without measurement, neither baseline status nor improvements over time are known. Consequently, if quality improvement is to embrace patient centredness then appropriate measures are necessary to capture the constructs embodied in the IOM definition of patient-centred care. Measurement should focus on patient views with current organization of care, ideally measured longitudinally to allow for time-trend analysis. Measurement should also aim at identifying the underlying reasons for patient assessments of care. In addition, patient-level assessments should be accompanied by assessments of organizational characteristics, similar to assessments of clinical outcomes which are often accompanied by assessments of supporting structures and processes of care.
Patient-level measures

Patient views of patient centredness are usually assessed using standardized questionnaires, even though qualitative research such as in-depth interviews and focus groups are also used to explore patient views. A major limitation to assess and improve patient centredness is the lack of a gold standard measure [4]. This is partly due to the conceptually broad nature of the construct, including a wide range of different constructs, disease-specific and generic measures, different forms of conceptualization and psychometrics (experience measures, satisfaction measures and gap-based measures), and differences in intent and administration (pre-admission to assess patients preferences and post-discharge to assess patients views of hospital services) [21]. The advantage of generic measures is their global assessment across various dimensions of patient centredness, while specific measures provide a more in-depth assessment of one or more dimensions. Measures of patient satisfaction or experience are typically administered at discharge or post-discharge. However, depending on the information required to improve the quality of care, measures may require administration before a contact with the health-care provider. For example, considering patients’ characteristics as an input into the hospital work processes, it may be necessary to elicit preferences for shared decision-making or to understand patients’ ability to comprehend and process the information that is exchanged between professionals and patients. While some generic measures of patient centredness include questions regarding professional’s oral expression and listening skills, the actual level of health literacy of the patient and preferences for involvement and decision-making are not routinely assessed. However, without such prior information, information and education strategies employed in hospitals settings may have a limited effect. Considering the differences in approaches, administration, timing and conceptual basis, the use of measures to assess patient centredness should be driven by the information required to improve practice and by the extent to which they support management in improving patient centredness. A single standard measure may not fit all these purposes (Table 1).

Table 1  Selected patient-level measures of patient-centred care by type

<table>
<thead>
<tr>
<th>Type of measure</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing preferences for decision-making role</td>
<td>Control preferences scale</td>
</tr>
<tr>
<td></td>
<td>Decision involvement questionnaire</td>
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<tr>
<td></td>
<td>Problem-solving decision-making scale</td>
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<tr>
<td></td>
<td>Role and information preferences</td>
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<tr>
<td></td>
<td>Locus of authority scale</td>
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<tr>
<td></td>
<td>Information styles questionnaire</td>
</tr>
<tr>
<td>Evaluating patient involvement in decision-making</td>
<td>Observing patient involvement in decision-making scale</td>
</tr>
<tr>
<td></td>
<td>Decision support analysis tool</td>
</tr>
<tr>
<td></td>
<td>Elements of informed decision-making</td>
</tr>
<tr>
<td></td>
<td>Rochester participatory decision-making scale</td>
</tr>
<tr>
<td>Assessing patients perception of involvement</td>
<td>Satisfaction with decision-making process</td>
</tr>
<tr>
<td></td>
<td>Participatory decision-making style</td>
</tr>
<tr>
<td></td>
<td>Patients perceived involvement in care scale</td>
</tr>
<tr>
<td>Assessing preparation for chronic disease self-management</td>
<td>Patient activation measure</td>
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<tr>
<td></td>
<td>Health-care transition measure</td>
</tr>
<tr>
<td>Generic measures to assess patient experience</td>
<td>Hospital consumer assessment of healthcare providers and systems</td>
</tr>
<tr>
<td></td>
<td>PICKER survey</td>
</tr>
<tr>
<td>Generic measures to assess patient satisfaction</td>
<td>Press Ganey Associates</td>
</tr>
<tr>
<td></td>
<td>Ware’s patient satisfaction questionnaire</td>
</tr>
<tr>
<td>Disease-specific measures of patient involvement</td>
<td>Diabetes empowerment scale</td>
</tr>
<tr>
<td></td>
<td>Patient perception of involvement in acute myocardial infarction care scale</td>
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</tbody>
</table>

*Detailed references can be provided upon request from the author.*
Table 2  Selected instruments to assess organizational preparedness of patient-centred care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Domains and example topics</th>
</tr>
</thead>
</table>
Mission and definition of quality: includes articulates and reflects the patient-and family-oriented care, and is taught to new staff and part of continuing education.  
Charting and documentation: patients and families have easy access to the chart, their goals are included in the chart, they have the opportunity to record observations and concerns.  
Patients and families as advisors: functioning patient and family advisory council and patients and families involved in hospital committees and task forces.  
Patient and family support: staff ask patients to identify family members to participate in their care, provision of range of emotional, spiritual and practical support, peer and family-to-family support is available.  
Patterns of care: family can remain with patients at all times, and patients and families are viewed as integral part of the health-care team, open disclosure policy.  
Quality improvement: patients and families are involved in assessing and improving quality.  
Information/education for patients and families: patient and family involvement in decision-making, range of instructional material is provided, written information in various languages.  
Personnel: patients and families are involved in recruiting and developing staff, staff assessment includes patient- and family-centred care concepts.  
Environment and design: welcoming first impressions, architecture and interior design, clear signage in the language of the community served, examination rooms allowing privacy and presence of family members.  

| Health literacy environment of hospitals and health centres. (Rudd/Anderson: Harvard School of Public Health⁵) | Navigation: availability and easy access to telephone system, entrance, lobby, staff assistance, hallways easy to navigate, service and specialty areas.  
Print communication: documents prepared in clear writing style, organization and design, type style, size and contrast, photographs and illustrations  
Oral exchange: staff providing support and giving advice, multilingual staff available if necessary, clear communication practice including the use of audiovisual support, availability of translation services.  
Technology: technological components including television, telephone, computers are available and easily accessible.  
Policies and protocols: procedures govern the availability of print material and the provision of orientation programs for staff and volunteers, information sessions and workshops for staff address patient demographics and literacy level, staff skills building and training.  

| Planetree self-assessment tool. (Planetree⁶) | Human interaction: creating a healing environment for patients, families and staff members.  
Family, friends and social support: promoting caring connections between the patients and their support systems.  
Information and education: patients, families and community members are provided with increased access to meaningful information.  
Nutritional and nurturing aspects of food: choice and personalized service, in combination with sound nutrition practices, add pleasure, comfort and familiarity.  

(continued)
Organizational assessment

In addition to assessing patient views of hospital services, organizational assessment tools allow to assess the underlying characteristics that form patient views. These include structural and process factors conducive to patient-centred care (such as physical barriers), organizational and team culture known to be associated with patient perceptions of care, or policies and procedures that need to be put in place in order to systematically deploy a patient-centred approach. Such measures are used in hospitals championing patient-centred care; however, they are not widely known, implemented nor used in research (Table 2).

Existing quality improvement models and standards partly address these domains (in particular addressing issues around informed consent, patient education and patients’ rights), but they may not address them in sufficient detail. For example, a hospital quality assessment procedure may request an informed consent policy. In order for such a policy to have a real effect on patient-centred care, assessments would need to entail whether the policy has been translated into procedures to assess informed consent, whether informed consent forms exist and are up-to-date, whether they are available in different languages (if applicable) and whether the forms are legible to patients. In addition, even though forms are comprehensible, they may be administered in awkward situations, under patient emotional stress and, though legally sufficient, do not fully support patient centredness. Organizational assessment tools of patient centredness provide more substantial assessments of the structures and processes required for realizing patient-centred care than generic quality assessment frameworks.

Next steps: renewing patient-centred care

Quality improvement activities that aim to strengthen patient-centred care, or that involve patients, have become integral...
to the quality improvement agenda. However, there are lessons to be learned about the current effectiveness of strategies to improve patient-centred care.

**Target those most in need**

Improving patient centredness often entails strategies of informing, involving and educating patients. Quality improvement efforts that aim at improving patient centredness may face a paradox: often, those who are more educated get involved most, understand most, ask more questions, but are those least in need. In fact, not everybody wants to be involved and in general, less educated patients tend to prefer less involvement than better educated patients [22, 23]. In the context of patient safety projects, it is also often assumed that patients have the desire and capacity to being proactive in asking factual (such as ‘when can I get back to normal’) or challenging questions (such as ‘did you wash your hands’) to health-care staff regarding safety practices. Davies et al. demonstrated in a survey that challenging health-care staff is less likely among men, less educated and unemployed [24], which may reinforce social gaps. Finally, those most in need may be least equipped to understand written or oral communication [25]. Developers and evaluators of strategies to improve patient centredness should reflect on these findings and address the paradox that those who are most in need probably benefit least.

**Patient representatives**

One strategy to increase patient centredness taken up by many hospitals recognized for their leadership in this field is the involvement of patients or patient representatives in formal quality functions (such as setting standards, targets and discussing results) [26]. Patients or patient representatives involved in such functions are often middle-class citizens, such as retired teachers, lawyers or members of other professions. The examples from the Dana Faber Institute and the Children’s Hospital in Boston in the USA provide evidence that patients make valuable contributions to quality management work. The success of patient involvement however may depend largely on being able to recruit patients with the right experience and their ability to express their views constructively [27, 28]. Thus, despite the strong policy agenda in some countries to increase patient involvement in quality improvement functions, further assessments of patient centredness should examine its effectiveness in terms of the type of patients performing the functions, the criteria used for their selection, the training they received to perform their functions, the contributions they make to quality improvement and the consequences of their contributions in care design. Further research should also address patients’ views on these functions and how patient involvement in quality improvement might affect the professional–patient trust relationship.

**Underlying theory**

Although there is broad literature on patient-centred care, the evidence-base on which interventions are most effective in improving health outcomes needs further strengthening, partly because of the lack of clear conceptual models and lack of gold-standard measures of what constitutes patient centredness. More importantly, from a health education perspective many quality improvement interventions to improve patient-centred care appear to be restricted to providing health-related information. The underlying behavioural theory thus relies on the effectiveness of a rational-choice theory approach in which behaviour is conditioned by cognition, which can be modified by information leaflets, educational interventions, financial incentives or patient decision aids. Health education literature demonstrates the limitations of this paradigm and suggests alternative behavioural strategies such as social cognitive theory [29] in which social marketing and peer modelling are key strategies to modify behaviour, or Prochaska’s trans-theoretical model of change that recognizes that behavioural change requires passing different stages from pre-contemplation to action, which is not necessarily a linear process [30]. Thus, the underlying theoretical model should guide actual interventions to improve patient centredness.

**Conclusion**

The causal pathway through which quality improvement affects and/or is associated with patient centredness is complex. From a quality improvement perspective, a patient-centred approach may be justified by better meeting patients’ rights, improving health outcomes or using information provided by patients to contribute to organizational learning. With regard to the measurement strategy embodied in a patient-centred approach, no gold standard measure is available and patient-level measures should be accompanied by assessments of organizational policies and processes. There is a risk that strategies aiming at improving patient centredness may benefit less those that have higher information needs. Interventions to improve patient-centred care should revise their conceptual and theoretical basis in order to improve their effectiveness.

**References**


