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Defining Shared Values in Patient-Centered Care: A Case Study

Abstract

There are limited studies that turn the lens on an organization's chosen patient-centered care program, and there is a gap in the literature that exists for defining shared values within these models. The purpose of this research was to identify and analyze emergent themes related to various stakeholders. This includes exploring the definition of patient-centered care from the perspective of medical professionals and patients to determine if an association of shared values exists. The research was accomplished through a descriptive, single, embedded-case study to develop defining characteristics of the phenomenon of patient-centered care for patients and medical professionals in a large, urban, acute healthcare setting. The research was conducted using a qualitative case study design with a focused methodological triangulation process that consisted of a cross verification of two sources of data related to the same phenomenon of patient-centered care. The purpose of the triangulation of data was to explain more accurately the complexity and connections from both the patient and medical professional perspective. Triangulation of the data showed that there were clear connections for both medical professionals and patients relating to the value of family inclusion, consistent communications, human connections, and the provision of comfort measures in the patient-care process. Based on the research, it is recommended that medical professionals and the patients they serve have the opportunity to share their voices. Furthermore, it is recommended that health care institutions make an effort to pull together those populations to get to the recognition and understanding of their shared values.

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Defining Shared Values in Patient-Centered Care: A Case Study

By

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Submitted in partial fulfillment
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Ed.D. in Executive Leadership

Supervised by

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St. John Fisher College

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Dedication

This dissertation is wholeheartedly dedicated to ‘my boys’...we did it!
Without you and your support none of this would have made sense. We committed to it as a family, traveled the long road together, and now we can reflect on what we have experienced and achieved together. Thank you so much.

Rob – you are my biggest fan and best friend. You do it – ALL – and there is nothing more to say on that. There is no one else like you – thank God (and I know *you* are saying, ‘you’re welcome’!).

Quinzi – the most awesome boy! This was not easy for you with so much time dedicated to the process. Thank you for being patient and resilient...when I know that you just wanted your ‘movie partner’ back. I promise not to miss another one!

Grandma and Maima – thank you for support and for helping to ease the impact of this for Q. So many sleepovers, movies and fun times with you...we appreciate all of it.

TEAM SEEDS – thank you to the family that I never knew I was missing!

Cohort 3 and my instructors – all great minds and stellar people!

Thank you to Dr. Evans, Dr. Clayton, Dr. Robinson, Dr. Pulos and Dr. Van Der Linden.

Biographical Sketch

Nancy Williams is a Registered Nurse and Certified Patient Experience Professional who currently serves as the Director of Patient and Guest Relations, Volunteer and Spiritual Care Services, for a not-for-profit health system serving Central and Northern New York. Mrs. Williams attended SUNY Brockport from 1991 to 1993, graduating with a Bachelor of Science degree in Health Science with a concentration in Counseling. She attended Syracuse University and graduated with a Bachelor of Science degree in Nursing in 1999. In 2008 Mrs. Williams earned a Master of Science degree from Walden University with a concentration in Nursing Leadership and Management. She entered St. John Fisher College's Ed.D. Program in Executive Leadership where she pursued research in patient-centered care under the guidance of Dr. Linda Hickmon Evans, and Dr. Laurie Clayton, receiving the Ed.D. degree in 2017.

Abstract

There are limited studies that turn the lens on an organization's chosen patient-centered care program, and there is a gap in the literature that exists for defining shared values within these models. The purpose of this research was to identify and analyze emergent themes related to various stakeholders. This includes exploring the definition of patient-centered care from the perspective of medical professionals and patients to determine if an association of shared values exists.

The research was accomplished through a descriptive, single, embedded-case study to develop defining characteristics of the phenomenon of patient-centered care for patients and medical professionals in a large, urban, acute healthcare setting. The research was conducted using a qualitative case study design with a focused methodological triangulation process that consisted of a cross verification of two sources of data related to the same phenomenon of patient-centered care. The purpose of the triangulation of data was to explain more accurately the complexity and connections from both the patient and medical professional perspective.

Triangulation of the data showed that there were clear connections for both medical professionals and patients relating to the value of family inclusion, consistent communications, human connections, and the provision of comfort measures in the patient-care process.

Based on the research, it is recommended that medical professionals and the patients they serve have the opportunity to share their voices. Furthermore, it is

recommended that health care institutions make an effort to pull together those populations to get to the recognition and understanding of their shared values.

Table of Contents

Dedication	iii
Biographical Sketch	iv
Abstract	v
Table of Contents	vii
List of Tables	x
List of Figures	xi
Chapter 1: Introduction	1
Problem Statement	3
Theoretical Rationale	6
Statement of Purpose	10
Research Questions	10
Potential Significance of the Study	11
Definition of Terms	11
Chapter Summary	11
Chapter 2: Review of the Literature	13
Introduction and Purpose	13
Review of Literature	14
Randomized Controlled Trial Studies	27
Outcomes: Quality, Safety, Perceptions	30
Ancillary Opportunities	36

Chapter Summary	44
Chapter 3: Research Design Methodology	46
Introduction.....	46
Case Study Parameters.....	48
Research Context	50
Research Participants	51
Instruments Used in Data Collection	53
Data Analysis	53
Chapter Summary	58
Chapter 4: Results	59
Research Questions.....	59
Data Analysis and Findings	60
Medical Professional Focus Groups	61
Patient Archival Data.....	72
Summary of Results	78
Chapter 5: Discussion	82
Introduction.....	82
Implications of Findings	83
Implications for Practice.....	90
Limitations of Study	92
Recommendations.....	92
Conclusion	96
References.....	100

Appendix A.....	106
Appendix B.....	107
Appendix C.....	109
Appendix D.....	111

List of Tables

Item	Title	Page
Table 4.1	Shared Values and Cross Verification of Two Sources of Data	81

List of Figures

Item	Title	Page
Figure 1.1	McKinsey 7S Framework	7

Chapter 1: Introduction

American healthcare leads most other high-income nations in its spending per capita while concurrently reporting lower life expectancy rates and reduced overall health of its population. Reform is essential to improve the quality and safety of healthcare and the value of the services provided (Berwick, Nolan, & Whittington, 2008). Hobbs (2009) reported that the United States healthcare system is under intense scrutiny due to high service costs, poor patient outcomes, and the system's overall inability to adequately address the needs of patients with chronic illness. Dehumanizing patient experiences, poor quality care, and limited access to appropriate care in hospitals have triggered the need for a focused effort to reduce the negative effects within this fractured system (Hobbs, 2009). There is a sense of urgency within healthcare to decrease cost per capita, improve upon population health, and to better a patient's overall experience of care (Carman et al., 2012). Policy makers, clinicians, researchers, and administrators see patient-centered care (PCC) as an approach that has the potential to address these overarching concerns and to bring the needed reform that healthcare requires (Hobbs, 2009). Patient-centered care is recognized and accepted by healthcare advocacy groups and regulatory agencies as a measure of quality within healthcare (Robinson, Callister, Berry, & Dearing, 2008).

The concept of patient-centered care has become widely visible and is an important aspect of the patient experience and satisfaction in healthcare. It is an element of strategic planning for hospitals, a specific aim of governing bodies, and a key strategic

component of private and nonprofit organizations (Wolf et al., 2008b). Despite the universal focus on patient-centered care, Wolf et al. (2008b) noted there continues to be a lack of a universally accepted definition for patient-centered care. Healthcare institutions adopt various models of patient care and align their patient-centered care definition based on individual organizational preferences.

Hobbs (2009) posited that for healthcare to deliver patient-centered care effectively, clarity of patient-centered care's precise meaning is necessary. Patient-centered care is a concept that is not well understood and, presently, it can represent a variety of meanings. The inconsistencies seen across the literature, both in the clinical and research realms, makes applying a patient-centered care definition a difficult undertaking (Hobbs, 2009).

Robinson et al. (2008) reported that there are benefits to patient-centered care, but there are also problems with its implementation and use. They acknowledged that the definition of patient-centered care varies based on the healthcare setting, and it is subject to the perspectives of an organization and the actions and capacity of its employees. Furthermore, what complicates a formal definition of patient-centeredness is the absence of the perspective of the patient (Robinson et al., 2008).

Luxford and Sutton (2014) noted that hospitals recognize the importance of patient-centered care in the evolving healthcare landscape, but they continue to struggle with the difficult task of involving patients in the patients' care and learning from those experiences. Luxford and Sutton (2014) stated that employees must take healthcare to a new level by empowering patients and partnering with them in their care; they should be considered actual members of the healthcare team by those caring for them.

Understanding the experience of staff members is equally as important because the connection between employee satisfaction and patient experience is slowly gaining merit (Luxford & Sutton, 2014).

Hospitals and healthcare providers should know what approaches will result in overall patient satisfaction and lead to a patient-centered approach. Organizations that can clearly define the actions necessary by their employees to positively influence a patient-centered care approach will have an advantage as healthcare shifts from being volume focused to an accountable care model (Needham, 2012). Identifying what defines a collective understanding on the delivery of patient-centered care has been a long-standing challenge within the healthcare delivery system.

Problem Statement

The lack of clarity around a universal patient-centered care concept presents a problem in healthcare. Epstein, Fiscella, Lesser, and Stange (2010) noted that there should be a coordinated and focused national policy to support patient-centered care that includes assistance for healthcare professionals to acquire and maintain the skills needed to support patient-centered care. Patient-centered care's definition and process for implementation is questionable; therefore, a comprehensive analysis of the term and practices is needed are healthcare (Hobbs, 2009).

Quality and safety in healthcare have long been the measures of positive patient experiences and satisfaction. The addition of public reporting and its financial impact on hospital reimbursements through the Center for Medicare and Medicaid Services' (CMS) value-based purchasing program (VBP) have made patient experience the top strategic priority for hospitals (Kutney-Lee et al., 2009).

Public reporting of hospital performance was established to assist patients with informed decision making and to help healthcare providers monitor and drive needed quality-based improvements (Elliot et al., 2010). In 2007, CMS submitted to Congress the VBP program. This pay for performance (P4P) program was designed, in part, to reward hospitals who performed well or showed improvements on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores (Elliot et al., 2010). The VBP program provides financial incentives to hospitals that achieve certain quality standards; these metrics include a focus on patient perception of care (Cliff, 2012). Incentivizing and penalties serve as motivators for healthcare leaders to foster a culture of patient centeredness within their organizations. Snide and Nailon (2013) reported that hospitals receive optimal Medicare reimbursement when their performance ratings are within the top decile of the patient satisfaction survey and when patients rate their overall hospital experience as favorable. The financial impact associated with patient responses make it necessary to develop innovative ways of delivering care, especially in a market where the focus is shifting from volume to value-based care (Snide & Nailon, 2013).

Cliff (2012) stated that patient-centered care hospitals should look to patients to help define the factors that lead to improved patient experiences and overall satisfaction. Luxford and Sutton (2014) said patient satisfaction scores can present a limited understanding of healthcare and that detailed information from patients and families is more valuable. Ponte et al. (2003) noted that patient-centered care models need to move past one-dimensional approaches where patient input informs what patient-centered care encompasses. Jha, Orav, Zheng, and Epstein (2008) indicated that a patient's perception of care in a hospital setting is not well understood, furthering the support for the Ponte et

al. (2003) move to multidimensional approaches in patient-centered care. The healthcare industry needs to include patients in defining what encompasses patient-centered care and leads to satisfying patient experiences.

Making patients and their families' vital members of the health care team is a change from the traditional model of care, and it often challenges long-existing hospital cultures (Ponte et al., 2003). Ponte et al. reported that when patient-centered care is developed to its fullest capacity, it should assist in defining how patients, families, and caregivers interact with one another, how care is delivered, and how healthcare services are structured.

Needham (2012) stated that a positive patient experience requires good management of the patient's well-being, which includes the emotional and physical impact of being a patient. To achieve this, care should be delivered around the framework of individualizing medicine, partnering with patients, and empowering employees (Needham, 2012).

Cliff (2012) stated that references to patient-centered care date back to the 1950s. Hobbs (2009) concurred with Cliff (2012), noting that patient-centered care has been referenced in nursing literature for over half a century, and Cliff further described patient-centered care as care that focuses on patient-specific problems rather than on task-oriented or provider-centered care. Hobbs (2009) noted that a lack of conceptual clarity on the part of caregivers makes it very difficult for healthcare to operationalize patient-centered care and to include it into research or clinical projects.

Patient-centered care is a relatively new and evolving concept devoid of a universal definition. Lutz and Bowers (2000) noted that in the 1980s and 1990s, patient-

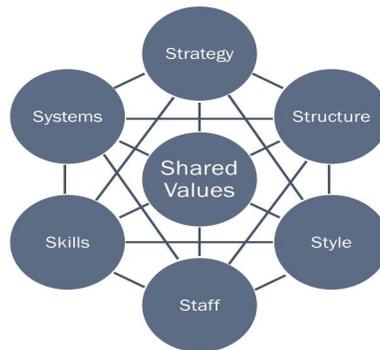
centered and patient-focused care were being used synonymously and added to even greater ambiguity around the concept of patient-centered care. The Agency for Healthcare Research and Quality (AHRQ) (2015) reported that patient-centered care is defined by the Institute of Medicine (IOM) as “providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions” (Institute of Medicine [IOM], 2001 p. 6). This is one of many definitions currently being utilized to explain and address patient-centered care parameters. Within IOM’s definition, partnerships are central, to ensuring that decisions are made with respect to patients’ wants, needs, and preferences. The expectation is that patients have the education and support they need to make decisions and to participate in their own care (Wolf et al., 2008b). Patient-centered care is one of the IOM’s six identified quality aims alongside other quality indicators thought to improve patient experience including (a) effective, (b) timely, (c) efficient, (d) equitable, and (e) safe patient care. CMS incorporated the six aims into their quality improvement road map in 2005, placing significance on the inclusion of patient-centered care as one of their 12 detailed actions to improve quality and safety (Wolf et al., 2008). The IOM’s (2001) definition was shared with focus group participants as one of many potentially adoptable definitions for patient-centered care.

Theoretical Rationale

The McKinsey 7S framework (Singh, 2013) was utilized as the lens through which to assess the organizational structure of this study and assess the current status of the institution under review. Further, it informed the research questions and interview process. Maintained throughout the case study, the framework assisted in identifying and

analyzing emergent themes and associations of patients and medical professionals related to shared values in patient-centered care in a hospital setting.

Robert H. Waterman, Jr. and Thomas J. Peters, working as organizational consultants, developed the 7S framework that undergirds this study. Of primary concern was the effectiveness and the interconnection of several factors, namely, the inherent: structure, strategy, systems, style, staff, skills, and superordinate goals (shared values). Structure, strategy, and systems encompass what has been labeled as the hard elements; while style, staff, skills, and shared values indicate the framework's soft elements. The consultants-turned-theorists advanced the notion that organizational change is best understood through the complex relationship between the two sets of elements (Waterman, Peters, & Phillips, 1980).



*Figure 1.1. McKinsey 7S Framework. Adapted from “A Study of Role of McKinsey's 7S Framework in Achieving Organizational Excellence,” by A. Singh, 2013, *Organization Development Journal*, 31, p. 46. Copyright 2013 by The International Society for Organization Development (ISOD).*

The framework endured several iterations of streamlining throughout its development, between the late 1970s and into the 1980s, including the change from superordinate goals to shared values. The 7S framework was formally birthed in the

article published by Waterman, Peters, and Phillips in *Business Horizons*, titled *Structure Is Not Organization* (Waterman, Peters, & Phillips, 1980).

Within the 7S framework, the structure focuses on the way organizational units relate to one another. Strategy represents the organization's plans to reach identified goals. Systems are associated with the procedures, processes, and routines of the organization. Style relates to organizational culture. Staff represents the status of personnel; this includes the numbers and types of all employees. Skills are directly tied to the unique capabilities of the organization's personnel and to the whole group. Finally, the superordinate goals (shared values) serve as the interconnecting center of the model, identifying what the organization stands for collectively; it represents the central beliefs, organizational attitudes, and the core values (Waterman et al., 1980). Waterman et al. noted that the interconnecting center of the McKinsey 7S model (Singh, 2013) *shared values*, emphasize that an organization's values are central to the development of all other critical elements. If a value changes, so do all other elements within the framework.

The 7S framework envisioned by Waterman et al. (1980) claimed that for an organization to perform well, elements needed to be interrelated, mutually reinforcing, and aligned. The shape of the framework's diagram (Figure 1.1) is important, as it illustrates the interconnectedness of the seven factors. The framework offers no starting point or hierarchy; each one is interconnected and equally important to organizational success (Waterman et al., 1980).

The 7S framework can help to identify what needs to be addressed in an organization to improve performance and/or maintain alignment. The framework can be useful with restructuring, implementing new processes, assisting with organizational

mergers, and changing organizational systems. Further, the model can be used to analyze a current situation, propose a future state, or to identify gaps or inconsistencies (Waterman et al., 1980).

Singh (2013) noted that the McKinsey 7S framework is a strategic assessment and alignment model that lends itself to the discussion of organizational activities, interactions, and infrastructure. The McKinsey 7S model allows for the comparison of the present state with the desired state, showing how each of the components is linked and how change can occur. Thus, the 7S framework can be used to transform an organization (Singh, 2013). For the purpose of the case study, the model provided a lens to view the current state of the organization in terms of patient-centered care; serving as a mechanism to assess infrastructure related to patient-centered care practices, and the potential for shared values to reach a unified definition.

The 7S framework lends itself to today's unpredictable and rapidly changing healthcare environment by providing a structure to analyze an organization's internal environment and assess alignment. Additionally, the 7S framework serves as a guide in which organizations come to understand the impact of unfamiliar events and changing environments concerning organizational factors, which describes the evolving state of healthcare. The seven key factors of the McKinsey framework serve as a model to view the organization and to evaluate how aligned an organization is around patient-centeredness and shared values. Specifically, for this study, utilizing the McKinsey 7S's for an alignment purpose allowed for understanding how the organization was structured, what influenced employees and their general abilities, their skills, and their superordinate goals (shared values/core values evidenced in the culture) related to patient-centered care

and the values of medical professionals and patients within the healthcare setting. Utilizing various factors of the framework to assess medical professionals, patient activities and interactions, and the organization's infrastructure, allowed for an opportunity to assess shared values in patient-centered care.

The McKinsey 7S framework (Singh, 2013) is used when an alignment perspective is useful and therefore is helpful in examining shared values in patient-centered care for medical professionals and patients. The framework assists in providing a structure for how to operationalize what is learned in the research.

Statement of Purpose

The purpose of this descriptive, single, embedded-case study was to propose a definition for the phenomenon of patient-centered care for patients, medical professionals, ancillary staff, and leaders at a large, urban, acute healthcare setting in Central New York. Findings for this study was drawn from medical professionals focus groups and archival data from previously conducted patient-focus groups. A reference starting point for developing a definition for patient-centered care began with introducing the definition advanced by the Institute of Medicine (2001):“the care that is respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions.” (p.6)

Research Questions

The research questions that guided this case study are:

1. How do medical professionals in a large, urban, acute care hospital located in Central New York define patient-centered care?

2. How do patients in a large, urban, acute care hospital in Central New York define patient-centered care?

Potential Significance of the Study

The research has the potential to assist in demystifying patient-centered care for patients and medical professionals and leaders at a large, urban, acute healthcare setting. Further, it may identify the foundational framework for a model of shared values in patient-centered care. The current healthcare system warrants reform with a focus on the patients' experience of care and, more specifically, how healthcare organizations and providers engage patients and medical professionals in a model that consistently practices patient-centered care.

Definition of Terms

Medical Professionals – includes all staff members within the organization interacting with patients for this case study. This includes medical professionals, ancillary staff, and leaders.

Chapter Summary

The current state of uncertainty in healthcare and ambiguity surrounding patient-centered care are factors that lend support to studying whether shared values relative to patient-centered care exists within healthcare organizations. Many healthcare organizations and industry leaders struggle to understand, adopt, and implement a patient-centered care model for their providers and institutions because there is ambiguity around the concept and by extension, implementation. Conversely, others in the field believe that they are already providing patient-centered care.

Regardless of where healthcare organizations are on the spectrum of implementing patient-centered care effectively, attention must be given, beyond lip service, in a competitive healthcare market. Embedding patient-centered care into the existing culture, or altering the culture, is the responsibility of individual healthcare organizations. An organization's patient-centered care model contains actionable, observable, and measurable aspects of its mission and daily practice.

Chapter 2 provides a selective review of the literature that is indicative of the research problem and supports the need for a study focused on shared values in patient-centered care from the perspective of both patients and the medical professionals employed by a large, urban, acute-care hospital in Central New York. Chapter 3 details the methodology, and validates its qualitative design to address the research questions. Chapter 4 presents the findings of the research, with Chapter 5 providing a discussion of: recommendations, limitations of the study and personal discoveries.

Chapter 2: Review of the Literature

Introduction and Purpose

Hospitals and healthcare organizations choose patient-centered care models and apply their definitions to practice based on organizational understanding. Patient-centered care approaches are linked to patient safety, quality care, and patient satisfaction. Although the practice of patient-centered care is considered to result in positive outcomes for organizations and the patients they serve, an understanding of shared values in patient-centered care is unknown.

Various studies have been conducted to clarify the impact and links between patient-centered care, perceptions, and outcomes. Several studies utilized patient experience data from the HCAHPS, which is publicly reported and readily available for inclusion and comparison. Still, other researchers relied heavily on a qualitative approach to understand the impact of patient-centered care. Few randomized trials have been conducted on this phenomenon. Various methods of research were explored in the review of literature. The literature review is focused on studies involving HCAHPS indicators; caregiver impact; organizational culture, quality, safety, and perceptions; and ancillary opportunities involving patient-centered care.

Research has lent credence to and validated the importance of patient-centered care, however, ambiguity surrounding a universally accepted definition of patient-centered care persists. Given the lack of a universally accepted definition, healthcare providers struggle with knowing what to adopt, implement, and/or measure. This gap in

the research warrants study to identify the emergent themes identified as important in patient-centered care by stakeholders.

Review of Literature

Hospital consumer assessment of healthcare providers and systems, caregivers, and culture. Patient experience is measured through the Hospital Consumer Assessment of Healthcare Providers and Systems survey, which includes specific composite questions that provide an understanding of quality, safety, and satisfaction ratings for healthcare organizations. Many researchers utilized this publicly reported data, along with other survey findings, for inclusion in their studies on patient experience, patient engagement, and patient-centered care. It can be hypothesized that survey data results may reflect an organization's culture and communicated values through their practice.

Hobbs (2009) indicated that to render patient-centered care in an effective manner, clarity around what is precisely meant by patient-centered care is required. Hobbs conducted a dimensional analysis of patient-centered care from 69 clinical and research articles that were published between 2000 and 2006. The purpose of the study was to look at the extent and depth to which patient-centered care was found in the literature. Coding of the literature was completed and included a focus on the perspective, conditions, process, context, and consequences of patient-centered care. The codes were used to determine which literature was selected for inclusion, to organize the content, and to provide a suggested framework of what represented patient-centered care (Hobbs, 2009).

Hobbs (2009) concluded that the “alleviation of vulnerabilities” (p. 55) was a central theme throughout the literature and that therapeutic engagement was a process that helped to sustain the patient during illness. Vulnerabilities were identified as compromised psychological states and threats to individualized identity (Hobbs, 2009). Hobbs suggested that the interaction between the nurse and patient is a central relationship to the effective study and implementation of patient-centered care, and that the nurse-patient interaction should be further explored. The researcher further noted that despite the identification of impactful dimensions, there remains an urgency in healthcare to further develop a patient-centered care framework that has universal value and that can be applied to both clinical applications and much-needed research (Hobbs, 2009).

Hobbs (2009) also presented the concern that there has been very little published on the examination of how nurses and physicians deliver patient-centered care together, or how they integrate with other caregivers working on the healthcare team (Hobbs). Although their individual practices within their disciplines are important, understanding this phenomenon may be one way to begin to better understand the interdisciplinary perspectives of patient-centered care (Hobbs, 2009).

Jha et al. (2008) conducted a study to evaluate patients’ perceptions of hospital care in the United States. The researchers noted that this is not a well understood concept, especially in the hospital setting. The researchers assessed 4,032 hospitals’ performances across multiple domains of patient experiences using the HCAHPS data results. Jha et al. specifically looked at whether certain characteristics that are thought to enhance patient experiences were related to better experiences for the patients. The study further looked

at whether a hospital's performance on the HCAHPS survey was related to their performance on measures of quality and safety (Jha et al., 2008).

Jha et al. (2008) utilized chi-square tests and *t*-tests to analyze hospitals that did and did not report HCAHPS data, and they compared the characteristics between them. The researchers posited for-profit hospitals and hospitals with more nursing staff may be more focused and attentive to their patients and therefore more patient centered. The bivariate relationships between these characteristics were explored, and the HCAHPS ratings were examined; a multivariable linear regression model was constructed to adjust for these characteristics and other confounders (Jha et al., 2008).

The researcher found that hospitals with moderately high levels of satisfaction had a high degree of correlation among the measures of the patient-experience domains. Hospitals with a high level of patient satisfaction were noted to have slightly higher quality scores for all the evaluated conditions as well (Jha et al., 2008). The findings further suggest that patient experience offers insight to needed improvements in health care, and Jha et al. suggested that the organizations with higher nurse-to-patient ratios may also be linked to higher patient satisfaction.

Wolosin, Ayala, and Fulton (2012) noted that with Medicare's value-based purchasing program, linking a portion of hospital reimbursements to the HCAHPS survey results for hospitals, there might be an increasing interest in patient satisfaction, engagement, and patient-centered care. Wolosin et al. (2012) indicated that, in addition to this interest, studies have shown that a patient's satisfaction with his/her own health care experience is positively related to improved patient outcomes, including adherence and safety.

Wolosin et al. (2012) intended to investigate how domains of patient satisfaction in hospitals predict HCAHPS global rating scores in an effort to support hospital administrators in dealing with reimbursement changes. Wolosin et al. utilized a logistical regression analysis of patient-level satisfaction domain scores taken from a standard available survey, along with HCAHPS top-box scores that were controlled for potential confounding variables to assure internal validity of the research. The major dependent variable of interest was the top-box percent for the HCAHPS domain of “overall satisfaction.” The researchers included controls for patient demographics and those characteristics that were found to impact a respondent’s satisfaction, such as general health status, number of days hospitalized, and English as a primary language (Wolosin et al., 2012). The results showed that with each 1-point increase in the nursing domain score, the odds of achieving a HCAHPS top-box score increased by 4.9%. There were increases in other domain scores that impacted top-box scores as well, but they were identified to a much smaller degree in the study. Wolosin et al. recommended, based on the study findings, that hospital administrators should focus on nursing care to yield the greatest impact on patient satisfaction. They noted that patient rooms, physician care, and meals were all significant predictors of patient satisfaction but that nursing care was clearly the most important (Wolosin et al., 2012).

Looking to assess the relationship between certain organizational characteristics and publicly reported HCAHPS scores, Manary, Staelin, Kosel, Schulman, and Glickman (2014) surveyed chief patient experience officers at VHA hospitals. Of the 416 hospitals asked to be involved in the study, 143 participated, with most reporting a high level of agreement that the patient experience was a very important strategic indicator. The

respondents reported that 68% of hospital boards, and 81% of chief executive officers viewed the patient experience as extremely important (Manary et al., 2014).

The results of the study indicate that doctors and nurses were supportive of efforts to improve the patient experience over the top-level executives, 34% to 15%, respectively. It was noted that hospitals with collaborative cultures and higher physician engagement had higher HCAHPS scores (Manary et al., 2014). The researchers therefore suggested that employee engagement and cultural development should be addressed in an organization's efforts to improve upon the patient experience and overall patient satisfaction (Manary et al., 2014).

Manary et al. (2014) concluded that hospital boards and hospital CEOs were closely aligned in their belief in the importance of the patient experience. The study results suggested that there is an apparent disconnect between organizational culture, hospital management, and physicians, related to the importance of the patient experience in today's healthcare environment. The researchers noted that the study presented limitations, including the sample size being very small, and that all hospitals in the study were associated with the common network of the VHA. Manary et al. indicated that the study team experienced high consistency but that the study would have been stronger if all hospitals had multiple responders. A more longitudinal approach may have yielded better information on how changes in hospital culture impact patient experience and satisfaction (Manary et al., 2014).

Smith (2014) looked at patient satisfaction levels in Magnet hospitals. "The Magnet Recognition Program recognizes health-care organizations for quality patient care, nursing excellence and innovations in professional nursing practice. Consumers rely

on Magnet designation as the ultimate credential for high quality nursing” (UC Davis Medical Center, n.d., para. 2). These types of hospitals are known for quality care and positive cultures and work environments. The purpose of the Smith’s study was to validate whether significant relationships exist between patient satisfaction and Magnet status. The research design was a secondary analysis of data collected and compiled from the American Hospital Association’s hospital database, American Nurses Credentialing Center’s Find a Magnet Hospital List (ANCC-FMHL), and HCAHPS results (Smith, 2014). The sample consisted of 2,001 hospitals that had greater than 100 responses on the HCAHPS survey and received Magnet status on or before December 31, 2007 (Smith, 2014). Smith utilized multiple univariate analyses of variance (ANOVAs) to conduct a multivariate analysis. The null hypothesis was rejected, and outcomes showed statistical significance for Magnet hospitals for all the variables apart from “always received help when wanted” (Smith, 2014, p. 35). Limitations of the study included the large administrative database that lent to risk of data entry errors and an inability to audit integrity of data collection. The cross-sectional approach limited the collection of data to a specific time period, making it difficult to know if the outcomes were trends or reflections of good or poor performance periods (Smith, 2014).

Hwang (2013) developed and tested a patient-centered care competency scale for hospital nurses. The purpose of the study was to test the soundness of a patient-centered care competency scale. Hwang stated a need for the design of appropriate instruments to measure patient-centered care competency in a reliable and economic way. The researcher referenced previous studies that suggested that high-quality care tools for measuring patient centeredness in healthcare settings were needed. Based on the

researcher's knowledge, there had been no validated instruments for evaluation of hospital patient-centered care competency to date (Hwang, 2013).

Hwang's (2013) study was conducted in two phases. The first phase addressed development aspects, and the second phase was geared toward evaluation of the scale. The development phase included a panel of content experts, and the evaluation phase consisted of dedicated psychometric testing of the scale that was developed (Hwang, 2013). The researcher defined patient-centered care as knowledge, skills, and attitudes related to patient-centered care (Hwang). The researcher conducted a cross-sectional questionnaire survey of 594 nurses in two teaching hospitals, with an overall response rate of 99.5%. The sample consisted of 394 nurse participants who worked in inpatient care units referred to as hospital A and 200 nurse participants who worked in similar units referred to as hospital B (Hwang, 2013).

The scale assessed 17 items that were divided into four subscales. The Cronbach's alpha coefficient of the scale and subscales indicated that satisfactory convergent and discriminant validity existed (Hwang, 2013). Hwang noted that there were significant correlations found between the total patient-centered care competency scores and overall self-ratings of patient-centered care performance of the nurses. Hwang further noted the necessity of understanding nurses' competency for patient-centered care to transition an organization toward the practice. Hwang (2013) determined through the study that the patient-centered care competency scale was a highly valid and reliable tool to assess this competency.

Weech-Maldonado et al. (2013) studied whether hospital cultural competency can reduce disparity in patient experiences within healthcare. The subjects consisted of a

merging between the HCAHPS surveys and the Cultural Competency Assessment Tool of Hospitals Surveys for California hospitals, which resulted in 66 hospitals and 19,583 HCAHPS respondents (Weech-Maldonado et al., 2013). The dependent variables included 10 of the HCAHPS measures, including six composites, two individual questions, and two globally impacting questions (Weech-Maldonado et al., 2013).

The study results show that hospitals with greater cultural competency had better HCAHPS scores for overall hospital rating, recommendation, and physician communications (Weech-Maldonado et al., 2013). The HCAHPS scores for minorities were higher at hospitals with higher cultural competency on four of the other dimensions, including nurse communications, staff responsiveness, pain control, and room quietness (Weech-Maldonado et al., 2013). The results may be an example of value sharing based on the collective importance of cultural competence and its intended impact on patient experience and overall satisfaction with aspects of care.

McClelland and Vogus (2014) examined the benefits of compassion practices on two indicators of patients' perceptions of care quality: the HCAHPS overall rating and the likelihood of a patient to recommend a hospital. The cross-sectional study included 269 non-federal acute-care U.S. hospitals with the surveys being collected from hospital executives in top-level positions and from the publicly reported HCAHPS October 2012 data survey (McClelland & Vogus, 2014).

The researchers used the American Hospital Association database to acquire their initial random sampling of 639 non-federal acute-care U.S. hospitals. McClelland and Vogus (2014) used Dillman, Smyth, and Christian's (2009) tailored design method to increase response rates, and they found no difference between early and late responders.

Further evaluation was completed and showed no difference between respondents and non-respondents related to organizational size, Magnet or teaching status, staffing ratios, or other variables (McClelland & Vogus, 2014). The compassion practices were assessed using five items that were measured on a 1-7 Likert-type scale. The scale measured the extent to which the practice was used to reward compassion or to compassionately support employees within a hospital. Tests were conducted to assure that the scale was meaningful, including assessing hospital differences using an ANOVA with the hospital as the independent variable and compassion practices as the dependent variable (McClelland & Vogus, 2014).

The findings show that compassion practices are significant and positively associated with the likelihood of a patient to recommend a hospital and to a hospital's overall ratings. Compassion measures and practices were described as the extent to which hospitals compassionately supported employees and rewarded their acts of compassion. The study noted that specific interventions to enhance patient and family compassion were associated with the perception by the patients of higher quality and responsiveness of employees (McClelland & Vogus, 2014). The authors indicated that patients benefit when an organization takes action to provide and reinforce compassion. McClelland and Vogus (2014) recommend further research to build on the foundation of compassionate practice and to determine where and at what level these practices can have the greatest impact on patients and organizations.

Carter et al. (2008) explored a culture of caring with the aim to evaluate patient-centered care behaviors in a large Midwestern healthcare institution. The hospital was known to place high value on the practice of patient-centered care and for the concept to

be part of their organizational mission and daily practice. Even though patient-centered care was embedded within the organization's culture, nurses on one medical unit questioned whether technology had impacted care, causing desensitization (Carter et al., 2008).

The researchers set out to explore the state of patient-centered care in this unit through the lens of the nursing staff and the patients they cared for. Jean Watson's theory of human caring (Watson, n.d.) was used as a theoretical framework for the study that included 93 participants, with 31 nurses and 62 patients. A descriptive, comparative survey design was utilized and administered to the subjects, and a focus group was held for the nurses to explore ideas for innovation related to patient-centered care (Carter et al., 2008). The focus group was facilitated by a doctorate-prepared nurse researcher who had previous experience with facilitating focus groups and analyzing focus group data. A nursing research specialist with advanced training and experience in focus group methodology and analysis was also in attendance, serving as an observer for the group (Carter et al.). The study setting was a 36-bed medical specialty unit whose patient population included both acute and chronic health conditions. Relationships of care encompassed four elements, including teamwork, building expertise, personal support, and connecting with patients (Carter et al., 2008).

The study results show that both nurses and patients perceived high levels of caring on the unit. Carter et al. (2008) noted that while technology had impacted the pace of work on the unit, the participants of the study valued caring as the inspiration for quality patient care and quality work teams. The key elements of patient-centered care in the work environment included personal support from peers, teamwork, building

expertise, connecting with the patient, culture, physical environment, and workload (Carter et al., 2008). The focus group resulted in the theme that “caring begets caring,” (Carter et al., 2008, p. 61) and two subthemes, “relationships of care” and the “context of caring,” (p. 61) emerged. Essentially, the subthemes related to care for the caregiver and the idea that when a staff is satisfied and cares for one another, the patient benefits (Carter et al., 2008).

Luxford, Safran, and DelBanco (2011) conducted a qualitative study with eight U.S. healthcare organizations that had a reputation of being patient centered. The researchers investigated organizational support systems and obstacles to patient-centered care through semi-structured interviews of 40 senior leaders and patient advocates. Luxford et al. selected organizations based on geographic location and based on the variations of healthcare services that were offered. The study included three acute inpatient hospitals, three medical groups that provided ambulatory care and two health-management facilities that practiced a group approach. Site selection was based on the organizations that had a proven reputation of improving the patient experience of care or were high ranking in the patient experience data (Luxford et al., 2011).

The study sample involved 40 subjects, including chief-executive-level leaders, directors, physician leaders, administrators, and patient advocates. One interviewer was responsible for conducting all of the in-person interviews that lasted between 45 and 60 minutes. Prior to the interviews, questions had been tested at an interview pilot site and were refined as needed. Each interview was recorded and later transcribed precisely. One researcher conducted the primary content analysis from the interviews, while an

independent coder randomly sampled the interviews and conducted coding validation (Luxford et al., 2011).

Luxford et al. (2011) reported that the study yielded several organizational attributes and processes that were identified as key factors in making care more patient centered. The study shows that significant barriers to implementation of patient-centered care were the challenge of changing a culture from being provider focused to patient focused as well as the length of time it takes to transition to such a culture (Luxford et al.). The researchers concluded that organizations that have succeeded in patient-centered care have incorporated innovative tactics and implemented strategic organizational approaches to hardwire patient-focused care into their organizations (Luxford et al., 2011).

Kleefstra, Zandbelt, de Haes, and Kool (2015) noted that continuous assessment of the patient perspective on care is a major component of quality management. The researchers further noted that the cultural change that is needed to impact patient-centered care likely takes many years to cultivate. Thus, improvements in patient experience and patient satisfaction are not quick wins but, rather, require consistency in practice and culture and a hardwiring of the chosen patient-centered care approach (Kleefstra et al., 2015).

The researchers completed four large-scale nationwide comparative studies. The national data was analyzed as well as the data from each of the hospitals. Kleefstra et al. (2015) performed a univariate analysis of variance to measure the polynomial contrasts in the four measurements. The data set was made up of 58,055 inpatients and 79,498 outpatients. The researchers noted response rates of 53% for 2003, 2005, and 2007; the

response rate in 2009 was 42%. The patient demographics, including level of education, age, and health condition, showed a significant difference throughout the study (Kleefstra et al., 2015).

Kleefstra et al. (2015) concluded that noteworthy trends in patient satisfaction are present in both inpatient and outpatient units, specifically around information, discharge, and aftercare, at both the national and hospital levels. The researchers indicated that they believed their study was the first to report on the magnitude of the change in patient satisfaction scores by way of Cohen's *d*. Thus, it was noted that common effect sizes were not known and that the practical value of the findings is meaningful (Kleefstra et al., 2015).

Kleefstra et al. (2015) noted that the studies were consistent with design, application, and participants at each hospital. The findings indicated that health care organizations have opportunities to make positive changes, including hospitals who had high satisfaction scores. In an effort to improve patient-centered care for all patients, the recommendation from the study was to move to include other subgroups that represented unsatisfied patients (Kleefstra et al., 2015).

The studies associated with HCAHPS survey data, caregiver roles, and cultural impact yielded interesting results. Staffing, particularly related to the position of nursing, may have an important role in how patient-centered care is delivered and perceived. Organizational cultures should be further explored for better understanding of their impact on patient experience and perceptions of patient-centered care practices, including communications, discharge impacts, and aftercare at both the hospital and national levels. Assessing the understanding and fidelity to a patient-centered care concept would

enhance the current research data and understanding of patient-centered care effectiveness. Overall, the research validates the ambiguity of patient-centered care as a defined model of practice in healthcare. The research also informs the need to define the shared values for the concept and implementation of patient-centered care in practice.

Randomized Controlled Trial Studies

To further understand the impact of patient-centered care on patients, caregivers, and the healthcare culture as a delivery model, it is important to explore the data available from controlled studies. The number of these types of studies specific to patient-centered care is limited, but their findings are important.

Wolf, Leman, Quinlin, and Rosenzweig (2008a) conducted a randomized study using a control group and posttest design to determine if nurses using a patient-centered care model impacted patient satisfaction, lent to the patient's perception of nursing care, or influenced quality outcomes. The purpose of the study was to extend statistically significant findings to a pilot study that had previously examined the impact of patient-centered care on patient satisfaction, at discharge, from an acute healthcare setting (Wolf et al., 2008a).

A total of 116 patients participated in the study and were randomized to the intervention patient-centered care or control group, with 58 patients designated to each group. Originally, there were 138 patients approached for the study; 129 consented to participate. Of that original total, nine declined for personal reasons, and 13 were lost to attrition.

Patients who received patient-centered care were called before their admission, and they were cared for by nurses with specialized training to administer patient-centered

care. The control patients received the usual nursing care (Wolf et al., 2008a). Both groups completed two surveys, the Schmidt Perception of Nursing Care Survey (SPNCS) and the Baker and Taylor Measurement Scale (BTMS), before being discharged to home. Both groups also received a phone call within 24-48 hours of their discharge, with the call data evaluated via content analysis (Wolf et al., 2008a).

No notable differences were found between the groups for their length of stay, their assessment of the quality of care, their satisfaction level, or their perceptions of the overall nursing care (Wolf et al., 2008a). Positive and negative findings were equally distributed within the groups. Therefore, it was concluded that the delivery of a defined patient-centered care approach did not impact the patient's degree of perceived satisfaction or perception of quality of care. One distinguishable difference noted for the patient-centered care group was that patients were more open to communication, more talkative, and better able to express negative experiences. The control group was noted to be more cautionary (Wolf et al., 2008a). The lack of variability may have resulted from the extensive training of all the staff involved in the study as it was conducted in a bariatric center of excellence. There may also have been some sharing of patient-centered care knowledge between the nursing groups (Wolf et al., 2008a).

Tanco et al. (2015) conducted a randomized clinical trial at an outpatient cancer center. The study objective was to compare patients' perceptions of physicians' compassion after watching videos of two physicians conveying optimistic and less-than-optimistic patient information (Tanco et al., 2015). The intent was to establish patients' preferences for the physician delivery after the viewing and to identify predictors of compassion. One hundred patients were randomized to observe the two videos. Both

physicians made an identical number of empathetic statements and utilized similar posturing (Tanco et al., 2105). Post-viewing, the patients completed a Physician Compassion Questionnaire.

The study findings report significantly better compassion scores for the physician (video) with the more optimistic message than that of the less optimistic message. A higher perception of compassion was associated with greater trust, and patients identified the more optimistic physician to be more trustworthy (Tanco et al., 2015). Patients perceived higher levels of compassion and preferred physicians that provided more optimism in their messages. This indicates that more research is needed related to the structuring of less-optimistic message content in order to support physicians in the delivery of less-optimistic news (Tanco et al., 2015).

Wolf, Lehman, Quinlin, Zullo, and Hoffman (2008a) studied the effect of patient-centered care on patient satisfaction and quality of patient care. A randomized study using a posttest design was conducted to examine whether patient-centered care influences patient satisfaction, perceptions of nursing care, and overall quality of patient care (Wolf et al., 2008a). The Baker and Taylor Measurement Scale was used, with differences seen in two of the three subscales.

The patient-centered care groups rated satisfaction and quality of patient care services higher than the control group. The results indicated that patient-centered care may impact the patient's perception of satisfaction and their overall level of satisfaction and perception of the quality of care received (Wolf et al., 2008a).

Randomized controlled trial studies are valuable research that serves to inform the impact of patient-centered care. There are a limited number of these types of studies on

this topic; therefore, more research may be helpful to learn more about what impacts this aspect of healthcare culture.

Outcomes: Quality, Safety, Perceptions

To further understand patient-centered care and its role in healthcare, it is important to look at healthcare outcomes. Studies that focus on quality and safety, as well as patient perceptions, are valuable for gaining insight and understanding around what is currently understood and wanted from patient-centered care experiences.

Bowie et al. (2014) conducted a participatory mixed-method study. The participatory design principles set forth to develop the *always event* (AE) concept for the primary care setting. The AE is a representation of what is personally important to patients, so much so that it should always happen when they engage in healthcare (Bowie et al., 2014).

The convenience sample consisted of 195 patients from a study setting that included 13 general physician practices. The subjects either participated in interviews or completed questionnaires. The surveys consisted of brief semi-structured interviews along with short cross-sectional questionnaires. Qualitative and quantitative data were combined using content analysis (Bowie et al., 2014). Themes and subthemes were generated by the researchers, and variances in opinions were resolved by a joint data and a theme checking process to reach consensus. Four themes were identified as of high importance to patients, and that represented AEs. These included emotional support, respect, and kindness, clinical care management, communication and information, access, and continuity of healthcare. Each AE was connected to a measurable process or behavior

to allow for needed quality improvement changes that would directly impact the patient's care experience (Bowie et al., 2014).

Bowie et al. (2014) indicated they believed theirs to be the first known study to develop an AE concept as a quality improvement, person-centered approach. The study was small and it focused on a patient subpopulation. Furthermore, it relied on volunteer managers to assist in delivery and collection of the surveys, which can be problematic due to the potential for participant influence. Aside from the study limitations, Bowie et al. noted that the findings could potentially be used to help healthcare administrators identify what patients always want related to care quality, and that knowledge could potentially drive quality improvements. The researchers further shared that additional research and assessment of effectiveness of the method is necessary (Bowie et al., 2014).

Taylor et al. (2008) noted that service deficiencies related to quality are common in healthcare but that little is known about adverse events and medical efforts. The researchers hypothesized that patients reporting poor service were at increased risk to be subjected to errors or poor service quality (Taylor et al.). The researchers conducted a pre- and post-interview study of 228 hospitalized patients. Subjects were interviewed during and after their admissions about issues they encountered during their hospitalization. Information from the interviews was used to identify deficiencies, including service issues and quality deficiencies (Taylor et al., 2008).

Following the interviews, the researchers performed a blinded retrospective chart review to precisely identify adverse events and errors (Taylor et al., 2008). The researchers noted that a multivariable method was used to analyze whether the patients who reported service quality issues experienced adverse events, close calls, or what they

classified as low-risk errors. The 228 participants reported a total of 183 service quality deficiencies. Based on the medical chart reviews, there were 52 occurrences identified, including 34 adverse events, 11 close calls, and seven low-risk errors (Taylor et al., 2008).

Taylor et al. (2008) noted that when a service quality issue is present, it more than doubles the odds of an adverse event, close call, or low-risk error. The researchers concluded that poor coordination of care was associated with adverse events and medical errors, and that patients who report service quality issues may help deter safety issues in healthcare (Taylor et al.). The study was limited by a small sample size and use of a single site, impacting its generalizability. The researchers stated that, although they used a prospective cohort design, the analysis was restricted to a cross-sectional examination deterring the ability to determine causality between variables and an adverse event. Recommendations were noted for further understanding and research around the temporal relationship between adverse events and service quality judgments. Taylor et al. (2008) posited that additional research would assist in clarifying whether poor service perceptions result from medical injury or whether they result independently from that occurrence.

Doyle, Lennox, and Bell (2012) conducted a systematic review of patient and clinical safety and effectiveness, looking specifically for evidence of linkages. The researchers utilized a variety of settings, including hospitals and primary care centers, in the review. The study summarized evidence from 55 studies that represented participants from a wide range of demographic groups (Doyle et al.). The broad range of patient

safety and clinical effectiveness outcomes that were explored, included mortality, length of stay, physical symptoms, and adherence to treatment (Doyle et al., 2012).

Doyle et al. (2012) reported that a consistent positive association between patient experience, patient safety, and clinical effectiveness for various diseases, settings, outcomes, and study designs existed. Positive associations were reported to outweigh no associations by 429 to 127. Doyle et al. (2012) noted that of the four studies, where no associations outweighed the positive associations, there was not a suggestion that those studies were methodologically superior. Doyle et al. (2012) suggested that the study supported the argument that patient experience, patient safety, and clinical effectiveness are linked to one another and should be looked at cohesively and, because the data positively associated patient experience and clinical effectiveness and safety, it supported the inclusion of patient experience as one of the pillars in quality health care. The researchers noted that the study was impacted by time as a limitation, and there is an opportunity to expand upon the research to broaden global understanding and to further identify evidence to support the existing links (Doyle et al., 2012).

Lee and Yom (2006) conducted a comparative study of nursing service quality, patient satisfaction, and the intent of patients to revisit a hospital. The study consisted of 272 patients and 282 nurses who completed questionnaires. The study findings were analyzed using *t*-test, standard deviation, and the Pearson correlation coefficient (Lee & Yom, 2006). The study results indicated that nurses' expectations and performance were higher than those of patients and patients' overall satisfaction with nursing was rated higher than nurses' perceptions (Lee & Yom, 2006). Lee and Yom (2006) noted that there was a positive relationship between patient satisfaction with nursing and a patient's

intent to revisit the hospital. Performance was lower than expectations, which resulted in lower nursing care quality. Lee and Yom (2006) posited that the differences that were noted between nursing, patient expectations, and performances should be further researched.

Sidani (2008) studied the effects of patient-centered care on patient outcomes. The non-experimental design study with repeated measures was used to explore the extent to which acute-care nurse practitioners (ACNP) provided patient-centered care and their impact on patients' functional status, their self-care abilities, and their overall satisfaction with care (Sidani, 2008). The study included 320 patient subjects who exhibited acute medical and surgical conditions.

Sidani (2008) noted that the patients perceived the ACNPs to be providing patient-centered care, evidenced by the nurses providing encouragement to patients to participate in their care and individualizing their care to a moderate extent. Implementations of patient-centered care factors were found to be positively associated with the domains of self-care ability and satisfaction with health care (Sidani). According to Sidani (2008), further studies are needed to more fully understand the contribution of advanced-practice nurses on patients' perceptions of patient-centered care.

Sarkissian, Sidani, Ferguson-Pare, and Doran (2010) examined the relationship between patient-centered care and outcomes. Additionally, the researchers were examining the extent to which staff nurses provided patient-centered care as evidenced by staff nurses and patients (Sarkissian et al.). In this descriptive correlational design, descriptive statistics, correlations, and *t*-tests were calculated. Convenience sampling was utilized and study participants consisted of 63 nurses and 44 patients. The results

indicated that, overall, nurses delivered patient-centered care to a moderate extent as perceived by other nurses and patients. The study also moderately associated other care provisions to patient-centered care, such as self-care and satisfaction with care (Sarkissian et al., 2010).

Rathert, Williams, McCaughey, and Shade (2012) conducted a survey study from patients with overnight stays at 142 U.S. hospitals. The aim of the study was to empirically examine a conceptual model of patient-centered care using patient perception survey data (Rathert et al.). Rathert et al. (2012) noted importance for the study due to the belief that most hospitals hold that they deliver patient-centered care when, in reality, they continue to deliver disease- or physician-centric approaches.

Rathert et al. (2012) noted that there is emerging support that offering patient-centered care can impact clinical outcomes and patient satisfaction. The researchers indicated that they were adding to this evidence by empirically testing a model that was based on the seven theoretical dimensions of patient-centered care developed by the Picker Institute and the Institute of Medicine. Regression analysis found support for the theoretical model. Overall care ratings were most significantly associated with patient perceptions of emotional support, coordination of care, and physical comfort measures (Rathert et al., 2012).

The Rathert et al. (2012) study concluded that it is important to understand how patients experience their care to understand what patients believe is patient centered. Furthermore, an improved understanding of patient-centered care from the patient's perspective will help to move research and clinical practice forward in a positive manner. Further evidence is needed for organizational leaders to impact and justify needed

changes for improvement in the implementation of patient-centered care (Rathert et al., 2012).

Quality, safety, satisfaction, and other positive-patient and organizational outcomes are attributed to patient-centered care throughout the research. There is an understanding that adopting a model will influence various outcomes and may positively impact overall patient experiences of care. Fidelity to adopted models is an unknown factor in the study of patient-centered care. There is an opportunity to define whether patient-centered care models are effective by adding to the existing body of research.

Ancillary Opportunities

Studying patient-centered care makes sense from the perspective of wanting to better understand quality and safety measures, and it may also offer the opportunity to learn more about patient experiences of care. Assessing the research available from ancillary healthcare perspectives can lend to an overall knowledge base of patient-centered care, and it further lends itself to the understanding of what influences positive patient perceptions within patient-centered care practices.

Jayadevappa and Chhatris (2011) conducted a comprehensive literature review and noted that the term *patient-centered care* is used in various contexts, and that one of the barriers to effective implementation is the ambiguity of the definition. The researchers stated that there are significant opportunities in hospitals to enhance their patient centeredness and that health care organizations should aim to facilitate the attributes of patient-centered care by supporting education, knowledge, and integration. Patient-centered care that involves informed decision making can improve choices, outcomes, and quality of care (Jayadevappa & Chhatre, 2011).

Jayadevappa and Chhatre (2011) pursued their study with the intent to suggest a conceptual model for patient-centered care. The study evaluated information from abstracts and titles of studies to determine inclusion or exclusion for the review. To be included, the studies had to address patient-centered care as well as a minimum of one of the key components impacting patient-centered care. Examples of acceptable components were cost, disparity, chronic care, and patient outcomes (Jayadevappa & Chhatre, 2011). The researchers reviewed 832 abstracts, which led to the retrieval of 263 full papers for review, and 143 full papers were ultimately included in the study.

Jayadevappa and Chhatre (2011) suggested that the review findings indicated that patient-centered care, as a model, is promising regarding improving quality of care, decreasing costs, and improving satisfaction. The researchers expressed that the challenge remains at the organizational level where attributes of patient-centered care must be identified as an actionable item for implementation and adoption. Jayadevappa and Chhatre posited that additional research is necessary to better understand the various qualities of patient-centered care, its limitations, and its effectiveness within the healthcare system.

Irani, Middleton, Marfatia, Omana, and D'Amico (2009) studied the impact of electronic medical record (EMR) implementation on patient satisfaction in the exam room. There is fear among some physicians that this practice may decrease patient satisfaction; therefore, the researchers conducted a systematic review to evaluate the use of EMRs on patient satisfaction (Irani et al., 2009). Qualitative and quantitative research, and publication years no earlier than 2000, were included. The results were mixed. Six studies found that physician EMR use in the exam room had positive or neutral effects on

patient satisfaction. One study found negative effects of patients' perception of care (Irani et al., 2009). Some concerns were identified to be the methodology of the studies. It was noted that further research is warranted to better understand whether the use of how EMRs significantly impact patient satisfaction (Irani et al., 2009).

Little et al. (2001a) noted that patient-centered care is a widely advocated approach, but problems exist with understanding of the concept and implementation. Little et al. (2001a) conducted a study to identify patients' preferences for patient-centered consultation in general practice. A questionnaire study was conducted on 865 patients in the waiting rooms of three doctors' offices. Of the sample of participants 824 patients returned pre-consultation questionnaires, and 661 patients returned post-consultation questionnaires. Little et al. (2001a) stated that when they compared the responders and non-responders of the post-survey questionnaires, there were no significant differences of individuals feeling moderately or very unwell, worried, or strongly wanting partnership, good communication, or health promotion. Factor analysis identified three domains of patient preferences, including communications, partnership, and health promotion (Little et al., 2001a). The study limitation included time as a factor. The questionnaires took 3 to 5 minutes to complete; therefore, the yield of high-quality data was impacted because relatively few questions could be included. Demographic variability and the setting may have influenced the study results as well (Little et al., 2001a).

Little et al. (2001a) noted that a significant problem with implementing patient-centered care is that little empirical evidence exists from patients identifying which components are most important to them (Little et al., 2001a). It was further noted that

there is a problem with the feasibility of implementing all domains of patient-centered care in practice. The study looked at domain preferences to target a patient-centered care approach to patient groups (Little et al., 2001a). The study results concluded that patients in primary care have a strong desire for a patient-centered care approach that includes good communication, partnership, and health promotion.

In a subsequent study, Little et al. (2001b) measured patients' perceptions of patient-centeredness and the impact of these perceptions to outcomes. The researchers utilized an observational study using questionnaires that they administered to 865 patients at three general healthcare practices (Little et al., 2001b). A pre-survey was administered before the patient's consultation, and a post-consultation questionnaire was given. A total of 661 patients returned the completed survey; at 76%, this was a strong yield rate. Little et al. (2001b) noted that the respondents and non-respondents were similar in feelings related to health, worry, and strongly wanting good communication, health promotion, and partnership. The study focused on measures of patient enablement, patient satisfaction, and burden of patient symptoms.

To determine whether there were distinct aspects within the data associated with patient-centeredness, the researchers utilized a factor analysis technique. Five components were identified, including communication and partnership, personal relationship, health promotion, positive approach, and interest of the effect on a patient's life (Little et al., 2001b). The researchers utilized Cronbach's as a statistic to evaluate internal reliability (Little et al., 2001b). Little et al. (2001b) noted that the components that make up a patient's perception of patient-centered care and a positive patient-centered care approach can be measured in a reliable way. Little et al. (2001b) indicated

that patients will experience greater satisfaction, be more enabled, and will have fewer symptoms of burden if doctors provide a positive, patient-centered care approach. The measurement of patients' perceptions in relationship to patient centeredness provided clear indicators of the quality of care that they are receiving (Little et al., 2001b).

Hudon, Fortin, Haggerty, Lambert, and Poitras (2011) acknowledged that patient-centered care is generally accepted as a central value in family medicine practices. They suggested that patient-centered care is associated with reduced litigation and fewer complaints and formal grievances, improvements in physician engagement, improvement in a patient's emotional state, and betterment of a patient's medical adherence (Hudon et al., 2011). They further suggested that patient-centered care may also improve patient satisfaction and empowerment through engagement as well as lead to decreased symptom severity and use of health care resources, thus positively impacting healthcare costs.

Hudon et al. (2011) conducted a systematic literature review to identify and compare instruments, subscales, or items assessing patients' perceptions of patient-centered care in family medicine practices (Hudon et al., 2011). The researchers covered the time period from 1980 through 2009, using a designated search plan for each database. Research articles were included based on the following criteria: describing self-administered instruments, patient perception of patient-centered care measurement tools, quantitative or psychometric report results of development or validation of tools, and the material being relevant to an ambulatory family medicine practice. Article quality was assessed by using a modified version of the Standards for Reporting of Diagnostic Accuracy. The instrument items were mapped to the dimensions of the patient-centered care framework (Hudon et al., 2011).

Hudon et al. (2011) noted that of the 3,045 articles identified, 90 were examined in detail, with 26 covering 13 instruments, meeting the inclusion criteria. The review process was based on important domains and criteria that have been identified by the Agency for Healthcare Research and Quality (AHRQ) for systematic reviews. Two instruments that represented five articles were dedicated to patient-centered care, patient perception of centeredness, and the consultation care measure; 11 instruments representing 21 articles were related to subscales that were also determined to be relevant (Hudon et al., 2011).

In conclusion, two visit-based instruments were identified for use in the measurement of patient-centered care. For broader-based assessments in healthcare, 11 instruments were identified, each including at least three dimensions from the domain framework (Hudon et al., 2011). The study was limited because there was potential for omission of relevant articles and published information.

Kitson, Marshall, Bassett, and Zeitz (2012) aimed to identify the common core elements of patient-centered care in health policy, nursing, and medical literature. The researchers noted that there is an evolving attention and acceptance in healthcare to implement patient-centered care coupled with a lack of agreement on how it is defined and how to make it a reality in everyday clinical practice (Kitson et al., 2012).

The researchers conducted a narrative review and synthesis based on the thinking that healthcare reform is being driven by rhetoric around patient-centered care, has no common definition, and that limited reviews are being undertaken. Data sources included publications from 1990 through March 2010. In total, 60 papers were included in the review and synthesis. Two reviewers carefully read all articles and extracted relevant

terms and descriptors used to identify patient-centered care. Kitson et al. (2012) addressed differences in the descriptor match by going back to the original articles and reviewing them for consensus.

Kitson et al. (2012) noted that there were few common definitions found. The three core themes identified from the study were patient participation and involvement, the relationship between the patient and the caregiver, and the situation in which care is delivered (Kitson et al., 2012). These themes may indicate a common conceptual framework for patient-centered care, but each professional group tends to focus on, or value, different aspects of the elements within the themes.

Kitson et al. (2012) concluded that the three core themes that emerged from the health policy, medical, and nursing literature review may be what affects and deters the success of implementation of patient-centered care in practice (Kitson et al., 2012). The researchers recommended, based on their findings, that it is an ideal time for a relatively simple conceptual framework for patient-centered care to move the general principles forward and see the practice reflected consistently at the organizational level (Kitson et al., 2012).

Chaudoir, Dugan, and Barr (2013) conducted a systematic literature review to assess constructs that predict the implementation of evidenced-based health innovations. The goal of the research was to identify a multilevel framework that captures the driving factors that impact outcomes from implementation measures (Chaudoir et al., 2013). The researchers completed a systematic review of the literature, reporting the use or development of design measures that were utilized to predict the implementation of evidenced-based health innovations.

The search strategies yielded 589 peer-reviewed journal articles, with 201 full-text articles being reviewed and vetted. That review identified 125 articles where 62 measures were extracted. The 62 measures fell within one of five factors, with the Barriers and Facilitators Assessment Instrument used to assess each factor (Chaudoir et al., 2013).

Organization, provider, and innovation were found to have the highest number of identified measures available for use, while patient-level and structural constructs had the lowest number (Chaudoir et al., 2013). There were very few constructs noted to demonstrate criterion validity or a reliable association with implementation outcomes or fidelity. The researchers noted that the field of implementation science plays an important role within research and practice. Chaudoir et al. (2013) further asserted that future research should focus on conceptualization and implementation-related constructs. Implementation science must translate existing frameworks into theories that allow for connections between the factors that impact implementation success and improve patient care and the human condition (Chaudoir et al., 2013).

Wild et al. (2011) conducted a mixed-methods study that involved closed-ended surveys and in-depth interviews of a hospitalist teaching service. The intent of the study was to examine the link between ratings for various physician types and the overall rating of physicians via the HCAHPS survey (Wild et al., 2011). The three HCAHPS communication questions specific to physicians were used to interview patients. Spearman correlation coefficients and linear regression were used to examine the association between overall score and the individual scores for each physician's type

(Wild et al., 2011). Data from the qualitative interviews was analyzed using a constant comparative method to identify recurrent themes (Wild et al., 2011).

The sample consisted of 96 patients, and the findings indicated that the patients' overall rating of physician communication is influenced by relationships with hospitalists. This correlation was less significant with specialists, and not statistically significant with emergency medicine physicians (Wild et al., 2011). Wild et al. 2011 noted that patient satisfaction was influenced by factors outside of the physicians' communication controls, including wait times and lack of care coordination. Harter, Hayes, and Schmidt (2002) conducted a meta-analysis that examined the relationship between employee satisfaction, engagement, and outcomes related to customer satisfaction, among other drivers. The study assessed 7,939 business units in 36 companies. The study found that employee satisfaction and engagement were related to meaningful outcomes. The research suggested that future studies of employee engagement and customer satisfaction should focus on useful instruments for employees and managers to resource and act upon (Harter et al., 2002).

Chapter Summary

It is evident in the literature that patient-centered care is a supported concept, but it is also one that is ambiguous with newly evolving and limited research around definition, practice, implementation, measurement, and impact. Government and healthcare entities believe that patient-centered care could hold the key to improving patient experience and satisfaction as well as have a positive impact on quality, safety, and healthcare costs. The literature shows support that patient-centered care can also have an impact upon an organization's financial viability, reputation, and market share. These

are all important aspects for organizational survivability, bringing more attention to an organization's practice and drawing the interest of additional stakeholders across the healthcare continuum.

Through the literature, it is evident that various disciplines are studying and researching the topic of patient-centered care using various methodologies to learn more about patient experience, satisfaction, population health, healthcare costs, and outcomes. There is a focus on trying to determine what drives a patient-centered approach to care and how it may impact the way patients respond to treatment and relationships with their caregivers.

The literature review described the dissertation topic of defining shared values in patient-centered care within a complex, academic healthcare center in Central New York. The preceding literature review cited various studies specifically related to patient-centered care and was organized by study type and impact. While few researchers used randomized control trials, more utilized quantitative methods, specifically surveys, to collect the data. The existing research provides a foundation for identifying the needs of patient-centered care; however, more study is warranted to define patient-centered care from the perspective of the patient and medical professional to identify what shared values may exist and to define a model that can be operationalized and evaluated.

Chapter 3: Research Design Methodology

Introduction

The concept of patient-centered care (PCC) is an important and recognized aspect of the patient experience and satisfaction in health care. It is a basis for strategic planning for hospitals and a focus of government both in for-profit and non-profit healthcare sectors (Wolf et al., 2008a). Regardless of the attention and interest in patient-centered care, Wolf et al. (2008a) noted that there continues to be ambiguity in applying a universal definition to patient-centered care within the United States health care system. Hobbs (2009) advocated for a clear definition for patient-centered care, noting that care and research are impacted by the ambiguity of the concept.

Limited studies exist that focus on the implementation, measurement, and/or impact of patient-centered care practices. Solidifying a definition of patient-centered care will allow organizations to operationalize patient-centered care practices in concrete and measurable ways.

A review of the literature organized by the following themes: Hospital Consumer Assessment of Healthcare Providers and Systems indicators, caregiver impact, organizational culture, quality, safety, perceptions, and ancillary opportunities involving patient-centered care, provided evidence that the current American health care system needs reform. One aspect of reform, according to the Institute for Healthcare Improvement's (IHI) (2016) Triple Aim initiative, must be focused upon the patient's experience of care and, more specifically, how health care organizations and providers

engage patients and caregivers in consistent and meaningful patient-centered care (IHI, 2016).

Through the literature, it is evident that there is an industry-wide attempt to identify the impact of patient-centered care on patient experience, satisfaction, population health, health care costs, and outcomes. The increased attention on patient-centered care seeks to determine what drives a patient-centered approach to care and how it may impact the way that patients respond to treatment and relationships with their caregivers.

There are varying definitions between the various healthcare entities that impact how they practice of patient-centered care within their respective specialties, as well as influence whether they work collaboratively. Healthcare administrators tend to place higher priority on the patient experience as a strategic goal, with a lesser sense of urgency identified at the point of service. This may be due to leadership's clearer understanding of the newly evolving financial implications tied to patient satisfaction.

Snide and Nailon (2013) stated that organizations that are willing to invest in their staff are those that will be most successful in developing a patient-centered care culture within the healthcare environment. Empowering staff members to lead through innovative efforts contributes to patient-centered care and the overall health of the organization. Supporting innovation and involvement of front-line staff members is thought to improve the patient experience and patient satisfaction because employees are more engaged. Snide & Nailon (2013) stated that healthcare needs to embrace change and support employee empowerment and innovative contributions based on these impacts, to be successful in the future of healthcare delivery.

Leonard et al. (2004) reported that organizations must understand their gaps and shortcomings to improve upon patient-centered care. Patient centric behaviors must be hardwired within an organizational culture. As organizations move toward HCAHPS survey improvements related to the value-based purchasing program, working to move health care from a volume-based to a value-based focus, it is necessary to improve upon emotional and clinical connections with patients and families to strengthen patient-centered care (Leonard et al., 2004). Conway (2008) reported that to make needed transitions in healthcare, an active partnership with patients and families is a necessity.

Case Study Parameters

This study was conducted using a descriptive, embedded, single-case study design to address the research questions. Yin stated that the rationale for a single case is to identify the conditions of a common, everyday situation because of lessons it may provide. Incorporating the embedded subunits (medical professionals and patient archival data) into the case study adds significant opportunities for deeper analysis and for broader insight to the single case (Yin, 2014).

Yin (2014) is a widely known scholar associated with explanatory, exploratory, and descriptive case studies. Explanatory case studies have the purpose of explaining how or why certain circumstances exist, exploratory cases identify the research questions or procedures that should be used in future studies, and descriptive case studies have an expectation to describe phenomenon in a real-world context (Yin, 2014).

The intent of the case study approach is to address the research questions and to meet the criteria of an exemplary study that includes significance, completeness, and

consideration of alternate perspectives, sufficient evidence, and an engaging presentation (Yin, 2014).

The case study sought to answer the following research questions:

1. How do medical professionals in a large, urban, acute-care hospital, located in Central New York, define patient-centered care?
2. How do patients in a large, urban, acute-care hospital in Central New York define patient-centered care?

The *how* questions are explanatory and therefore lead to a case study, history, or experiment as the preferred method of research (Yin, 2014). Yin stated that the distinctive need for case study research comes from the desire to comprehend complex social phenomena. Case study design methodology falls within the constructivist paradigm, meaning that learners define reality based out of their own experiences (Baxter & Jack, 2008).

A common concern with the case study approach is the tendency to answer a question that is too broad or to address topics that have too many objectives for one study (Yin, 2014). To combat this potential problem, it is advised to bind the case by time and place (Creswell, 2003), time and activity (Stake, 1995), and context (Miles & Huberman, 1994). Binding helps to ensure a reasonable scope for the study design.

For the purposes of this study, the research design focused on a single case study that included two groups of medical professionals via focus groups comprised of healthcare professionals, and organizational archival data gathered from patients. The McKinsey 7S model (Singh, 2013) was the theoretical framework that further informed the research design. The theoretical framework illustrates interconnectedness around

seven factors, namely, structure, strategy, systems, style, staff, skills, and superordinate goals (shared values). For the purposes of this study, four of the seven factors were utilized, specifically: staff, skills, system and shared values. These four factors were selected based on their ability to provide a lens to view the current disposition of the organization's culture as it related to patient-centered care. The framework offers no starting point or hierarchy to the factors; each one is interconnected and equally important to organizational success (Waterman et al., 1980). The 7S framework can help to identify what needs to be addressed in an organization to improve performance or to maintain alignment. The framework can also be used to analyze a current situation, propose a future state, or to identify gaps or inconsistencies (Waterman et al., 1980). Singh (2013) noted that the McKinsey 7S framework is a strategic assessment and alignment model that lends itself to the discussion of organizational activities, interactions, and infrastructure. The McKinsey 7S model allows for the comparison of present state with desired state, showing how each of the components is linked, and how change can occur (Singh, 2013).

Research Context

The research study took place at a large, urban, acute-care hospital situated in an urban setting in Central New York and provides urgent care services, emergency services, inpatient care, ambulatory outpatient surgery, women's and infants' services, outpatient imaging, and behavioral health services (Appendix A).

Medical professionals within the organizations that had the opportunity to participate in the study represented nursing, advanced practice nursing, palliative care

services, surgical services, spiritual care services, volunteer services, patient and guest relations, care coordination/social work, and ostomy care services.

Research Participants

Two distinct populations participated in the case study, namely, medical professionals (MP) and former patients (AP) from the same institution. The participants were identified by a purposive sampling approach. Purposive sampling is a non-probability sample that identifies people within a population who have certain characteristics relevant to the research (Crossman, 2017). Participants were either practicing medical professionals or previously treated patients at the same healthcare facility. They took part via audio taped interviews and previously transcribed focus groups (archival data).

Two medical professionals' focus groups were conducted by the researcher, with five participants in each session, for a total of 10. Patient focus groups were conducted by hospital staff, which was audio taped and transcribed, and constitutes archival data. There were 20 patient participants in each of the two patient focus group sessions.

Medical professionals were contacted through written requests sent to their direct supervisors requesting voluntary participation from their service line. The researcher did not influence which medical professionals were approached, and the opportunity was made available to all medical professionals within the respective departments contacted for involvement. The intent was to have representation from all service lines within the healthcare system to create rich and robust focus groups with diverse medical experience and patient points of contact. A diverse representation was achieved through the sampling technique.

For the purposes of this case study, heterogeneous sampling was used. Crossman (2017) noted that this type of sample is designed to provide as much insight as possible to the phenomenon being examined. The approach is less interested in group tendencies and looks, instead, at subjects from all available perspectives to achieve a more comprehensive understanding of the issue being explored (Palys, 2008).

Medical professionals' focus group sessions were held in an off-campus facility near the hospital. The healthcare environment can be unpredictable, and the researcher understood that participation could be influenced by unplanned emergencies. Because medical emergencies can occur, over enrollment was planned. Participants signed informed consent forms (Appendix B) to participate, and disclosure of the study's details was provided. Privacy was afforded to the participants to the greatest extent possible. The participant names were not associated with the focus group responses. Prior to conducting the focus groups, it was shared with all participants that their privacy and respect for confidentiality were an expectation. However, it was also made clear that there was an inability to control what individual participants chose to share outside the group, thereby creating the possibility of privacy risk (Appendix C). Audio recordings and transcription records are locked in a secure location, accessible to the researcher alone, to ensure confidentiality.

Previously conducted patient focus groups were audio recorded, and patients were randomly selected post discharge and invited by mail to voluntarily participate in the on-site sessions. There is no information connecting the participants to the information that they shared within the groups. The audio recordings do not identify the participants by

name or any other identifying factor outside their own disclosures on medical conditions and/or experiences.

Instruments Used in Data Collection

The medical professionals' focus groups were scheduled for approximately 1 hour per session, and the patient archival data included transcripts from 2014. An interview guide/script was used to ensure that the questions were asked in the same manner during the focus group interviews. The semi-structured interview questions were based on the primary research questions; and the McKinsey 7S theoretical framework served as a guide to the question design process (Appendix D). Pilot interviews took place, prior to the actual study, with team members from the Patient and Guest Relations Department within the study site to allow for practice and strategy building. These pilot group participants were not recruited for participation in the study. The pilot tested the instrument design and served as a basis of preparation. Replication of some focus group questions took place based on the known patient focus group questions that comprised the archival data. Based on the input and findings generated by the pilot group, the focus group process (questions and format) was restructured. Probing questions were asked during the focus groups based on variances of opinion or unexpected comments by the pilot group participants. To be consistent with the focus groups, the pilot group sessions were audio recorded and were scheduled in one-hour segments.

Data Analysis

Yin (2014) noted that case studies are designed to elicit viewpoints from the participants while using multiple sources of data. The case study approach to research is known as a triangulated research strategy (Yin, 2014). Triangulation is an attempt to map

out or explain more fully the complexities of human behaviors by studying them from multiple perspectives (Cohen, Manion, & Morrison, 2013). Triangulation is a way to increase the validity of research while looking at the same topic of interest. The purpose of triangulation involving the case study approach is not necessarily to cross-validate data; rather, it is to capture different dimensions of the same phenomenon (Yin, 2014). It is not a simple cross-checking of at least two data sources, rather a way to achieve an increased level of knowledge about an issue, while strengthening the research around it. The approach is noted to be a powerful tool that assists in validating qualitative research (Yin, 2014). Triangulation was used in the case study data collection and analysis process.

The medical professional focus groups were audio recorded with data transcribed, analyzed, and coded using thematic analysis. Archival data has been transcribed from audio recordings and, analyzed, and coded in the same manner. Coding is the primary process for the development of themes from the raw data; an important step is recognizing specific aspects of the data and encoding those particulars prior to interpretation (Boyatzis, 1998). Thematic analysis identified patterns across the data sets that were important in the description of the phenomena and to the research questions.

Fereday and Muir-Cochrane (2006) noted that the thematic method is a form of pattern recognition where emerging themes ultimately become the categories to be analyzed. Thematic analysis identifies patterns across data sets that are important in the description of the phenomena and to the research questions. The approach allowed for a detailed description of the data that goes beyond a simplistic counting method (Palys, 2008). Thematic analysis coding is performed through six phases that are established to

create meaningful patterns. The phases include (a) familiarization with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing the themes, (f) defining and naming the themes, and (e) producing the final report. Themes become the categories for analysis (Boyatzis, 1998).

For the research, code manual binders were used to organize any hard copy data; including communications, notes, professionally transcribed focus group interviews and professionally transcribed archival data. The first cycle promoted familiarity with the data and the generation of initial codes. These initial codes were identified and characterized by specific colors using highlighters and matching color tabs. Second level coding allowed for the emergence of patterns for categories. The data and the categories were then reviewed, followed by theme identification, with themes being defined, named, reviewed, and changed as needed. Third level coding occurred, leading to code weaving of the data as it continued to be reviewed and reinterpreted. The data were analyzed for patient-centered care related expectations or behaviors that informed values. Codes were identified across the focus groups and the values that emerged were linked for the comprehensive process of data coding and identification of the case study themes. Data from both groups (MP and AP) were triangulated in a convergence of evidence to determine themes of overlap, themes that complemented one another, and those that contrasted. Triangulation was conveyed using descriptive analysis.

A limitation noted with this method is the time consumed in conducting and analyzing the data (Braun & Clarke, 2006). The time concern was addressed by limiting to two focus groups made up of 5 to 15 individuals, and two archival focus groups with forty participants in total. According to Creswell (2007), researchers seeking to interview

the participants who have experienced a similar phenomenon should include 5 to 25 individuals in the process.

The focus groups helped to give a first-person perspective from the participants and their definition of patient-centered care within the research context. Qualitative data were generated using open-ended questions that allowed the participants to talk in depth based on their lived experience. Strength to the approach is that some participants might have felt more comfortable being with other people because they were used to talking in groups and natural settings. Limitations include the difficulty in keeping all details confidential; it could not be guaranteed that other people participating in the groups kept the information private.

Additionally, this approach could be seen as less reliable, because open-ended questions can deviate from the schedule, making them difficult to replicate. There are also the risks of the participants trying to impress other group members, conforming to peer pressure, giving false answers, or drifting off topic. Brinkmann and Kvale (2015) noted that the interviewer is the central research component in the interview inquiry process, and it requires skill to combat these potential challenges. It is therefore important that the facilitator have an ability to develop rapport and know when to probe or redirect. Finally, the depth and range of focus group responses are an unknown prior to the interview process; they are noted as a limitation. However, the way the questions were explored relates back to the facilitators' decisions and the results of planning and practice (Flick, 2014). Finally, researcher bias was addressed through consistent reevaluation of the participants' responses and the researcher to avoid leading questions or any wording

bias. This process included the researcher being cognizant of question-order bias, possible verbal and nonverbal cues, and the importance of member checking.

The data were collected from the semi-structured focus groups (medical professionals and patients) using open-ended questions and were coded using thematic analysis. Then the data were analyzed for patterns and themes. A code manual was developed to help manage the data and organize similar data. Crabtree and Miller (1999) noted that the choice of a code manual is an important one; it provides a clear trail of evidence and lends credibility to the study. Codes were written with thematic influence from the McKinsey 7S (Singh, 2013) shared values model and they were tested for reliability. The advantages to these methods were the ability to collect rich data from the perspective of the participants' lived experiences. The disadvantage associated with the collection methods were the potential for researcher and interviewee bias. To combat the potential for bias, the researcher did not impart a personal perspective during the focus group discussions. This was done through transparency regarding the existing role, consistent member checking, and audiotaping of the focus group discussions.

Patient focus group archival data was coded and assessed for themes, using the same approach taken with the medical professional focus groups. Analysis included two previously conducted patient focus groups that assessed patient perspective of the healthcare experience and patient-centered care.

Data from both groups were triangulated in a convergence of evidence to determine themes that might have overlapped, areas that possibly complemented one another, or themes that are in contrast. Yin (2014) noted that when data have truly been triangulated, the multiple sources of evidence provide multiple measures of the shared

phenomenon. Triangulation can provide a richer and more realistic account of the phenomenon (Yin, 2014). This was done to determine where the shared values might have existed between the medical professionals and the patients, related to the definition of patient-centered care. Triangulation is conveyed using descriptive analysis. The McKinsey 7S framework (Singh, 2013), and specifically the four factors (Ss) identified for this study, were utilized as part of the final analysis of data.

All data that was collected is password protected and kept in a locked cabinet in the researcher's residence. Three years after the completion of this research, all data will be destroyed. No incentives were provided to the participants. Upon completion of this study, the researcher will provide an executive summary of the findings in aggregate form to the participating healthcare facility. The completed dissertation will be made available on the St. John Fisher Digital Publication Database, at St. John Fisher College in Rochester, New York.

Chapter Summary

The study, using the case study approach as the primary research methodology, was selected based on the research questions and a desire to define how shared values inform patient-centered care. A case study approach with triangulation of the data allowed for an understanding of the phenomenon and the ability to study patient-centered care within the research context; furthermore, it lends to the ability to inform practice and application within the construct of the organization under study.

Chapter 4: Results

The American health care system is currently in a state of uncertainty, with many citizens believing that the system is fractured. Health care reform aims to enhance quality, safety, and patient experience and to improve the issues and inequities by addressing the way that health care is structured and delivered.

Patient-centered care has long been a supported practice, but a universal definition has not been adopted by U.S. health care systems, and the practice and delivery also lacks uniformity. The literature supports the need for healthcare entities to move past provider-centric practices, to include patients and other stakeholders in defining patient-centered care and its parameters.

In this chapter, the results of the data analysis from study participants (medical professionals and patient's archival data) will be presented. The research questions were designed to elicit understanding from patients and medical professionals on what defines patient-centered care and whether shared values exist within the definition. The findings will serve as a roadmap for implementation and practice.

Research Questions

The research questions that guided this case study are:

1. How do medical professionals in a large, urban, acute-care hospital located in central New York define patient-centered care?
2. How do patients in a large, urban, acute-care hospital in central New York define patient-centered care?

The research questions were designed based on case study methodology where the *how* questions were used to explain a phenomenon (Yin, 2014). The McKinsey 7S model (Singh, 2011) served as the lens through which the participant focus group questions were constructed and data analyzed. This model helped to identify questions to investigate the existing state and future needs of the organization studied, relating to patient-centered care and the potential for defining patient-centered care in an organization.

Data Analysis and Findings

The research included a total of 10 medical professionals who took part in two focus groups. They represented various medical professional specialties that interact daily with patients and families including nursing, advanced practice nursing, social work, care coordination, patient and guest relations advocates, spiritual care, and palliative care services. Information was also collected from archival data that included previously conducted focus groups with patients and their families or designated support personnel. For the purposes of the research, when family is noted, the reference refers to anyone whom the patient identified as a person of support for them.

Data was coded and will be referenced in this chapter in the following manner:

MP# = Medical Professional responses (2 groups, with 5 participants in each group, MP 1-10 and AP# = Archival Patient responses (2 groups, with 20 participants in each group, AP 1-20).

Medical Professional Focus Groups

Findings for Research Question 1: “How do medical professionals in a large, urban, acute-care hospital located in central New York define patient-centered care?” are presented below.

Family inclusion. A pattern emerged during the focus group discussions with medical professionals that related to the importance of family inclusion when defining and making provisions for patient-centered care. The medical professionals talked about the importance of involving those individuals whom a patient determined to be important to them.

Medical professional 3 (MP3) noted, “patient-centered care, for me, includes the patient and his environment and his family. So, I can’t treat just the patient, because everything is affecting the family that I do too.” This comment provided an example of the importance of understanding patients’ needs in relation to their environment of care, as well as the impact of the patient’s hospitalization on loved ones.

I would say that is my *perspective* providing them care that the patients sees as having them [family] be part of the development of the treatment plan, whatever that may be. So, they are fully engaged and understand what’s happening, but also choosing to participate in it. (MP6).

The medical professionals noted further the importance of the patient being fully aware that their loved ones are included in their care. This supported the importance of coordination of care efforts and consistent communication among everyone on the healthcare team, including the family. These actions described by the participants validate the need to keep all stakeholders involved and included, as a basic need of the

healthcare experience in its totality. MP6 noted that, “you need to give the family information; it’s like a whole process and everybody needs to be included.” Additionally, focus group participants described the practice of family inclusion as part of the fabric of the delivery of patient-centered care, and how that focus and emphasis should be assured whenever possible:

The family and the way the family interact with the patient are all part of the system. I do see them. I do incorporate the family into the education that I’m giving as much as I can. I try to find who the significant other is and just make sure that we include them as much as we can. I think of the family as being interwoven (MP3).

The medical professionals discussed the response from families when they are involved and engaged in the patient’s health care process, and they noted that this practice most often resulted in positive patient and family experiences. MP4 stated that, “it’s nice to see the family happy or relieved. You know they are being taken care of. It’s those little things that make a big difference to families and patients.” Discussion supported the idea that satisfaction resulted when family was included in the patient’s healthcare plan.

Focus group participants talked about their own personal health care experiences and noted that those interactions solidified their belief that involvement and engagement of family members was imperative to ensure an environment of patient-centered care. MP2 noted that, “I do think of the patient and family as being interwoven too.” They also stated that this level of engagement benefited everyone involved in the patient’s care. There was discussion that supported improved outcomes for patients when their loved

ones were invited by medical professionals to be more involved in their care and recovery. This included the positive impact of open visitation, inclusion in reporting, and information sharing related to the patient's plan of care. MP6, recounting her experience when her husband was hospitalized, stated:

They (medical professionals) were focused not only on him but on me too, making sure that I was okay. As a family member, even though I was in the medical profession, that was important to me because if I was okay, he was better.

There was clear connection and support of family inclusion as a necessary practice in the delivery of patient care. Participants felt that to promote patient-centered care, family members needed to be involved in the health care process and care plan and have as much information and access to the medical professional team as their loved one who was receiving medical care. This involvement was thought to promote better overall experiences and outcomes for the patient as well as their family members.

Cultural competency and communication. Consistent, concise, and culturally competent communications emerged as an important foundation for the provision of patient-centered care. The medical professionals discussed the value of the healthcare team being educated about, and aware of, variations in cultural needs as part of the health care delivery process. The challenges of understanding all cultures and the nuances related to them was acknowledged. There was discussion related to the need of sensitivity and understanding of regulatory requirements for response times and care standards in the case of language barriers, and especially when it came to patients and families from different cultures or the deaf community. Variations in literacy and education levels, as well as comprehension levels, were discussed as challenges as well. MP1 noted that, "it's

good being part of a group where that's [cultural understanding] important and worked at in spite of its [the system] shortcomings.”

We don't know about their cultures sometimes. It isn't always about their health care; it might be about their beliefs. You need to know what is important to the person. When patients come into the hospital, we often give them our rules and how we do things. It doesn't always fit into the structure of their life (MP6).

The participants shared examples of positive responses to health care providers who are considerate and aware of how one's culture impacts his or her life. “It's nice when they [medical professionals] can work together and understand cultural differences” (MP5). The participants noted that attention to this part of the patient experience is not only the right thing to do, but that it improved the relationship between patients, families, and medical professionals. MP3 shared, “when we consider care and the environment from other perspectives and different ethnic backgrounds, people do notice.”

Communication in a healthcare setting can be impacted by culture, physical and developmental needs, and education levels. For example, the medical professionals discussed the importance of evaluating the needs of the patients and families so that communication and other considerations could be addressed on an individual level. The medical professionals noted that understanding ones' shortcomings or *blind-spots* as a provider of care, was thought to be necessary in the delivery of clear and concise communication in patient-centered care. They shared that to deliver effective care, one has to be able to continually self-assess and acknowledge that you and your fellow medical professionals do not always *get it right* for the patients and their family members.

I made sure the woman understood and reprocessed [the details about her medical diagnosis and treatment plan] it with her. I knew enough to adjust my language in a different way. But I don't know where my blind spots are. I could have easily ignored something blatant in this situation today. I think we all have to be mindful that we have blind spots. The system, in some ways, helps to keep us blind because it's just built that way. But I think it takes a lot of introspection, and I think sometimes it's just asking patients, asking families. Have I explained things so that you understand them? Do you have other questions? Is there something that we haven't even talked about that you'd like to? Always trying to kind of create an opening to address something that I just haven't seen or sensed (MP1).

The medical professionals discussed how *blind spots* (a term that emerged from the participant data) can impact the patient and the family experience. These incidents, if not recognized or addressed, may also result in patients or family members being left with limited or inadequate understanding of important healthcare information.

It's true, we all have blind spots. Some people are blind to that because, like in the surgical center, so many doctors, I always say, it's like a factory line. It's like one after another, they come out and speak to the family and some of the families don't understand. And then they leave and families are asking me because they don't understand (MP4).

Using the same approach to communicate with every patient and family members does not work. The medical professionals identified patients and their families as unique beings that require "looking at them as individuals" (MP2). This means communicating

with them effectively and learning about their cultural beliefs in ways that are specific to that patient and/or family.

The medical professional group also discussed the alternative occurrence to this experience—when information is shared, in detail, but the recipient does not process or receive the information. Patients and families tend to provide cues in these situations; however, but providers may not pick up on them or work through them due to their blind spots.

You can look at people's faces, sometimes, and see that they are drawing a blank. They're hearing the words, but they don't understand what's happening, and I think, as you say, step into that void and try to make sure at least they understand all that's happening and that they can really consider all that's happening.

Sometimes it's giving them permission to ask questions of providers and others.

Giving the time. (MP1)

The medical professionals discussed the skills involved in effective communication and how patients and families may simply need time to process information. Often, patients and families are inundated with too many details, provided feedback with too many medical terms that are unfamiliar, or not given the time to sit with the information before being expected or rushed to respond. In other circumstances, they may not be asked what they need in the way of information, or able to understand the information being provided.

The skill of communication that I think is a little on the rare side is allowing silence into the communication. We all tend to fill anxiety-prone conversations with chatter because it makes us feel better. We think it makes the patient or

family feel better. I think we, or I, tend to feel like the more information that we share the better they will understand, and maybe the needs of getting to patient-centered care is really to help the patient express, or the patients' family express, what it is they need (MP1).

Human connection. The medical professionals who participated in the focus group talked about expectations and practices that lend to the idea of improved human connections. They discussed simple actions that are the tenets of patient-centered care. The conversation involved the idea of a synergy, or a positive connection that is established and nurtured among those providing and receiving healthcare between medical providers, patients, and families; and when this connection existed and was fostered, there was an assurance of a patient-centric approach. MP8 stated that, “they want to be heard. They want to know that you understand, that you hear everything they are saying about their concerns.” The focus group participants noted that when patients and families felt this validation, relationships with one another were better; there was a connection. Participants talked about the impact of being present, and noted that there may be no tangible outcomes in certain circumstances or interactions, but that the act of connecting can result in a positive impact on the perceived relationship between patients, families, and providers of care. It was stated that medical providers need to “provide a supportive presence to people” (MP3). MP1 added, “people want you to listen. You may not be doing anything more than listening. But just the listening, it’s powerful.” MP3 added that, “people just really want to know if you are caring about what they’re going through. They want you to be empathetic.”

Medical professionals noted that patients want connections and human kindness, in all interactions connection and kindness are factors that enhance the healthcare experience for patients and their family members. One participant noted that patients, “want to be well. They want to be comfortable. Who doesn’t? You want to feel like somebody cares that you are not well and you are not comfortable” (MP5). Participants talked about the importance of identifying with the human nature of healthcare, of humans caring for humans.

Systemic and external challenges. The medical professionals identified a complex series of issues that exists in the healthcare system that they believe preclude medical professionals from practicing and consistently providing patient-centered care. Lack of needed resources, including adequate staffing levels and equipment, and regulatory requirements were addressed and identified as obstacles. The medical professionals noted that they experience daily challenges in the environment in which they practice, that impedes their ability to consistently deliver the care and attention that they feel is optimal for patients and families. “You still hear people say, ‘I have X amount of patients,’ and that should never be told to a patient. Our being busy is not our patient’s problem” (MP1). MP1 further noted that, “the managers and charge nurses need to spend a lot more time with the patients because some of the patients don’t even know who they are.” The medical professionals indicated that these leaders needed to spend more hands-on time with the patients and families to improve the patient experience.

The healthcare system isn’t built to provide patient-centered care by a long shot. I mean by virtue of the example you [another focus group participant] used of hard-working, dedicated nurses who have too much on their plate. There are unmet

needs and challenges [staffing, equipment, and time constraints] that aren't being addressed, so it's a hot mess over there [refers to the organization and healthcare in general]. It seems like it should be a better, a different way [where allocation of resources and effort are consistently patient-centric] if it were truly designed for patient-centered care. (MP1)

The participants talked about the difficulty in delivering patient care, especially patient-centered care, in the current healthcare environment where clarity and direction is lacking. According to the medical professionals, healthcare institutions say they are focusing and consistently delivering patient-centered care, but that “in real life, it's really hard to do—to match the brochures. I wish there was a different way. We are trying. We're really trying hard to make this as good as we can for you [patients].” (MP1)

The medical professional participants discussed the realities of the healthcare delivery system and how a multitude of factors are impacting the ability for them to provide the kind of patient-centered care that they would like to. This feedback involved references to the infrastructures of healthcare organizations; staffing and time constraints; as well as the impact of regulatory and government agencies upon the organizations and the way they practice and document care.

The medical professionals identified the impact of the lack of resources on the delivery of care and the provision of effective communication to patients and their families. They noted that medical professionals feel too stretched to always be able to do the right thing. They further noted that because of the lack of resources and necessary personnel, the patient and family experience is impacted. Patient communication and

family involvement become inconsistent due to these challenges, which include time constraints and, potentially inadequate, staff levels.

One of the big challenges would be to give us enough [guidance, support, education, allocation of resources, opportunity] so that we could spend the time that is needed without any repercussions with the patient and the family. I bring my families in when I am doing treatments. Sometimes we need to rush it, and sometimes I can't wait for their families (MP2).

“Our staff still tell patients, ‘I’m busy, but our patients should not be worried about this’ (MP7).” This comment was met with another medical professional participant stating; “Exactly, a lot of patients realize that [the] nursing staff is way too busy. That’s a comment that I get often” (MP9). The medical professionals noted that because these types of occurrences and communications remain in the healthcare environment and in full view of patients and families, at times, patient-centered care is more concept than practice.

I think that the patient isn't always the person that's being thought of as the financial side of the equation is brought into play. It almost has to be a grass-roots effort in the other direction to have the institution speaking with patients and families and really hearing them and immediately validating that by doing something concrete for them. At the bedside, if your staff doesn't know your patients, then it [patient-centered care] doesn't really matter (MP5).

The participants noted that, if they could, they would add more nurses to care for the patients to ensure smoother healthcare operation. They felt that in doing this, “you would find out things sooner rather than later and better know what was going on with

the patient” (MP7). The participants believed that nurses spent the most time with patients, but that the time was less than optimal. It was noted that to promote an environment focused on patient-centered care, additional resources are needed in every facet of operation.

Nurses and nurse managers need to spend more time with the patients and less time in meetings. Patients don’t see them enough. They’re too busy. They’re too busy with a lot of paperwork and what not. They’re too inundated with other duties that don’t give them time to work one-on-one with patients (MP3).

The medical professionals noted that to promote patient-centered care, it required an organization that understood that you may have to spend a significant amount of time with one person to properly offer complete care for that person. If you don’t have that latitude, it may not be possible to even provide patient-centered care—at least not to everyone (this was not predictable and was said to be based on various factors in the patient care units). The participants also saw the design of the physical space in which patients were cared for as having a direct impact on the ability to deliver patient-centered care, particularly as it relates to privacy, communication, and healing.

It seems like it should be a better different way if it were truly designed for patient-centered care. I know there’s an economic side of this and in some ways, it can’t be. The biggest defense, in my opinion, that precludes patient-centered care is that we ask patients and families to share a room with complete strangers at a time when they’re most vulnerable. It’s bizarre (MP1).

The medical professionals further commented on the oddity of attempting to provide patient-centered care in an environment where patients are sharing rooms with

strangers. Collectively, the group felt that private rooms are necessary in the hospital setting to facilitate privacy, rest, healing, and to best meet the needs of each patient and their family.

The participants identified challenges to providing patient-centered care based on various complex aspects of the infrastructure of healthcare design. MP8 stated that care providers “are too inundated with other duties that [they] don’t give them time to work one on one with the patient.”

Patient Archival Data

Findings for Research Question 2: “How do patients in a large, urban, acute-care hospital in Central New York define patient-centered care?” are presented below.

Patient archival data was utilized from previously conducted focus groups, that were held at the same organization as the medical professional focus groups. Patient focus groups are conducted at the study institution on a biannual basis, and they are audio recorded and transcribed for educational purposes. Forty archived patients (AP) participated, and they answered similar questions to those asked of the medical professionals.

Human connection. Themes emerged from the analysis of the patient focus group archival data in relation to how patient-centered care was described. The archived patient participants described patient-centered care through the lens of human connections. They can be categorized and referenced as synergy, or a connection that is relational, that should be developed between patients and medical professionals that includes comfort and trust as a means to achieve human connection.

They treat you like a human being. They make you feel like you're number one. Because you are the number one person that should be on their mind, if you push your bell and they come in, they're ready to do whatever you need them to do, even if it's just to calm you down for a few minutes. They never make you feel like you're the second one. (AP2)

AP1 shared her experience of patient-centered care by relating a personal experience of the medical professional.

She stated: she acted like she cared, she was there for me. She was there, talking to me even though she had her thing to do and work and to get me signed in, and stuff like that, but she still showed me that she cared (AP1).

Other participants shared similar experiences and validated the idea that simple conversations and checking in on them regularly, and not rushing them, elicited a sense of caring and patient-centric care. AP2 noted that, "our whole being is in their hands at that point in time, and if we don't feel comfortable with them, we're not going to get better." This part of the conversation referenced how connections made in simple ways can lead to strong feelings of trust in healthcare settings. Patient data suggests that when medical professionals forge connections through the delivery of caring and kind interactions, patients understand this being patient-centered. It was noted that these connections eased anxieties and promoted a sense of well-being. AP5 shared, "if I know the people are going to take care of me, then I don't have to worry about it." AP7 agreed with the notion that small gestures of care can lead to a bigger connection, and stated, "that a little bit of caring, that little bit of, ya know, knowing your patient" was important in the human connection process. The archived patients' comments expressed the need

for safety, trust, and comfort as means that promote human connection and foster a patient-centered care experience.

Patient participants described the medical professionals that met these standards as kind, and compassionate, and that the efforts they made elicited trust through relationship building. They also commented that this was usually accomplished in a short amount of time.

He is the gentlest, most compassionate, awesome nurse I've ever had. No matter what he's doing, if I had a question on something that the doctor said, and I didn't understand, he would have an answer for me or get one. When he walked in the room, I felt safe. The person has to make you feel that they are trustworthy (AP3).

The archived participants discussed the connection between trust and relationships and AP10 noted, "there is one word that we use on our side, and it's the word relationship." They identified the importance of developing a relationship with the patient. AP10 further noted that, "its relationships; we have relationships while we're there. They're our friends. They're our buddies. They're our family." When asked about medical professionals who were highly competent and highly relationship oriented, the patients indicated that these are the providers that you trust.

Communication. AP4 stated, "Educate. Educate. Educate. Just keep on educating us," which was a standard theme that emerged for promoting good communications, patient experience and patient-centered care. The group shared the importance of being an informed patient, given the complexity of healthcare, and this was rooted in good communication. This related to medical care, as well as more routine things, such as directions related to hospital policies and services.

Things that we do not know about, like valet parking, everybody's going to be admitted someday or know somebody who's going to get admitted; I would just like to see some article or reference about it, I think that would be of general interest to everybody. Provide something that covers the topics that impact you as a patient, but also your circle of support and everyone, visitation, all those types of things (AP9).

The patient participants indicated that knowledge gained through effective communication helped to ease anxiety and allowed for their families to feel less stress, as well. They noted that, "if you know what you're going to be dealing with when you walk in, or when they wheel you in, most of the time would be good" (AP7).

It was an especially important aspect of a patient-centered care approach for family members, because it adds to patient stress when you are worrying about where your loved ones are parking, eating, how they are getting around and other things like that. (AP7).

The patients expressed that good communication with their family members helped to relieve any issues that might occur during hospitalization. They also felt that their "family members should be included in their care, as much as they want them to be" (AP8).

Family support. The patient participants talked about the importance of supporting family members beyond navigating the facility and literature. It was noted that "when your family members can be more comfortable, everybody's more comfortable, and that's huge" (AP8). The participants expressed that family members should be engaged in the healthcare process, made to feel included, and made comfortable in the

hospital setting. Because they are part of the support system of the patient, they should be welcomed and kept informed. They expressed that hospitals should be forward thinking and anticipate the needs of family members and prepare for their inclusion in the healthcare plan of the patient. This was thought to be a part of the process of providing patient-centered care.

I think that when you come in, you should be asked if there is anything that can be done differently than we have already talked about in terms of the family. What is it that we could do to better [to] improve the family experience and to help you so you're not so worried about it? (AP5)

Patient focus group participants indicated that including family members throughout the entire healthcare experience is what patients are looking to see from a patient-centered care approach. This is done through keeping their loved ones informed and engaged. This helps to reduce anxiety in patients during what is likely a stressful time, and to reduce concerns with family members during a time when they too are feeling stress while occupying a supportive role.

The patient focus group participants indicated that patients should choose who constitutes their family and how much involvement the patient wants them to have in the healthcare process. The archived data also indicated that medical professionals should be respectful of patient choices about family members' participation and should work to include family members consistently at the levels that patients identify. AP9 indicated that "we know who we need with us."

The patient participants talked about the importance of having family members with them throughout their healthcare process, and that a patient-centered care system

takes into account any special circumstances. AP5 noted that medical professionals could help to ease burdens by knowing any special needs or requests from the patient regarding their family members, including their schedules, availability, and the best way to connect with them.

Comfort. Patient-centered care involves measures of comfort because the need for care and treatment and possible hospitalization is scary. Patients look to medical professionals to interact with them from a place of care and compassion, and one that promotes a feeling of comfort. AP6 noted that when this happens, “you know you are going to be well taken care of.”

The nurses in that room just made me feel comfortable. I was scared to death, because I thought for sure that I was dying, and they just took the time each and every one of them, to calm me down so that my blood pressure would come down. (AP2)

The patient participants positively referred to actions that promoted comfort during times of anxiety and noted that it was the *small things* that impacted the feeling of comfort. Comfort measures included talking to patients, being present in the moment, taking time to help calm their nerves, and checking in on them regularly. They further noted that when medical providers talked with them about personal things, it helped them to feel better and have a greater sense of connection to that medical provider.

The patients also experienced feelings of comfort when they had privacy in the hospital setting, and they noted that private rooms helped to make the hospital experience more restful and tolerable. AP1 stated, “I know in a perfect world, we would all have private rooms, but it all doesn’t work that way.” It was made clear that in the ideal state,

patient-centered care affords privacy and excludes the discomforts that come with sharing a hospital room with strangers. The patients described the private room setting as the ideal state for hospitalization, and one that affords them rest, comfort, and opportunity to be with their family without issues.

The participants did, however, share that a private room was not something that would ultimately deter them from seeking care at their hospital of choice, “It would be fabulous but, yeah, and I don’t know the solution to that problem, ya know, but I would still go to my hospital” (AP11). The participants talked about a variety of other things that are impacted by room privacy. If they must share a room with another patient and family, they worried about getting enough rest, waking their roommate, and sharing the bathroom. These were all issues that the hospitalized patient should not have to think about, especially when recovery should be the number one priority. AP3 shared, that “a private room is a nice thing if it’s there and you can take advantage of that and things of that nature. You can focus on getting better.”

Summary of Results

Thematic analysis is described by Flick (2014) as a method used for identifying, analyzing, and describing data. Often the description of data goes further than identifying, analyzing, and describing, and it actually provides an interpretation of certain parts of the topic of research. Thematic analysis was utilized to analyze data collected from participants and archival data. This approach to coding was used in the analysis of both the medical professional focus groups and the patient archival focus group data.

Initial/first-phase coding allowed for familiarization with the data and the generation of initial codes. This phase was followed by secondary coding and the

identification of patterns for categories. The data and categories were then reviewed, followed by the identification of themes, with those themes being defined and labeled. The data were analyzed for patient-centered care-related expectations or behaviors. Lastly, participants and archival data were compared to one another. The themes from the two sets of data were triangulated, for the purpose of identifying overlapping themes and points of convergence.

The methodological triangulation process consisted of a cross verification of the two sources of data related to the same phenomenon of patient-centered care. The purpose of the triangulation of the data was to explain more accurately the complexity and connections of the data by looking at them from more than one standpoint and from both the patient and medical professional perspective.

The research questions investigated what defines patient-centered care for both patients and medical professionals. The results indicate that while there were some variations, there were commonalities that indicated shared values. Both groups noted in their discussions that there was less of a need for a shared definition. Instead, they held that a focus on the human aspect of care, individual needs of the person and the relationship between the patient, family, and medical providers was paramount to implementing patient-centered care in a healthcare setting. MP1 noted that patient-centered care is “how the person defines it, the goals and objectives of the patient or person.”

Patients are so unique that if you truly are looking at them as individuals and you are approaching them and placing their care in their hands with you as the expert to guide that along, then patient-centered care can be anything. It really is a

philosophy, and I think it is a long time coming for individuals who have felt maybe disenfranchised either because of the way they've been treated in the past or their inability to communicate. . . . When I think about a definition for it, it really seems to me that it should be definition-less (MP1).

The triangulated themes of the importance of family involvement and family support emerged from the data, and it was a shared theme of importance and value among both data sets. Both sets of participants believed that the involvement of family in the patient care process lent to a patient-centered care approach.

Human connections were identified by both sets of participants as being an important aspect of the promotion of patient-centered care. There was a convergence of the data on points of care, kindness, and trust.

Communication was an equally important part of patient-centric care for both groups, with the medical professional group further defining cultural competency as an aspect of patient-centric communication. This aspect was not evident with the patient group, however, effective and consistent communication with patients and families were themes shared by both groups for positive patient experiences.

The patient group identified comfort measures as a value of patient-centric care, while the medical professional group cited resources and regulatory impact as a significant pressure related to the provision of patient comfort measures. There was a variation of importance and impact on these themes between the two groups.

Both groups identified the importance of privacy as a means of providing comfort and opportunity. There was an overlapping value of affording the patient with a private

environment to rest, recover, and remain connected with family. Privacy in this setting was devoid of concerns that insist upon or ensure protection of medical information.

The results of analysis found that the following themes emerged from the medical professional focus groups: family inclusion, cultural competency and communication, human connections, and resources.

Predominant themes from the patient archival data included human connections, communication, family support, and comfort measures. Table 4.1 shows the shared values and cross verification of the medical professional and the patients and their families.

Table 4.1

Shared Values and Cross Verification of Medical Professional and Patient Qualitative Data

Medical Professionals	Patients/Families
Family Inclusion – Shared value	Family Support – Shared value
Human Connections – Shared value	Human Connections – Shared value
Cultural Competency and Communications	Communications
<ul style="list-style-type: none"> Effectiveness and consistency – Shared value 	<ul style="list-style-type: none"> Effectiveness and consistency – Shared value
Comfort Measures -Systemic and external challenges*	Comfort Measures
<ul style="list-style-type: none"> Privacy – Shared value 	<ul style="list-style-type: none"> Privacy – Shared value

*The system impacts the ability to consistently provide privacy, comfort, and other opportunities.

Chapter 5: Discussion

Introduction

There is no universally accepted definition or implementation strategy of patient-centered care within the American healthcare system. The lack of conceptual clarity on the part of medical professionals, health industry mandates, and incentives make it very difficult for healthcare to operationalize patient-centered care and to include it into research or clinical projects. The lack of clarity around a universal patient-centered care concept presents a problem in healthcare (Hobbs, 2009).

The purpose of this chapter is to discuss in detail the findings that emerged from the research in relation to the study's questions, data analysis and theoretical construct. Furthermore, this chapter serves to provide insight into the potential for shared values in patient-centered care as understood through the descriptive, single, embedded-case study of an urban, acute healthcare organization. The findings from this study are specifically discussed in relation to the research and findings that align with the literature review provided in Chapter 2, and it will be used to suggest opportunities for current practice and future studies. Finally, the limitations and recommendations of the study are shared, along with a concluding statement.

The research for this case study was completed utilizing a qualitative methodology within a case study design to explore the following research questions:

1. How do medical professionals in a large, urban, acute-care hospital located in Central New York define patient-centered care?

2. How do patients in a large, urban, acute-care hospital in Central New York define patient-centered care?

Implications of Findings

The findings were disclosed through focus groups with medical professionals who serve in a variety of clinical roles, and the review of patient focus group archival data. Findings revealed that patients and medical professionals place value on various aspects of the healthcare experience and they share certain values in what they described as a patient-centered care approach.

Triangulation of the data showed that there were clear connections for both the medical professionals and the patients related to the value of family inclusion, consistent communications, human connections, and the provision of comfort measures in the patient care process. There was a convergence of the data relating to comfort measures specifically in regard to the importance of the ability to provide patients and their families with private patient rooms during hospitalization.

The value of family inclusion was evidenced by the medical professionals citing the importance of including family, whenever possible, in the care plan, communication, and patient treatments. There was a distinct value noted in engaging family members in the process of care to patients and in the outcomes from those interactions.

The patient archival data validated family inclusion and its importance, focusing on: communication, inclusion in care, and providing family comfort measures to improve the overall patient experience. Based on the feedback, the patients felt more at ease and able to focus on their own rest and recovery when they knew that their families were being well attended and were allowed to participate in various aspects of their care. When

they did not have to *worry* about their families' experience, they could focus on themselves and their healthcare needs.

The actions and shared values between medical professionals and patients relating to family inclusion were identified as necessary by both groups to encompass a patient-centered care approach and help to provide improved outcomes for everyone involved in the patient's healthcare experience. Both medical professionals and patients identified family inclusion as a shared value that enhanced patient care outcomes, including recovery and comfort, and therefore overall patient satisfaction with their experience of care. It can be posited that when the patient's family is well cared for and included in the healthcare process, both medical professionals and patients believe that patient-centric care is occurring.

Human connection was the second finding that emerged as a shared value in the delivery of patient-centered care. Both patients and medical professionals noted that a true connection between everyone involved in the healthcare experience was an important shared value in promoting patient-centered care and enhancing the relationship and development of trust between the caregiver and the patient.

Human connections were supported through actions of listening, being fully present, and taking the time necessary to provide the level of support needed for a specific healthcare interaction. These actions were related to the provision of care and comfort measures, opportunities to exhibit respect and protect patient dignity, and promotion of circumstances that allow for a connection or sense of synergy to evolve between the patients and the medical professionals. Luxford and Sutton (2014) noted that healthcare providers must elevate healthcare by empowering patient involvement and

partnering with them. Developing human connections is a way to facilitate these partnerships and to enhance the level of engagement of patients within a healthcare setting.

The patients described the human connection as providing reassurance and finding a way to promote their ease, comfort, and recovery by enhancing their emotional well-being. The patients noted that medical professionals could do this through small gestures of care and concern, and that relationships could be forged in small windows of time, based on the vulnerability of their situation and their need for support. Fear and uncertainty could be thwarted if medical professionals took the time to reassure and connect with patients. Bowie et al. (2014) noted that emotional support is one of four themes identified as highly important to patients regarding patient experience. These aspects were all thought to further develop connections in care and to enhance the healthcare experience, therefore promoting patient-centric care.

The medical professionals noted that the development of a connection was essential because it allowed for the provider to know their patient better and to understand their patient's specific needs. Furthermore, the medical professionals believed that to provide patient-centered care, they needed to take the time to listen, understand, provide emotional support, and develop relationships with their patients. They indicated that patients and families wanted to know that their caregivers really understood them and, essentially, they come to care for them in a deeper way over time.

Communication, finding three, was a shared value that emerged through focus group discussions with medical professionals and in reviewing the patient archival data. The finding was determined to be an essential need in the healthcare experience for the

promotion of shared understanding, shared values, and positive patient-centered care experiences. Medical professionals found communication, cultural competency, and family inclusion to be interwoven aspects essential to patient-centered care, while patients focused attention on the importance of communication that was consistent, timely, and included their families.

The medical professionals were concerned with ensuring that education related to cultural competency was a strong component of patient-centered care, and that providers could evaluate their interactions and adjust them to best fit the needs of those they were caring for and communicating with. Self-reflection and understanding of one's *blind spots*, or lack of knowledge or ability to recognize the needs of others, were deemed to be essential in the communication process during health care interactions, because these unknowns can be impactful and cause issues with the delivery of care for patients and families. They can relate to confusion, misunderstandings, or complete lack of understanding. The medical professionals shared the value of consistent communication with patients, and they believed that continual education and awareness of cultural influences and individual comprehension levels was a necessity to provide proper and effective patient-centered care.

The patients felt strongly that consistent communication promoted patient-centered care, and that the process must include their family members. The patients noted that when they knew that their family members were well communicated with and were included in their care, they felt better about their overall experience because they did not have to worry about them. The patients wanted to be educated and informed and not rushed in their communication with medical professionals. Furthermore, the patients

wanted to feel like they were the number one priority for the medical professional caring for them and communicating with them at the time of their healthcare interaction.

Cliff (2012) noted that hospitals should look to patients and their families to help identify what leads to improved patient experiences and their overall satisfaction in healthcare. In the process of this study, inclusive and consistent communication that served to engage the patients and their loved ones were determined to be a shared value with the medical professionals and one that is a foundation of the definition of patient-centered care.

The final finding, comfort measures, the ability to provide experiences as close to *home* as possible, emerged as an important value held by the patients in patient-centered care and included the provision of privacy in the healthcare experience. The medical professionals also valued comfort and privacy for their patients, but equated these provision, and their ability to include them in their care delivery model, to the availability of resources (time, equipment, physical design of care spaces) at any given time. To provide patients with consistently positive patient-centered care experiences, the right availability of resources was essential, and according to both medical professionals and patients, this is not always a reality in the current healthcare landscape. According to Rathert et al. (2012), one of the most significant care ratings regarding patient's perceptions is related to physical comfort measures. Both the patients and the medical professionals agreed that comfort defines patient-centered care, but the medical professionals clearly struggled with the ability to deliver value depending on available resources.

Both the medical professionals and the patients shared the value of privacy for patient-centered care to thrive, and they believed that this was, in part, achieved by the provision of privacy in the way of private patient rooms during the rest and recovery process. Privacy and private spaces allowed for patients to rest, medical professionals to engage in private and more robust conversations with patients, and for family members to be more present and comfortable in the healthcare environment.

The medical professionals felt that the complexities of care [required documentation, regulatory restrictions or requirements, and physical design of healthcare spaces] including the stringent regulatory impacts, affected their ability to consistently provide privacy and other measures to enhance patient and family comfort. They further noted that due to the lack of appropriate resources, the ability to make patients comfortable and practice patient-centered care was not a reality for today's health care professionals. Too many obstacles are in the way, resources are too limited, and medical providers are bogged down in what was described as a *hot mess* [lack of time, resources, and ability to provide each patient the time and attention that they need] within the current healthcare system.

Patients recognized these challenges as well, noting that medical professionals were often too busy and could not provide the level of attention that they believed they would have liked to be afforded to them. Little et al. (2001) noted that one of the problems with implementing patient-centered care is identifying which aspects are most important to patients. The patients were clear that time and attention from their medical providers, was an essential part of the patient-centered care process.

The McKinsey 7S model. The McKinsey 7S model provided a lens through which to view the case study and to identify the current state of the organization's patient-centered care approach and what its future state portends. The model may serve as a strategic planning device that informs performance and alignment.

The framework lent itself to the research by providing a structured process to develop focus-groups questions and analyze the organization's internal environment to assess for alignment between the medical professional and patient perceptions related to patient-centered care. Additionally, the framework served as a guide to understanding the impact of events within the healthcare environment and influencing organizational factors, which describes the evolving state of healthcare.

Of the seven Ss of the McKinsey framework (Singh, 2013), four served as a guide to inform the organization's existing patient-centered care structure; including: *staff, systems, skills, and shared values*. These four were selected because they helped to inform the research questions. They provided a lens to view the current state of the organization, including the culture, attitudes, and overall understanding of patient-centered care. Additionally, alignment was identified through the interview questions. They combined both *hard* (systems) and *soft* elements (staff, skills, and shared values) of the framework. Hard elements are thought to be easier to define, with soft elements being more difficult to define and more influenced by culture. Utilizing the Ss for an alignment purpose allowed for an understanding of how the organization was structured, what influenced employees and their general attitudes, the actual skills of employees, and what their superordinate goals (shared values/core values that are evidenced in the culture) were related to patient-centered care. This approach assisted in identifying the shared

values in patient-centered care by applying the four factors of the McKinsey model to the research question design and to the focus group question layout. The other three elements of the 7S model: styles, strategy, and systems, may be used for future research, and a deeper understanding of shared values in patient-centered care based on this foundational study's outcomes.

The McKinsey 7S framework (Singh, 2013) is used when an alignment perspective is useful and therefore is helpful in examining shared values in patient-centered care for medical professionals and patients. The framework therefore assisted in providing a solid structure for how to organize the research questions, and more specifically, the focus group questions that were structured to flesh out understanding of the staff, skills, the system, and ultimately, shared values.

Implications for Practice

Focusing on shared values in patient-centered care could help to improve the overall experience of patients, families and medical professionals in the healthcare setting. Furthermore, the understanding and identification of shared values in a healthcare setting or community could prove to increase overall patient satisfaction, patient and family engagement, patient outcomes, and lead to an organization's definition or development of their chosen model of patient-centered care practice. Ideally, with the practice being based in shared values and developed upon a foundation of what is best suited for their patient population and community at large.

Society places an emphasis on the practice of patient-centered care, and regulatory agencies have an expectation for medical professionals and healthcare institutions to embody and practice from a patient-centric model perspective, but there is

currently no universal definition for this practice and a lack of understanding as to what constitutes true patient centeredness. Furthermore, there is a lack of input from patients regarding the values that they believe undergird patient-centered care practices.

Healthcare operates on a delivery system largely based on knowledge that is one dimensional and that has been historically centered on the physician or the provider. This is slowly changing with the implications of value-based care and the American healthcare system moving from a volume- to value-based model. The way that organizations define patient-centered care and how they implement and operationalize their models for this care may need to change as well.

The high-level expectations of patient-centered care that currently exist do not seem to be based on patient requests, nor do they reach the point of the service expectations of patient and medical professionals. A better understanding of the values that resonate for both, and that are shared between them, may help to bring the research around patient-centered care to an improved and more realistic model for practice.

Furthermore, focusing on shared values as a point of reference for patient-centered care may help to improve the overall engagement of patients, families, and medical professionals, because the focus is on values that are shared, established by both providers and patients and their loved ones, and make sense in the current healthcare climate.

In the research, it was suggested by a participant that patient-centered care is *definition-less*. This was met with agreement by the majority of other participants (both MP and AP). The participants agreed with a set of shared values, but noted that to be patient-centered, medical professionals must seek to understand the individual. This may

be true and healthcare may be entering an era based on this study's findings, where healthcare design will need to be customized based on the understanding of generally shared values and distinctions of what is important within certain communities, cultures, or regions.

Limitations of Study

There were two limitations identified in the study, including the participant selection process and study location, and the impact of a focus group study design. First, the selection process for the participants was one of convenience.

The study considered only the perspectives and definitions of patient-centered care from medical professionals and patients at one organization. The study did not address the healthcare experiences or alternate lived experiences of the patients or the medical professionals on a national perspective.

Focus groups were conducted; therefore, participants could have been influenced in their responses by other participant responses or through unintentional actions, such as non-verbal cues by participants or the facilitator. The researcher worked to reduce bias by frequently engaging in member checking to ensure that responses were understood, and to clarify any aspects around the essence of what the participant were expressing for questions. The researcher participated in focus group practice sessions to ensure that questions remained as aligned as possible.

Recommendations

Defining shared values. The findings presented in this chapter demonstrate the potential of utilizing a shared-values method to identify how to approach, implement, and operationalize the practice of patient-centered care. Additionally, there is a need to

understand what shared values exist between medical professionals and patients to influence the appropriate structures of these models of care.

The research validated that shared values exist and should be identified between medical professionals and patients in order to promote and enhance the delivery of patient-centered care. Rather than trying to apply a universal definition to the concept, which may be impossible to do, healthcare organizations may be better served to ensure that shared values are identified and are at the core of their individualized approaches. As opposed to having a high-level shared definition in healthcare, a shared vision is necessary that requires human understanding and individualized recognition of needs.

A shared values approach allows for the continuation of patient-centric, value based care in the American healthcare system, while promoting individuality among organizations or healthcare networks. Identifying and connecting shared values may allow for a more intimate relationship, which is needed between medical providers and their patients to improve overall satisfaction. In order to accomplish this, it is strongly recommended that those populations [medical providers and the patients they serve] have the opportunity to share their voices. Furthermore, it is recommended that healthcare institutions make the effort to pull together those populations to get to the recognition and understanding of their shared values. Government influence should focus on a shared vision framework that promotes expectations around patient-centered care but that allows for individualized strategies.

Medical professionals, patients, and their families expect high-quality, safe, and efficient care as a baseline of their patient-centered care experiences. Defining shared values at the individual level [organizational and human] may be the missed opportunity

to moving forward patient-centered care. A common definition may not be realistic, but rather a shared vision model rooted in shared values, that serves to guide an organization in design, practice and accountability.

Future research. Future research related to conceptualizing patient-centered care and the impactful aspects of patient-centered care will be helpful. This includes looking at the influences of technology, communication methods, innovations in practice, patient perspectives, and the environment of care. Whatever model of patient-centered care is adopted within organizations, understanding of shared values, adherence, and fidelity to those values should be further explored.

This case study could be expanded to include a larger group of medical professionals and patients that are not affiliated with the hospital system under review, or from larger hospitals or healthcare systems across the nation. Focusing on a larger sample may provide a greater understanding of the existence of shared values in patient-centered care, as well as to provide more clarity for the definition of patient-centered care and how defining shared values lends to the development and implementation of a shared-vision care model. A more in-depth qualitative study that includes various hospitals and health care systems, as well as more patients and providers, would allow for more comprehensive findings. There is an opportunity to include Patient and Family Advisory Council members in the research as well.

A qualitative study with family involvement may contribute to the findings by further defining the shared value of family inclusion and it may help to clarify the role of family members in a patient-centered care model. Their involvement in future research, based on the strong emergence of a shared theme and value of family from this case

study, would provide greater understanding how best to incorporate the family into patient-centered care.

The voice of the patient, family members, and medical professionals should be explored in more depth to ensure that all stakeholders have what they need at the point of service, based on shared values, to support the healthcare experience. They share a value in supporting and including one another in the patient's healthcare and more research would ensure that their involvement occurred in ways and at times that benefitted all involved in the process of care.

Furthermore, there is an opportunity to study shared values in patient-centered care in more depth in an organizational-specific manner to identify the shared community values that drive a patient-centered care approach for specific types of organizations, cultures, or regions. As opposed to one definition of patient-centered care for healthcare, there may be value in studying the need to allow for patient populations and medical professionals who care for those populations, to drive the definition for patient-centered care, utilizing the approach of assessing for shared values. Implementing a shared-values assessment tool for patient-centered care to influence how patient-centered care is adopted and operationalized within healthcare settings, may be an individualized delivery approach with the very basic tenants of shared values noted in this research at its core.

The healthcare system involves humans caring for humans, with a shared value of human connections. Patient-centered care may be more accurately described as human-centered care. The literature showed a gap in patients influencing how healthcare is delivered. The research validated the importance of their involvement in conjunction with the medical providers who care for them. Further exploration of shared values would

benefit the profession of healthcare and the experiences of those seeking care and treatment.

Further exploration of the potential for utilizing a shared values method in patient-centered care may inform healthcare on how to approach, identify, implement, and operationalize the practice of patient-centered care. Shared values move forward patient-centric, value based care that is multi-dimensional and promotes the individuality of organizations and the communities they serve.

Conclusion

This research relied on the McKinsey 7S (Singh, 2013) model to examine how the organization was structured and to determine what gaps or opportunities existed in the provision of a patient-centered care approach. The model provided for a way to look at the organization and to develop the research and focus group questions to gain understanding of the current state of patient-centered care practice. The framework served in a procedural capacity, providing a lens to look through when structuring the questions and thus informing the research.

The findings of this study proved significant as shared values emerged from the research, and more specifically, shared values were identified and aligned from the perspective of the medical professionals and the patients and through the lens of the McKinsey 7S model (Singh, 2013).

To collect the necessary data, this study relied on the lived experiences of medical professionals and patients and their ability to share their perspectives in focus groups. The findings that emerged from the data show that medical professionals and patients do, in fact, have shared values when it comes to a patient-centered care approach. Both place

a high value on the inclusion and engagement of family members in the healthcare process, importance of consistent communications, the need for a human connection, and purposeful privacy to meet the provision of patient-centered care.

The patients certainly expected to receive care that was quality based and safe, but the emerging theme in the research focused much more on how the experience of care made patients feel. If the medical professionals included patient's families, took time to listen, provided small measures that showed they cared, and were attempting to connect, such as checking on the patients frequently, being fully present in the moment and providing private healing spaces for the patient and their families, patient-centered care would be identified as taking place.

The medical professionals recognized many of the same values, but struggled within the context of the healthcare system to be able to provide these experiences and support shared values consistently. The medical professionals noted that they work within a system that is highly regulated and does not allow for them to provide the time and attention to patients and families that they need to for the patients to feel comforted and well cared for. Furthermore, the medical professionals shared the value with their patients for privacy in the recovery process, and more specifically, in the way of private spaces and room designations, but noted that the facilities in which they practice do not always allow for this due to overcrowding, physical layout, and design.

The medical professionals noted that healthcare organizations think that they provide patient-centered care and that they identify that they do so, but, the *brochures* [marketing literature] speak to practices that are not congruent with the reality of the healthcare environment or the constraints that exist within it. The medical professionals

believed in patient-centered care and in being part of a shared values system, but they struggled with obstacles, challenges, regulations, and unreliable resources that they believed limited their abilities to engage in consistent patient-centric care practices that are in line with the identified shared values found to be the essences of the definition of patient-centered care within this study.

The medical providers and patients agreed that to move patient-centered care forward, it is essential to understand what is important and valued by everyone involved in the healthcare process. The research findings validated the literature in that there is a need for more research on this important topic. The research findings also serve to inform current practice related to patient-centered care. As opposed to attempting to reach one universal definition for patient-centered care, healthcare may need to look toward identifying a shared vision for understanding shared values at the point of service. This may be accomplished by placing value on direct feedback from medical professionals and their patients (and Patient and Family Advisory Councils [PFAC]) to identify what shared values exist between them and impact their healthcare experiences. This would allow for organizations to implement and operationalize patient-centered care processes that are rooted in a shared vision of their specific patient population.

Health is a human right and a social justice issue. All Americans have the right to the highest attainable standard of health. The current issues in healthcare, including inequality and disparity must be solved. Knowledge about what values resonate and are shared between medical professionals and patients/families, and communities may lead to more realistic models of practice and improved healthcare outcomes. Committing to shared values in patient-centered care could help to improve the overall experience of

patients, families, and medical professionals and to improve quality, safety and patient satisfaction. A shared values approach allows for the continuation of patient-centric, value based care in the American healthcare system, while promoting individuality among organizations and valuing the “voice” of all, thus promoting social justice.

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Appendix A
Organization Approval

On behalf of _____ as acting Chief Nursing officer and direct supervisor to Nancy Williams; approval is extended to her as an employee and St. John Fischer College Doctoral Candidate to conduct research at the organization on the chosen research topic of Defining shared values in patient-centered care: A case study.

We are aware that archival data will be utilized, and that focus groups will be conducted comprised of _____ medical professions.

Signature 

Date: 11/17/16

Appendix B

St. John Fisher College

INFORMED CONSENT FORM

Title of study: Defining shared values in patient-centered care: A case study

Name of researcher: Nancy Williams Phone for further information: (315) 200-2236.

Faculty Supervisor: Dr. Linda Hickmann Evans Phone for further information: (315) 498-7265.

Purpose of study: The purpose of this study is to identify and analyze emergent themes related to stakeholders in patient-centered care to determine if an association of a shared definition and values exists.

Place of study: Crouse Hospital, Syracuse, New York 13210

Length of participation: 1 hour focus group sessions

Risks and benefits: There are no anticipated risks to you as a participant. The results of this study will contribute to current body of research around patient-centered care. There is potential that the findings will lend to the development of a shared values model for patient-centered care practice.

Method for protecting confidentiality/privacy: All information gathered from participants will be held in strict confidence, however anonymity and confidentiality cannot be guaranteed during participation in focus groups. The researcher will take the following steps to ensure privacy and confidentiality in the body of the published research. All files will be password protected, all participants will be identified by a code known only by the researcher, and all audio tapes will be transcribed by software and assessable only by the researcher in a locked cabinet in the researcher's home office. All data will be destroyed after 3 years. All published results will ensure participants' confidentiality.

Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer any questions without penalty.
4. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Print name (Participant) _____ Signature _____ Date _____

Print name (Investigator) _____ Signature _____ Date _____

If you have any further questions regarding this study, please contact the researcher listed above.

The Institutional Review Board (IRB) of St. John Fisher College has reviewed this project. For any concerns regarding this study and/or if you experience any physical or emotional discomfort, you can contact Jill Rathbun by phone at 585.385.8012 or by email at: irb@sjfc.edu

Audio Tape Consent Form

I consent to being audio taped during this study.

Print name (Participant)	Signature	Date
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Researcher statement: I certify that I obtained the consent of the subject whose signature is above. I understand that I must give a signed copy of the informed consent form to the subject, and keep the original in my personal, confidential files for 3 years after the completion of the research project. At the end of three years, this research will be destroyed.

Print name (Researcher)	Signature	Date
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Appendix C

Introductory E-mail Invitation

Dear Department Head,

My name is Nancy Williams. I am a doctoral candidate in the add. Program in Executive Leadership at Ralph C. Wilson, Jr. School of Education at St. John Fisher College, and the Director of Patient and Guest Relations and Volunteer Services at Crouse Hospital. To satisfy my dissertation research, I am investigating the topic of shared values in patient-centered care between medical professionals and patients within the urban, acute-care hospital setting.

I am assessing medical professional and patient perspectives on patient-centered care to identify a definition for patient-centered care and shared values between medical professionals and patients. The results of this study will help to further the knowledge base of those concerned with patient-centered care in the hospital setting.

As part of this study, I am asking for focus group participation from 2 of your medical professional team members. This will take approximately 1 hour of their time, and will be scheduled in a convenient location.

There is no compensation associated with participation, however the researcher will provide the results of the data if requested to participants through an electronic version of the dissertation.

All information gathered from the audio taped focus groups will be held in strict confidence, however anonymity and confidentiality are unable to be guaranteed during focus groups. The researcher will take the following steps to assure privacy and confidentiality in the published research. All files will be placed on a flash drive that will be password protected and each participant will be assigned a code known only by the researcher. The audio taped sessions will be transcribed by software and will only be available to the researcher. Data from this study will be destroyed after 3 years. Published results will assure participant confidentiality, and will be presented as aggregated data. There is no anticipated risk to you as a participant.

Department Directors should advise willing participants to contact me directly by e-mail or phone within 2 weeks of the sent date noted above. My contact information is provided below. I will provide participants with a confirmation e-mail.

Please contact me with any questions: _____ or _____

Thank you in advance for your time and consideration,

Sincerely,

Nancy Williams, RN, MSN – Doctoral Candidate, St. John Fisher Executive Leadership Program

Appendix D

Sample Focus Group Questions

Research Question #1: How do medical professionals in a large, urban, acute-care hospital located in central New York define patient-centered care?

Participant-Focused

1. Is patient-centered care important to you? (Patient Q.)
2. How do you define patient-centered care? (Patient Q.)
3. Do you practice patient-centered care? If so, define what it is like for you in daily practice.
4. Describe the skills you believe are required to provide patient-centered care.
(Patient Q.)
5. What do you believe patient's want from their healthcare experience?
(Patient Q.)
6. Describe how patient-centered care benefits you as a medical professional.
7. Describe how patient-centered care benefits the patients you care for.
8. Is there synergy around the implementation of patient-centered care; if so describe the shared values that inform this practice?

Organization - Focused

9. Based on your experiences, how does the organization define patient-centered care? (Patient Q.)

10. Do you see this definition being applied to organizational decision making; if so, how?
11. Is patient-centered care communicated well in the organization; if so, how?
12. Does the organization have core values that promote patient-centered care? Describe those.
13. If you could make any changes that would better promote a patient-centered approach in the organization, what would those be?

Research question #2: How do patients in a large, urban, acute-care hospital located in central New York define patient-centered care?

1. How do you define patient-centered care?
2. Is patient-centered care important to you?
3. Based on your experiences, does the organization practice patient-centered care?
4. Describe the skills you believe are required to provide patient-centered care.
5. What do you want from your healthcare experience?
6. If you could make any changes that would better promote a patient-centered approach in the organization, what would those be?