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ORIGINAL RESEARCH & CONTRIBUTIONS

Special Report

A Framework for Making Patient-Centered Care Front and Center

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Abstract

The concept of patient-centered care has received increased attention in recent years and is now considered an essential aspiration of high-quality health care systems. Because of technologic advances as well as changes in the organization and financing of care delivery, contemporary health care has evolved tremendously since the concept of patient-centeredness was introduced in the late 1980s. Historically, those advocating patient-centered care have focused on the relationship between the patient and the physician or care team. Although that relationship is still integral, changes to the health care system suggest that a broader range of factors may affect the patient-centeredness of health care experiences. A multidimensional conceptualization of patient-centered care and examples from our health care system illustrate how clinical, structural, and interpersonal attributes can collectively influence the patient's experience. The proposed framework is designed to enable any health system to identify ways in which care could be more patient-centered and move toward a goal of making it a "systems property."

Introduction

Patient-centeredness has long been recognized as a desirable attribute of health care. Proponents have described patient-centered care as that which honors patients' preferences, needs, and values; applies a biopsychosocial perspective rather than a purely biomedical perspective; and forges a strong partnership between patient and clinician.[1,2] Until recently, most studies of patient-centered care and its impact on care processes and outcomes were largely focused on the patient's relationship to his or her clinician or care team.[3,4] However, much of what a patient experiences occurs outside of the encounter in the physician's office. Interactions between patients and care clinicians have expanded beyond the in-office visit to include virtual medicine, peer support groups, and a range of information and communication technologies to support care. Moreover, the clinician's or team's ability to provide patient-centered care is affected by the context in which they operate; for example, a large hospital, small private practice, freestanding urgent care facility, or integrated multispecialty group practice.

As a result of changes to the notion of a care visit and the proliferation of care delivery arrangements, much of medical care and coverage in the US is fragmented; patients may visit a number of clinicians in different clinics or systems, especially for complex and chronic conditions, and continuity and coordination across clinicians and settings is often lacking.[5] Moreover, the electronic medical records held in one health care setting are often not shareable or interoperable,[6] further contributing to fragmentation. Hence, the absence of a true health care system has been detrimental to patient centeredness and continues to present obstacles to making care more patient centered.

Nevertheless, we believe that efforts to make the health care environment more responsive to patients' needs, preferences, and values will be most likely to succeed if they are based on a clear understanding of the full range of factors that promote or impede patient-centered care—that is, making patient-centeredness a "systems property."[7] Thus, given the changes in contemporary medical care over the past two decades, it is worthwhile to revisit the opportunities for increasing patient-centered care.

In this article, we offer a multidimensional characterization of patient-centered care that could be applied to a variety of care delivery systems and settings. We describe attributes within each of three dimensions of health care that can affect patients' experiences, for better or for worse. Our goal is to provide a framework and real-world examples to readers interested in improving the patient-centeredness of their health care organizations. We use insights from the literature and illustrative examples collected from Group Health Cooperative (Group Health), an integrated health care delivery system in Seattle, WA, to show how the attributes of patient-centered care can be embraced at a systems level.

What Is Patient-Centered Care, and Why Is It Important?

The Institute of Medicine[8] has defined patient-centered care as "care that is respectful of and responsive to individual patient preferences, needs, and values." Following a series of focus groups with patients, iterative feedback from research colleagues, and consultation with national advisers, we modified this definition slightly to describe patient-centered care as care that "*honors* and responds to individual patient preferences, needs, values, and *goals*." It is through this lens that we describe why and how patient-centered care should be an imperative for all health care systems, whether that "system" is a solo practitioner, a large multispecialty group practice, or a federally qualified health center providing care to underserved populations.

Several important arguments for making care more patient centered have been offered. Patient-centered care results in improved care processes[9] and health outcomes, including survival.[10] Two systematic reviews identified promising patient-centered interventions directed at patients, clinicians, or both, which

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resulted in improved communication and health outcomes.[3,7] Patient-centered care is the right thing to do.[11] In fact, it is hard to imagine how care that has not been patient centered could ever have been justified. There is a business case for patient-centered care, on the basis of evidence that patients who report stronger relationships with their clinicians undergo fewer tests and are less inclined to pursue legal action if a medical error is handled in a sensitive, patient-centered fashion.[12] Finally, it has been argued that clinicians and their teams may benefit from a patient-centered orientation by knowing that they have more effectively addressed the needs of their patients.[13,14] Collectively, these studies demonstrate that patient-centered approaches can lead to improved healing relationships.

Our Approach to Studying and Improving Patient-Centered Care

Group Health coordinates health care and coverage for more than 660,000 individuals in Washington state and operates as a consumer-governed nonprofit system. Nearly two-thirds of members receive care in Group Health-owned and operated medical centers, and promoting patient-centered care is an organizational guiding principle. Nevertheless, the complexity of patient-centered care in a large system—where every patient, clinician, team, and encounter varies across time and place—means that embedding patient-centeredness into all daily work remains challenging.

In 2009, Group Health Research Institute, the research arm of Group Health, initiated the Patient-Centered Care Interest Group to serve as a venue for stakeholders from across the organization to discuss timely topics, articles, projects, and related initiatives. The diversity of departments that are represented—including research, clinical care (primary, specialty, and nursing), health plan product development, organizational communication, quality improvement, measurement and analysis, and patient safety—shows that this is indeed a topic of interest across our system. The group provides a forum for formal and informal interactions with internal colleagues as well as outside colleagues who are regularly invited to share their expertise, and it fosters improvements to internal care delivery initiatives as well as research projects. Topics have included measuring patient experience in real-time, best practices for patient advisory boards, and user-centered design methodology, among many others. Medical Directors are among the regular interest group participants. As a marker of widespread leadership support for this work, patient-centered care was a featured topic of Group Health's annual internal conference targeted to all personnel in our integrated group practice (approximately 500 participants) in 2010 and 2011. The conference is a unique opportunity to describe high-profile organizational initiatives and to disseminate key messages to medical leaders and frontline staff simultaneously. Showcasing patient-centered care has spurred greater participation in the interest group.

The Group Health Cooperative Human Subjects Research Committee reviewed and approved this manuscript. However, no information on human subjects is included in this commentary.

What Are the Dimensions and Attributes of a Patient-Centered Health System?

The literature on patient-centered care spans a broad range of subtopics, including physician communication training, patient-centered health information technology, the built environment (the spaces and products in health care facilities), and strategies for measuring patient-centeredness. For this reason, Bensing[15] describes patient-centered care as a "container concept" that envelops several different attributes and behaviors. It is useful to acknowledge and differentiate patient-centeredness from

Table 1. Dimensions and attributions of a patient-centered health care system

Interpersonal dimension (relationship)	Clinical dimension (provision of care)	Structural dimension (system features)
Communication Begins with listening Creates a fabric of trust Promotes clear, empathic communication, tailored to patients' needs and abilities Welcomes participation of family, friends, and caregivers	**Clinical decision support** Ensures shared decision making on the basis of best-available evidence coupled with patient preferences Supports self-management	**Built environment** Provides calm, welcoming space Accommodates patient, clinician, and family needs Emphasizes easy "way-finding" and navigation through the system
Knowing the patient Uses knowledge of patient as a whole and unique person for effective interactions Finds common ground on the basis of patient preferences Facilitates healing relationships	**Coordination and continuity** Manages care transitions and seamless flow of information—whether for a broken arm or life-altering illness Coordinates with community resources	**Access to care** Eases appointment-making process Minimizes clinic wait times Payment system accommodates patients' circumstances Coordinated, consistent, efficient
Importance of teams Ensures responsiveness by entire care team to patient and family needs Recognizes that actions of both clinicians and staff can influence perceptions of care	**Types of encounters** Accommodates virtual visits (phone, e-mail) as well as in-office visits Reimbursement structure supports range of encounters that meet patients' varied needs	**Information technology** Supports patient and clinician before, during, and after encounters Tracks patients' preferences, values, and needs dynamically Provides self-management tools and information

the patient-centered medical home model, which has gained traction in primary care as a practice model and is predicated on how a practice is organized to better support the patient's experience. With or without adoption of the patient-centered medical home model, care can be very patient centric, or not. For example, a clinic or practice may incorporate features in the evidence-based care plans and same-day appointments, or other operational improvements, but one unpleasant interaction with a team member can leave its imprint—a perception that the patient was not put at the center. Thus, patient-centeredness is a quality that must be earned time after time, encounter by encounter, and it is fragile, even in a medical home setting.

Within Group Health, we sought to make the overarching concept of patient-centered care more concrete and operational by identifying attributes of patient-centered care that recur in the literature, and organizing them into the three dimensions that we believe must be present and integrated to make patient-centered care part of the *culture* of care. Table 1 shows the attributes in these three dimensions: interpersonal, clinical, and structural. We have organized these dimensions to be applicable, and the attributes to be actionable, in any health care setting. These attributes build on and extend previous conceptualizations of patient-centered care[1,2,16] by explicitly acknowledging the role of the entire health care team, emphasizing new modes of patient-clinician interactions, and characterizing aspects of the health care system beyond the built environment. Indeed, many of these attributes are part of the medical home model, but a practice model and a mindset are not synonymous. Group Health has adopted the medical home model systemwide and is endeavoring to fully embed patient-centeredness into the culture and fabric of the organization.

Table 2 presents examples of specific changes we have made and how these changes tie to the attributes in Table 1. Leadership support is imperative, and Group Health leaders have endorsed specific tactical changes and embraced the philosophy of patient-centered care. Still, culture change is a dynamic and living process, especially in a large organization, and ours is a journey in progress.

In the course of reviewing the literature to identify key attributes, we also identified two fundamental tenets of patient-centered care that were reflected in all of the attributes. The first is *consistency*. Whether the patient is communicating with a physician or a radiology technician or a claims adjuster, whether being seen for a lifelong condition or an acute illness, whether the "visit" is in a clinic or via e-mail, and whether the patient's preferences are stable or change according to their health status, the patient should be able to rely on the health system to consistently provide a patient-centered experience.

The second underlying tenet is *trust*. Does the patient trust that the clinician is fully present and listening with the patient's needs in mind? Also, the patient and clinician must be able to trust the system on which the clinician relies to support high-quality, patient-centered care. Can the patient trust that the environment in which s/he is receiving care is safe and committed to error-free care?[17] Can the patient and clinician trust that someone is looking out for the patient's interests as s/he transitions between health care settings? Can the patient trust the skills of the medical assistant who is inserting an intravenous catheter? All of these

Table 2. Patient-centered changes made at Group Health Cooperative by related dimensions

Patient-centered feature	Related dimension
Online self-management program introduced to accommodate growing demand for peer-support workshop for individuals who could not attend in-person version of workshop	Clinical
Previsit outreach to patients by medical assistants to ensure that encounter focuses on most important problem, and that patients bring relevant history and medications to visits	Clinical
Direct access to specialty care clinicians	Clinical
Secure e-mail access to clinician for virtual visit	Clinical
Smartphone "app" to give patients mobile access to their medical record, ability to reach their clinician or 24/7 nurse service, find locations, check symptoms, and view wait times for laboratory and pharmacy services	Clinical
Regular surveys of patient experience, with feedback to individual clinicians and comparative data across facilities	Interpersonal
Communication training for new clinicians, and retraining as needed on the basis of patient ratings of clinician communication	Interpersonal
Patient-centeredness training for nurses caring for complex, chronically ill patients	Interpersonal
Electronic medical record tracks patient preference for "what I'd like to be called"	Structural
Integrated electronic medical record and participation in regional "Care Everywhere" program to promote continuity and coordination within and outside of Group Health system	Structural
Way-finding signs and maps improved following ethnographic study of how patients see and interpret signage in facilities	Structural
New clinic designed with input from patients to improve flow, decrease wait times, and colocate frequent services	Structural
Billing statements modified following input from patients about unclear elements	Structural
Design of new clinics included patients as part of the team with clinicians, nurses, technicians, and architects to collaboratively address "the ideal patient experience"	Structural

questions require both a system-level commitment to organizing care processes to meet patients' needs, preferences, and goals, and a philosophical commitment on the part of all of the participants in the health care setting.

In the next section, we explore the dimensions and attributes in depth, and provide examples of how they are being applied at Group Health. In some instances, the examples may evoke more than one dimension, again illustrating that patient-centeredness has a permeable quality and "contains" many aspects.[15]

Interpersonal Dimension

This dimension unites several well-studied aspects of patient-centered care: communication, knowing the patient, and acknowledgment that all members of a team affect the team's relationship with the patient. Effective communication must begin with active listening—empathically attuning to both the patient's medical and nonmedical needs (eg, values, fears, life events)—that can have a major impact on both the process and outcomes of the interaction. Effective communication will facilitate the ability for patient and clinician to find common ground.[4,18] It is often critically important to involve the patient's friends, family, and/or caregivers, especially in times of stress (eg, acute events or serious illness) or when family support is important for achieving clinical goals (eg, management of chronic disease). Defining the team to include both clinical and service providers can also contribute to patient-centeredness of care. Sevin and colleagues[14] note that becoming a patient-centered, highly functional care team takes deliberate work to define roles and responsibilities, and to ensure that everyone has the necessary information to meet the needs of the patient. Moreover, placing responsibility on everyone who interacts with a patient helps create and reinforce a culture of caring. Everyone on a team or in a system must recognize that one unpleasant or uncaring encounter can have a lasting negative impact on the patient and makes the lives of coworkers who have to deal with an upset patient more difficult.

… all members of a team affect the team's relationship with the patient.

Group Health has undertaken several initiatives in recent years to improve this interpersonal dimension:

- Enriching its physician- and nurse-training programs to focus on the importance of interpersonal communication both with patients and between clinicians
- Enhancing engagement among all employees through front-line improvement workshops that bring entire teams together to identify strategies to improve care
- Surveying patients regularly about their care experience, and using results to identify opportunities to improve communication at the individual clinician level
- Actively piloting patient advisory boards that tap into specific ways to improve ancillary clinical departments within our system, for example, pharmacy services.

Clinical Dimension

Many attributes in the clinical dimension—particularly decision support, coordination, care management, and continuity—are prominent in the health care improvement literature.[19-21] These attributes are more important than ever, considering today's diverse and increasingly fragmented health care delivery landscape. Recent innovations in delivery system design, notably virtual medicine and redesign of primary care around the medical home model, lend themselves particularly well to ensuring a patient-centered experience. By its very name and nature, the patient-centered medical home model is intended to more fully support clinicians in delivering coordinated care across settings and types of encounters. For care to be fully patient centered, it should allow patients the option of interacting with their clinician or care team without visiting a facility. Similarly, the system should have a routine approach for equipping patients with the skills needed to prevent or manage illness outside of the clinician's office and should be able to connect patients with community-based agencies that provide social, instrumental, or emotional support.

Among the patient-centered improvements that Group Health has made in the clinical dimensions are:

- Leveraging health information technology to extend care options beyond the office visit, via secure e-mail to clinicians, a smartphone "app," and online health risk assessment with personalized feedback
- Longer in-person appointments
- Ability to self-refer to medical specialists
- Both online and in-person peer support programs for persons with chronic illnesses
- For preference-sensitive conditions, (eg, bariatric surgery, prostate cancer treatment), a formal shared decision-making program has been established to give patients and clinicians a foundation from which to carefully explore trade-offs when more than one clinical option may be available.

Structural Dimension

The built environment is outmoded in many ways. Many existing facilities were designed to facilitate the clinician's experience and navigation; signage is often in medical jargon, as is paperwork (claim forms, test results, prescription instructions). The nurses' station in a hospital ward is often physically distant from patient rooms, which may contribute to patients feeling isolated. Patients are physically moved to procedures or services, rather than having the procedure or service performed wherever they are. System-level investments can go a long way toward creating a more humanized care experience, and principles for improving the health care environment have been articulated in the Planetree Model, which aims to shift the health care environment from one designed around the convenience of clinicians to one centered around the patient, with a more personalized and holistic approach.[22] Design of Group Health's newest clinical facilities was undertaken with extensive input from its consumers as well as care delivery personnel, with the goals of making clinic visits more efficient and less stressful, by colocating patient services (laboratory, pharmacy, imaging), and developing more comfortable examination rooms.

Similarly, access to care—where clinic wait times are minimized, appointment making is efficient, and payment structures

accommodate patients' ability to pay—can greatly enhance patients' experiences. Making patients wait 40 minutes to be seen, while feeling unwell or being around others who are ill, is likely to have negative consequences for the rest of the encounter for both the patient and the clinical team who must then deal with an upset patient. Finally, information technology innovations in health care, if developed and used properly, hold tremendous value and promise and have the potential to greatly enhance the patient-centeredness of care, especially as the "meaningful use" provisions of electronic health record adoption come to fruition. These provisions are designed to help clinicians better know their patients and use this knowledge to inform and improve care. As an example, increased use of electronic health records can dynamically capture and store a range of patient information around needs, goals, values, and preferences. Group Health regularly adds such features to its electronic medical record system. Another information technology-enabled enhancement at Group Health is the incorporation of laboratory and pharmacy wait times by clinic, built into the smartphone application.

Conclusion

Bergeson and Dean[23] observed that "well-designed support and delivery systems are essential if care is going to center reliably and consistently on patients' needs and priorities." We have provided a new conceptualization of patient-centered care by identifying pertinent attributes in the interpersonal, clinical, and structural dimensions of health care, along with concrete examples of ways in which those wishing to improve the patient-centeredness of their care can intervene at various levels, using this actionable framework. However, because the attributes typically do not exist in isolation, all have the potential to affect a patient's care experience. Hence, a comprehensive, integrative, consistent approach to making patient-centered care a *system property* is most likely to succeed.

Although the goal of delivering an optimal patient-centered care experience may seem aspirational, the mounting pressures on health care settings make this a particularly opportune time to explore the ability of patient-centered innovations to improve care processes and health outcomes. A parallel may be drawn from the literature on improving reliability in health care. Just as each patient should reasonably expect care that is free from errors, there is every reason to set a similarly ambitious expectation that every patient will not only receive reliable and error-free care but also will consistently receive patient-centered care—in any health care setting, every time. We have the tools, the business case, and the evidence base—now we need the will. ❖

Disclosure Statement

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