THE MYTHS OF PATIENT-CENTERED CARE

For some, the concept of patient-centered care is self-evident, and simply put, the way they feel health care should be delivered. For others, the concept can evoke apprehension and/or skepticism—not because they object to the underlying philosophy of restoring empathy, humanity and patient-provider partnerships to health care, but because introducing changes to the standard operating procedures of most hospitals often requires a host of considerations, from cost and resource consumption to infection control and privacy protections. This is, after all, how health care earned its reputation as an industry disinclined toward change.

In this section of the Improvement Guide, we address some of the most commonly cited reasons why models of patient-centered care will not, or cannot, be effective, clarifying misconceptions and demonstrating once and for all why these persistent myths need no longer thwart the more widespread adoption of patient-centered care.

MYTH #1: PROVIDING PATIENT-CENTERED CARE IS TOO COSTLY.

The misconception that providing patient-centered care requires a substantial infusion of financial resources overlooks a key point: that while certainly patient-centeredness can be enhanced with technology, renovations, and new equipment, fundamentally providing patient-centered care is about human interactions. It is about attitude, kindness, compassion and empathy, all of which are completely free! Providing compassionate and personalized care does not require hiring more staff, but rather optimizing interactions with patients and families at your current staffing levels.

A recent study demonstrated the operational benefits of providing patient-centered care.¹ A five-year comparison of two comparable hospital units (same types of patients, skill mix, and with standardized organizational pay rates, supply costs, policies, procedures, contracts, and regulatory compliance programs), one implementing the Planetree model of patient-centered care and the other not, found that the Planetree unit consistently demonstrated a shorter length of stay, lower cost per case, and a shift in use from higher-cost RN staff to lower-cost ancillary staff. In addition, the Planetree unit demonstrated higher average overall patient satisfaction for each of the five years studied.

This myth of the cost of providing patient-centered care has been perpetuated by another misguided line of thinking—that patient-centeredness requires significant investments in either renovations or new construction to ensure a striking and spacious physical facility within which these interactions can occur. This thinking fails to understand that a healing environment encompasses not only architecture and interior design, but the atmosphere of the space. Yes, the atmosphere can be improved by a number of low- to no-cost cosmetic improvements (including art work, soothing paint colors, plant life, and reorientation of furniture), but perhaps the most effective means of brightening up and demystifying an intimidating, institutional space is through

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the development of arts and entertainment programs, the presence of volunteer ambassadors in the lobby, by providing abundant information, and by establishing behavior expectations for staff that they acknowledge everyone they encounter. Even those hospitals that do undergo renovations need not spend more to create a patient-centered, healing environment. In fact, in the early 1990s when Griffin Hospital in Derby, Connecticut approached the state authority responsible for granting certificates of need with its plans for a patient care facility that would reflect its patient-centered philosophy, the plans were approved with one caveat: that the renovation must cost no more than a traditional renovation. The hospital met the challenge and the facility went on to be awarded all four of the top national health care design awards.

For many hospitals, volunteers have proven to be invaluable resources for advancing a culture of patient-centered care. By exploring new and creative ways that volunteers may enhance the environment of care and may support staff in their efforts to provide personalized care, these hospitals are not only better able to meet the needs of their patients and families, but they are also cultivating a more engaged, loyal cadre of volunteers who are ever-more willing and eager to donate their time and their talents to the hospital.

This is not to say that there are no expenses associated with the implementation of patient-centered care. For many hospitals, the most significant resource consumption is in making staff available for initial and ongoing education and training. But in the current landscape of the health care industry and the imposing forces of health care consumerism, these relatively small costs are wise investments, particularly as we consider the financial implications of substandard HCAHPS scores, of rising malpractice claims, and of the unrelenting challenges of the health professional staffing shortage. By making investments that set the stage for care to be delivered in a way that meets patients’ needs, that treats them with dignity and respect, that fosters an environment of trust and transparency (even when things go wrong) and that inspires employee pride in the workplace, the costs of implementing patient-centered care are clearly dwarfed by the priceless potential benefits.

For a more comprehensive discussion of the business case for patient-centered care, refer to “Building the Business Case for Patient-Centered Care” by Patrick Charmel and Susan Frampton in the March 2008 edition of HFM Magazine.

**MYTH #2: PATIENT-CENTERED CARE IS “NICE,” BUT IT’S NOT IMPORTANT.**

With the Institute of Medicine’s identification of patient-centeredness as fundamental to quality care, one would think that this myth has been summarily debunked, but the perception of patient-centered care as all about cookie baking, pianos, and pet visits continues. There are some aspects of patient-centered care that perhaps are not essential to patient care, but they certainly do contribute to an outwardly more pleasant hospital experience. And just because something is “nice,” does not mean it is not important. By strengthening partnerships between patients and caregivers and by actively promoting family involvement in patient care, patient-centered practices set the foundation for a characteristic of care that is of the utmost importance: that it be **safe**. Patient and family-initiated rapid response teams enable those closest and most familiar with the patient to initiate a rapid response team. Encouraging patients to review their medical
record not only promotes an atmosphere of trust and patient empowerment, it is a practice that can lead to patients averting what could have been costly medical errors by their identification of incorrect or missing information (such as an allergy). Involving patients and their loved ones in important aspects of care, including medication verification, prepares them to be discharged, well-equipped to manage their care at home. Responding promptly to call lights not only provides reassurance to patients, but it may also mean that a patient does not jeopardize their own safety by attempting to make it to the bathroom on his or her own. All of these practices are part of a comprehensive culture of patient-centered care, and while they all may be “nice,” they are first and foremost, important. In its national patient safety goals, The Joint Commission has recognized the involvement of patients and families as a key patient safety strategy, stating:

Communication with [patients] and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When [patients] know what to expect, they are more aware of possible errors and choices. [Patients] can be an important source of information about potential adverse events and hazardous conditions.2

Providing consumer-responsive, patient-centered care is also increasingly important from a financial standpoint, and will become even more so if the Centers for Medicare and Medicaid Services introduces value-based purchasing, tying reimbursement to a number of measures, including performance on the HCAHPS patient perception of care survey.

**MYTH #3: PROVIDING PATIENT-CENTERED CARE IS THE JOB OF NURSES.**

This, in and of itself, is not a myth. What is a myth, however, is that providing patient-centered care is exclusively the job of nurses. On the contrary, implementation of patient-centered care is akin to a complete transformation of organizational culture and its success requires buy-in and involvement from every department, clinical and non-clinical, and every tier of the organization, from front-line staff to the medical staff and governing board.

In patient-centered hospitals, caring for patients is not just a function of nursing, it is a function of every staff member, whether they be a housekeeper changing linens, a billing specialist reviewing a patient’s balance, a dietary aide delivering a patient tray, a librarian compiling a diagnosis-specific information packet, a maintenance person shoveling snow from the sidewalk, an infection control coordinator monitoring for hand hygiene, or a public relations specialist coordinating a community event. Every staff member in a patient-centered hospital is a caregiver, and accordingly every staff member is expected to be responsive to patient and family needs, which may mean personally escorting a visitor to their destination or alerting a nurse when a patient has a clinical concern.

Recognizing that every person on staff contributes in some way to the overall patient experience reinforces that patient care is a team effort. If a patient is met by a cold or disinterested admitting clerk upon arrival, for instance, it will not matter how kind and compassionate the nursing staff is; the impression has already been made. On the other hand, in patient-centered

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hospitals, staff of all disciplines leave positive and lasting impressions because they are empowered as caregivers to go above and beyond their basic job description to enhance the patient experience in whatever ways they can. “Is there anything more that you need?” is a question asked not only by nurses, but by any staff member who interacts with a patient and/or their family.

Because providing patient-centered care is a universal responsibility within the hospital, the implementation of patient-centered care needs to be inclusive of staff from all areas of the hospital, with representation on patient-centered care committees from nursing, administrative personnel, ancillary departments, and the medical staff. It is only with this broad base of input and engagement that the complete patient experience can be considered—from arrival in the parking lot through discharge and care transitions. This also reinforces that responsibility for patient-centered care does not fall on the shoulders of one, but on many, and cultivates a wellspring of patient-centered care champions throughout the organization.

Strategies for engaging leadership, staff, physicians, volunteers, and patients and families will be described in Section VI.

**MYTH #4: TO PROVIDE PATIENT-CENTERED CARE, WE WILL HAVE TO INCREASE OUR STAFFING RATIOS.**

Somewhere in between the notions that patient-centered care requires an infusion of money and resources, and that patient-centered care is all about nurses, is the myth that hospitals will have to increase their staffing ratios to accommodate the additional time staff will be administering to patients. This reasoning is based on the assumption that nursing staff in patient-centered hospitals devote more time meeting the needs of patients, which increases their workload. The experiences of several hospitals implementing models of patient-centered care demonstrate that this assumption is erroneous, and in fact, the converse may be true: that nursing time is actually decreased. For example, open medical records are a hallmark of the patient-centered approach to care. Patients are informed about having access to their record and staff set aside time to go over and explain those sections of interest to the patient. In hospitals implementing this policy, nurses find that rather than increasing their work, they save time by fielding questions all at once, cutting back on time spent responding to multiple calls and questions spaced throughout the day.

That patient-centered care does not necessitate an increased amount of resources for bed-side care is also borne out by data. In a discussion with four hospitals that have successfully implemented patient-centered care for more than five years, each found that both their RN staffing ratios and hours per patient day had not changed after their adoption of a patient-centered care approach. In fact, their data from surgical, medical, step down and maternity units all fell within the range of similar hospitals published in the Annual Survey of Hours Benchmark Report.³

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Additional confirmation comes from recent research that compared a hospital that had adopted a patient-centered approach to other hospitals within the same system. Over the course of the patient-centered care implementation (a five year period), the patient-centered care unit was able to reduce the higher cost RN hours by using more lower cost clerical and aide/LVN hours, compared to an increase in these higher cost RN hours by the other hospital units.\(^4\)

**MYTH #5: PATIENT-CENTERED CARE CAN ONLY BE TRULY EFFECTIVE IN A SMALL, INDEPENDENT HOSPITAL.**

With its emphasis on personalized care, patient-centered care may seem impractical, or even impossible, in a large institution or an integrated health system. Today, though, even some of the country’s largest hospitals and systems are recognizing the need to complement clinical excellence with a superior patient experience.

To overcome the challenges presented by organizational size and scope, many of these larger institutions and systems opt to use a phased approach. Aurora Health Care, a fourteen-hospital, 120+-clinic system out of Milwaukee, Wisconsin, has developed a standardized four-phase process for implementation that focuses on leadership engagement, patient and staff input and identification of areas for improvement, staff engagement and continuing innovation. While every system entity will ultimately go through each phase of implementation, the process leaves ample room for customization to meet the specific and expressed needs of a particular site’s key stakeholders. Each site’s culture change endeavors are guided by the system, but ultimately it is the leadership at each site that is accountable for their outcomes. Among these individual entities, though, it has been important to also emphasize the collective, system-wide commitment to patient-centered care, which has meant sharing both best practices and struggles among sites, communicating consistently (both internally and externally) about patient-centered care, and setting common behavioral expectations. The Aurora system has made system implementation of the Planetree model of patient-centered care part of its ten-year long term strategy.

At the Cleveland Clinic, the system-wide *Patients First* initiative is being spearheaded by a new division, the Office of Patient Experience, created exclusively to focus on the patient experience. Led by the Chief Experience Officer, physician and nurse Experience Officers are also appointed in every institute within the system and within every regional hospital in the system. In addition, a Patient Experience, Quality and Safety Committee of the Board of Trustees has been formed to bring even greater support and visibility to this effort enterprise-wide.

The University HealthSystem Consortium (UHC), an alliance of academic medical centers, their affiliated hospitals and associated faculty practice groups, recently conducted a benchmarking study with 26 of its members aimed at identifying common strengths and opportunities as they relate to patient-centered care in the academic medical center setting. This benchmarking study was followed-up by an implementation collaborative to address the opportunities for improvement identified. The Executive Summary of UHC’s Patient- and Family-Centered Care 2007 Benchmarking Project is included as a tool at the end of this section, along with a Strategy

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Map that outlines approaches organizations can use to transform their organizational culture to be more patient-centered. See page 34-38.

The Illinois Hospital Association also conducted a collaborative designed to help member hospitals enhance patient-centered care in 2007, which included both large and small hospitals and health systems.

**MYTH #6: WE MAY THINK PATIENT-CENTERED CARE IS AN EFFECTIVE MODEL FOR CARE DELIVERY, BUT THERE IS NO EVIDENCE TO PROVE IT.**

In an industry where evidence-based practice is the standard, systematic and rigorous study of the components of patient-centered care will go a long way in paving the way to more widespread adoption of such models. While considerable opportunities exist to build upon this growing evidence base, the foundation for this work has begun. A bibliography of research and evaluation projects designed as a companion to this Guide will be available on the Planetree (planetree.org) and Picker Institute websites (pickerinstitute.org).

Although the bibliography focuses on traditional published “evidence,” each organization should also take into account its own organization-specific evidence when considering implementation of patient-centered care. What are your patients, families, and staff telling you they need? For some practices, compelling quantitative evidence is available from traditional research methods, but in other cases the most compelling “evidence” that a practice is beneficial in your organization may be the qualitative perspective of your patients, families, and staff, coupled with experience and common sense.

**MYTH #7: MANY PATIENT-CENTERED PRACTICES COMPROMISE INFECTION CONTROL EFFORTS, AND THEREFORE, CANNOT BE IMPLEMENTED.**

Fundamentally, patient-centered care must be safe care, and any new practices being explored should be thoughtfully and rigorously examined through the lens of patient safety. A common stumbling block for hospitals introducing a patient-centered approach are concerns with regard to infection control, specifically around practices like open visitation, animal visitation, the installation of fish tanks in public gathering areas, and the introduction of carpeting, water features and live plants. In fact, Windber Medical Center in Windber, Pennsylvania has incorporated almost every one of these elements and yet the hospital’s infection rate is less than one percent. Clearly, opportunities exist to create a vibrant and healing environment without compromising infection control efforts.

Concerns about the spread of infection are a common barrier to lifting traditional restrictions on visitation. A recent study focused on the particularly vulnerable population of ICU patients concluded, however, that “restricting visiting hours might be unjustified and unnecessary for protecting the sickest patients in the ICU because it does not reduce the rate of infectious
complications.”\textsuperscript{5} It should further be clarified that open visitation does not call for the universal elimination of all visitation limitations. Certainly, in cases of communicable disease or when the risk of infection is particularly high, precautions (such as providing gowns) and/or limitations may be necessary. In all cases, however, communication to the patient and family of the concerns and the rationale for any limitations and/or precautions is of paramount importance.

Just as risk of infection need not be a barrier to lifting restrictions to visits from people, nor does it need to be a reason for restricting visitation of animals. Numerous studies document the therapeutic value of pet visitation programs\textsuperscript{6,7} and others have found that the introduction of dogs into the hospital did not increase infection rates.\textsuperscript{8} Policies for pet therapy programs must specify grooming and health criteria, and oftentimes certification requirements that animals must meet prior to being invited into the hospital.

Beyond developing policies and procedures to limit the possible spread of infection from some of these practices, it stands to reason that a culture of patient-centered care could actually enhance efforts at infection control. When patients and providers work together in partnership, and when communication is open and trusting, sensitive conversations may be approached more easily. For instance, in many hospitals patients are advised to ask their providers if they have washed their hands. For patients, this may feel awkward and uncomfortable, so much so that they do not ask the question. In a patient-centered hospital, however, a foundation of mutual respect and partnership means such a conversation can be initiated in the spirit of partnering for quality patient care, rather than an accusation. One patient-centered hospital has taken this spirit of partnership even further, engaging patients as “mystery shoppers” to monitor staff’s hand hygiene practices.

Finally, since preserving and maintaining patient privacy is a priority of patient-centered care, many patient-centered hospitals opt to make the change from semi-private, shared rooms to private rooms, which growing evidence suggests is not only a patient-satisfier, but also decreases the incidences of hospital-acquired infections.\textsuperscript{9}

**MYTH #8: THE FIRST STEP TO BECOMING A PATIENT-CENTERED HOSPITAL IS RENOVATION OR CONSTRUCTION.**

A healing physical environment is just one of several key aspects of a patient-centered approach to care, and many hospitals in outdated, space-challenged facilities have nonetheless managed to create remarkably healing environments by introducing music, humor, artwork, aromatherapy, pet visits and the like, all at a low cost, but yielding a high impact. Section VII.F. of this Guide presents a number of such strategies.


For one hospital on Long Island, New York with a rundown physical plant and limited financial resources to undertake facility improvements, a staff-led “Extreme Makeover” competition provided a fun, low-cost way to spruce up areas of the facility. With a budget of $1,000 per department, and their own creativity to spur them on, staff from several departments transformed their spaces. Over a twelve-month period, eight departments underwent an “extreme makeover,” using only volunteer labor and their budgeted $1,000. Their renovations helped to eliminate clutter, resolve regulatory issues, improve work flow, and create a cleaner, brighter, more welcoming space, while also improving staff morale and fostering a sense of teamwork and collegiality.

**MYTH #9: PATIENT-CENTERED CARE IS THE “MAGIC BULLET” I’VE BEEN LOOKING FOR TO ___________. (IMPROVE PATIENT SATISFACTION, IMPROVE EMPLOYEE MORALE, ENHANCE REVENUE STREAMS, ETC.)

As addressed in Section IV of this Guide, patient-centered care is far from a “magic bullet.” It is not a set of practices that when implemented according to a strict prescription will alter the experience of your patients, their families and your staff. For while such “magic bullet” changes are possible in the short term, they are not sustainable. Patient-centered care is about changing culture, not moving data points, and that requires a long-term commitment and understanding that change of this magnitude is gradual and not without its setbacks and challenges.

This long-term and steadfast approach may be a culture shift in and of itself. Employees in many hospitals have become accustomed to, and often disillusioned by, “flavor of the month” initiatives that are launched with much fanfare only to disappear when results do not materialize quickly enough. By communicating—and “walking the talk”—that patient-centered care is *not* a magic bullet, but rather a steady and measured effort toward comprehensive culture change, hospital leadership will set this effort apart from previous improvement endeavors that may have left staff feeling deflated and skeptical.

This “journey approach” also means that there are always opportunities for improvement, no matter how long your organization has been on the path to patient-centeredness. Sustaining a patient-centered culture demands adaptability and flexibility to meet the needs and expectations of your patients, families and staff—needs that will inevitably evolve over time. Patient-centered hospitals recognize that the goal is not to reach the destination, but to continue approaching it.

**MYTH #10: WE CAN’T IMPLEMENT A SHARED MEDICAL RECORD POLICY. THAT WOULD BE A VIOLATION OF HIPAA.**

Inviting a patient to read his or her medical chart is not only *not* a HIPAA violation, it is, in fact, a patient right, recognized by both federal and state law.

Patient-centered hospitals optimize the opportunities for education and communication that arise when a patient reads his or her chart by ensuring they understand the information contained and
have the opportunity to ask questions about its implications on their health, lifestyle, or prognosis. Of course, patient privacy and confidentiality are of paramount importance, and a review of the medical record should only be done privately with the patient, or with loved one(s) whom the patient has expressly identified as those with whom such information can be shared. To protect patient confidentiality, only the patient has access to his or her medical record. If the patient would like a family member to have access to the chart, he or she can sign a form, releasing medical information to the designated person.

**MYTH #11: WE HAVE ALREADY RECEIVED A NUMBER OF QUALITY AWARDS, SO WE MUST BE PATIENT-CENTERED.**

Although patient-centered care is a core foundation for quality, the presence of award-winning clinical outcomes does not necessarily imply patient-centeredness. Many quality awards continue to focus solely on the outcomes of care, without considering the way in which the care is delivered. This distinction is not lost on patients faced with the choice of being treated at a highly-regarded, clinically renowned institution versus a lesser-known hospital with a reputation for patient-centered care. Anecdotes abound of patients opting to receive care at the site where they expected to receive comparable clinical care, but a superior patient experience.

The development, implementation, and national public reporting of HCAHPS survey results has raised the visibility of the patient experience to a new level. The forces of health care consumerism are now compelling even some of the nation’s “best” hospitals to reconsider how well they are doing on areas other than clinical outcomes. With value-based purchasing and new patient-centered mandates from The Joint Commission on the horizon, patient-centered care is rapidly becoming a business imperative.

Despite these pressures, in some organizations the dichotomy persists that patient-centered care is essentially customer service “window dressing” on the more important clinical aspects of care. The patient safety literature highlights the fallacy in this thinking—by promoting effective communication and partnerships between and among patients, family and staff, a patient-centered approach can take quality and safety to new heights. As the Institute of Medicine has acknowledged, “[p]atient-centered care that embodies both effective communication and technical skill is necessary to achieve safety and quality of care.” Patient-centered care is not separate from or less important than quality, it is an essential part of it.

**MYTH #12: OUR PATIENTS AREN’T COMPLAINING, SO WE MUST BE MEETING ALL THEIR NEEDS.**

Even for hospitals that are top performers in patient satisfaction, opportunities for improvement exist. While it is no doubt gratifying to report high percentages of patient satisfaction “always” ratings, perhaps more useful is to drill down into those survey questions where patients have responded “sometimes” or “never.” Another strategy for identifying perhaps overlooked and unmet patients needs is to complement traditional patient satisfaction surveys with patient rounding or focus groups. These qualitative approaches provide opportunities for dialogue, moving beyond standard “always,” “sometimes” and “never” responses to the sharing of
complete stories that may very well shed light on areas for improvement not identified previously through the survey process. A Patient and Family Advisory Council can serve as a group by which hospital personnel can test new ideas and is an ongoing source of input into hospital programs and practices.

Furthermore, just because patients are not complaining, does not mean that all their needs are being met. Despite the industry’s preparation for a more discerning and empowered patient population, patient focus group comments underscore that hospitalization is a scary and overwhelming time when a patient may feel unsure about what to expect or what to ask, may fear reprisal if a suggestion for improvement is made or dis-satisfaction is expressed, or may simply be glad to be discharged, never looking back to consider what could have been better about my stay?

The truth is that there is no such thing as being too good at meeting patients’ needs. There are always opportunities for improvement, and engaging your patients, families and staff in identifying where those opportunities are is an ideal first step toward becoming more patient-centered. Section VI of this Guide presents a number of strategies for engaging patients and families in organizational performance improvement efforts as a strategy for understanding and being responsive to the full range of patient needs.

**Myth #13: We’re already doing _INSERT NAME OF MODEL_, so we can’t take on patient-centered care.**

Health care organizations have a well-deserved reputation for adopting models and then rapidly changing them, leaving staff confused and frustrated by shifting priorities and demands. Overwhelmed staff members are understandably reluctant to embrace new initiatives that seem to be just one more thing to do and leaders sometimes express concern about how patient-centered care will interact with other operational initiatives. The beauty of patient-centered care is that it is an enduring philosophy that transcends any “flavor of the month.” Recognizing and responding to the needs of your patients, families, and staff, promoting effective partnerships and open communication, and acknowledging all staff as caregivers will affect all aspects of hospital operations in a way that complements and enhances any other initiatives. Many organizations that have grown and sustained a patient-centered culture find it difficult to articulate precisely what they “do” that is patient-centered, because it has long since become “who they are” rather than a task list. Whether they are participants in another program, Baldrige award winners, Magnet hospitals, or organizations striving to achieve another goal, they approach all of these things from a patient-centered perspective.

**Myth #14: Being patient-centered is too time-consuming. Staff is stretched thin as it is.**

Few health care professionals entered the field for the documentation, administrative duties and meetings that today are consuming much of their time. Patient-centered care provides a framework for enabling staff to do the work they likely entered the health care profession to do—caring for patients, interacting with and supporting families, and developing supportive,
mutually beneficial relationships with colleagues. Furthermore, with its focus on anticipating needs, a patient-centered approach has the potential to reduce the time- and emotionally-intense interactions that occur when patients feel alienated, disempowered, and upset that their needs are not being met.

Ultimately, many staff have discovered that patient-centered practices have saved them time. For instance, in one hospital, initial fears about the time it would take to educate family members as Care Partners to participate in patient care were unfounded. In fact, nurses have found that because Care Partners are able to respond to simple patient requests like a glass of water, their jobs are, in fact, made easier.