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THE COST AND IMPACT OF PATIENT-CENTERED CARE

A Comparison of Hospital Managers' Perceptions towards Patient-Centered Care under the Evaluation of Financial and Performance Pressures

Master Thesis

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Declaration in Lieu of Oath

“DECLARATION IN LIEU OF OATH

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The paper has not been submitted for evaluation to another examination authority or has been published in this form or another.”

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Abstract

Research Question

The aim of this study was to identify whether patient-centered care (PCC) as a core value of healthcare delivery is able to align the needs of health care professionals and patients in a partnership that is designed to improve quality and outcome of patients. Models, enablers and areas of improvement for the successful realization of PCC in the context of financial and operational targets within health care organizations across Europe were examined. A major focus was placed on the relationship between top-down directed management strategies and local autonomy. Important elements in this regard are organizational culture, values and responsible autonomy.

Methodology

An explanatory sequential design was chosen for the primary research study based on a comprehensive literature review. This involved a semi-structured interview (n=9) including a short-questionnaire that was conducted with healthcare professionals, predominantly in leading positions, between April and June 2018. A total of four healthcare organizations across Europe were included in this study, respectively in Austria, England, Finland and the Netherlands.

Results

Major differences exist within the evaluated organizations, particularly in terms of care models and organizational strategies. Facilitators of PCC were identified and include (a) a strong leadership that commits to an agenda of patient-centered values, (b) the engagement of patients, staff and the public in the design of processes, (c) an open and improvement-focused communication, (d) the intrapersonal skills education of leaders, managers and health care professionals and (e) a robust measurement framework to differentiate between effective and ineffective PCC strategies.

Conclusion

Patient-focused aims and objectives have been proven achievable and maintainable under the increasingly tightened fiscal and operational performance targets. PCC has been identified to be a driving force to adapt to the constantly changing financial and operational environments by implementing local and responsible autonomy as well as to move towards a patient-responsive organization with strong values at its core. Nevertheless, challenges and barriers remain in the current economic climate.

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Abbreviations

CEO	Chief Executive Officer
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
ICT	Information and Communication Technology
LWB	Life Without Barriers
NHS	National Health Service (United Kingdom)
OECD	Organization for Economic Cooperation and Development
PCC	Patient-Centered Care
PFM	Patient Flow Manager
UK	United Kingdom
VBHC	Value-Based Health Care
WHO	World Health Organization

1 Purpose and Significance of the Study

The term patient-centered care (PCC) underlies an almost self-evident humanitarian principle which originates from the Hippocratic oath. Since 1950, it has continuously been progressing as a core value of healthcare delivery and many policy initiatives highlighted its importance. However, “patient-centred care is a widely used phrase but a complex and contested concept” as stated by Groene (2011). Despite the increasing prominence of PCC, policy, and practice little research exists about the differences and contrasts of the implementation in different health systems (Paparella, 2016). In addition, it is not always clear to all involved parties why a patient centered approach is of importance. Many initiatives focus only on patient satisfaction and experience and ignore the bigger picture. Common strategies may even contribute to gaps in the implementation and raise concerns about the effectiveness of PCC (Groene, 2011).

The problem is intensified by the overarching financial and performance pressures which often leads to conflicts between patient quality and adherence to government fiscal performance targets. This was demonstrated in the catastrophic collapse in patient quality at Stafford Hospital in the UK NHS. It was described by the UK Red Cross as a “humanitarian crisis”. Despite the self-evident aim in the NHS of sustaining quality of care, staff were “struggling to cope with the intense demands” placed on them. Inadequate care, patients in the wrong beds, long waiting hours and even deaths were the results of these pressures (Campbell, Morris & Marsh, 2017). Similar events of conflicts between rhetorical strategies and their practical implementation are happening to a greater or lesser extent across many healthcare systems in Europe. The core value of PCC which underpins the vocational drive of almost all front-line healthcare clinical, professional and nursing staff is at risk of corrosion under the weight of performance and financial pressures. In addition, limited resources, the increase of chronic illnesses related to the ageing population and scarce workforce resources are challenging the national health systems. Due to the fact that the prevalence of long-term conditions such as hypertension or diabetes are increasing it becomes a necessity that health care systems adapt to these issues by establishing more effective management of chronic diseases (Fiorio, Gorli & Verzillo, 2018; OECD 2017). Quality and responsiveness to patient need lies at the heart of this requirement.

Purpose and Significance of the Study

To “do more with less” is a major challenge not only for policy makers, but also for managers, clinicians, nurses and all health care professionals and raise the demand for innovative approaches. PCC was identified by many policies and strategies as the key movement to deal with the current requirements and needs (Fiorio et al., 2018 & OECD 2017). Research suggests that if PCC is realized it ought to lead to individual as well as economic benefits which would in turn result in improved clinical outcomes and cost-effectiveness. However, the evidence regarding the costs is not conclusive. Evidence suggests that simply adding a survey regarding experiences and satisfaction of patients to existing performance measures is not very effective. It may be informative and raise awareness about the topic, but it is not sufficient enough to be significant. The use of a few generic instruments for capturing the experience of patients leads to a selection bias and as a consequence to the ignorance of essential challenges in delivering patient-centeredness (Groene, 2011).

This study aims to examine how well the concept of PCC is progressing and holding up as a core value of healthcare delivery under the increasing pressures, both financially and operationally which are now evident in most health systems in Europe. It also seeks to identify any potential conflicts, possibilities and resolutions between top down directional management and local autonomy within the hospital setting as well as the balance between local initiatives and centrally directed patient-centered strategies. An important element that has to be considered in this respect are cultural dimensions. Culture, values and responsible autonomy have a great impact on how systems operate in balancing local autonomy and decision-making against top down policy and fulfilling the overarching targets (NHS England, 2014).

There is a growing need in understanding the views of managers and healthcare professionals of European hospitals regarding their efforts to provide PCC in an effective manner and to define common success factors. Therefore, this study seeks to explore the perceptions of European health managers regarding the effectiveness of PCC and what types of models are evolving. Furthermore, it aims to examine if there are inconsistencies or shared opinions between objectives and aims of PCC under operational and fiscal targets (Taylor & Groene, 2015).

1.1 Hypothesis and Research Questions

The principle of PCC aims to align the needs of health care professionals and patients in a partnership that is designed to improve quality and outcome of patients. Therefore, health policy strategies as well as local initiatives in the care process should be embedded into each other with the goal to deliver PCC. Where this is the case, standards of care should be able to be sustained and maintained against the increasingly evident fiscal and performance pressures currently evident in European health systems.

The study aims to test this hypothesis with the following main research questions:

- *Are PCC models more progressively evolving across European health systems and which types of models and what is the balance between centrally directed patient-centered strategies, local initiatives and patient autonomy in the hospital setting?*

- *Are patient focused aims and objectives achievable and maintainable under the increasingly tightened fiscal and operational performance targets in the perception of European health managers and what are common success factors when dealing with any potential conflicts between top town directed management and local autonomy?*

2 Review of the Literature

The following chapter provides a comprehensive theoretical and research literature review. It will deliver a deeper analysis of the terminology and identify significant concepts and challenges in the delivery of PCC. Organizational structures, cultural dimensions, the role of management/ leadership, including measurements and outcomes of PCC will be presented. Empirical studies that have investigated PCC specifically are included in this research and provide a foundation for the primary research.

2.1 Methodology

A literature review was conducted to identify and critically analyze available secondary research relevant for the study. According to Cronin, Ryan & Coughlan (2008) its “primary purpose is to provide the reader with a comprehensive background for understanding current knowledge and highlighting the significance of new research.”

The following databases were used for advanced searches of empirical literature published either in German or English: Science Direct, PubMed, the Cochrane Library, Medline and Google Scholar. The university library catalogues of the MCI Management Center Innsbruck and of the University of Economics in Prague were accessed to find related literature. In addition, health journals, OECD data, NHS data, WHO data and data of national research institutes were used for this investigation.

During the review progress, it soon became apparent that related definitions concepts, theoretical foundations and models related to PCC and the study context are quite complex and extensive. And, according to Yoder & Morgan (2011) “the word person in PCC is used interchangeably with patient, client, and resident. This variance depends on the context in which care is provided”, for example, patient in hospital setting or resident in nursing homes. In addition, terms such as person-centered, personalized, individualized, client-centered, value-based health care or similar expressions are used alike (Health Innovation Network, n.d.).

A significant challenge was the amount of available research e.g. >1000 on PubMed. The results were reduced to a more manageable number by using different term

combinations and search criteria. In the first research step, the abstracts of the first 100 articles were screened. Reference lists were examined by hand to identify additional articles relevant for this survey. Additional sources were retrieved by contacting experts in the field. Articles in the German and English language were included in this survey. No time period was set for the development of the concept of PCC. Articles that clearly did not meet the inclusion criteria were excluded. If the full article was not accessible but met the inclusion criteria the author was contacted.

The following key mesh terms and key words in different combinations were used for the literature review:

Definitions of PCC	*Cost and impact*	*Hospital setting*
patient-cent(e)red care	financial pressures	patient / staff
patient-cent(e)redness	performance indicators	• feedback
client-c(e)ntered	outcomes	• involvement
integrated	measurement	• satisfaction
value-based	quality improvement	• empowerment
person-cent(e)red	heath policy	patient experience
personalized	hospital manager	organizational culture
individualized	effectiveness	cultural dimensions
		local autonomy/ initiatives

Table 1: Key mesh terms

2.2 Patient-Centered Care (PCC)

The existence of similar definitions and strategies can lead to confusion about the real meaning of PCC. A potential danger is that PCC carries a different meaning for different people which results in a considerable variance in its implementation across countries, health systems and institutions (Taylor & Groene, 2015). Naturally this variance also exists within organizational cultures. In the following section, the most frequent definitions of PCC will be analyzed in greater detail and the most common PCC models will be reviewed.

2.2.1 Definitions of PCC

Already in 1969, Balint as one of the first authors in this field, identified a new approach to medical thinking in "seeing the patient as a unique human being". Furthermore, he states that "this should include everything that the doctor sees and understands about his patient".

As a multi-dimensional concept PCC has been identified as one of the key aspects of high quality in healthcare by the Institute of Medicine (IOM) in building on this initial premise. High quality is referred to as "care that is safe, effective, timely, efficient, equitable and patient-centred" (IOM, 2001a). Furthermore, the IOM states that it "is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient's values guide all clinical decisions" (IOM, 2001b). The definition of the IOM is probably the most prominent throughout literature. In response to it, the World Health Organization (WHO) stated in 2005 that patient "safety will be improved if patients are placed at the center of care and included as full partners".

The Agency for Healthcare Research and Quality (AHRQ, 2008) describes PCC as healthcare that

> *"establishes a partnership among practitioners, patients and families to ensure that decisions respect patients' wants, needs and preferences and solicit patients' input on the education and support they need to make decisions and participate in their own care."*

In 2009, Berwick identified 3 persuasive slogans regarding PCC: "(1) 'The needs of the patient come first.' (2) 'Nothing about me without me.' (3) 'Every patient is the only patient.'" Following this, his own proposed definition is as follows:

> *"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."*

Epstein & Street (2011) state that it "is an approach to care and perceived as the right thing to do [and] based on deep respect for patients as unique living beings, and the obligation to care for them on their terms". This means that the patients are seen "as

persons in context of their own social worlds, listened to, informed, respected, and involved in their care—and their wishes are honored (but not mindlessly enacted)" within their whole health journey.

Yoder & Morgan (2011) argue that "the practice of PCC creates an interpersonal relationship that shifts the focus from the clinician to the person for whom care is being delivered, thus giving control to that individual." According to the two scholars, PCC is defined as follows:

> *"PCC is a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care."*

A more recent article by El-Alti, Sandman & Munthe (2017) argues that:

> *"PCC is about the complexity of the patient (including interpersonal connections and dependencies) and the variability between people, recognizing the person or the individual behind 'the patient', valuing this person and respecting her dignity and rights. The interaction between the healthcare professional and the person receiving the care happening at the action level consists of getting to know the patient through her personal narrative, and collaborating through shared decision making within the framework of a continuous partnership in care."*

Based on the literature review, the following short definition of PCC has been generated for purpose of this master thesis which also guided the primary research survey, stating that:

> *PCC is an approach that tries to ensure that all clinical decisions and patient interactions are guided by a respectful, understanding, supporting and encouraging collaboration between patients and all members of the organization with the aim to improve clinical outcomes, to achieve greater involvement of patients and their families, to accomplish better allocation of resources, and to increase overall patient satisfaction.*

During the evolution of PCC, it moved from a very patient focused concept to one that encompasses the whole environment of care including the social context (family/ carers) and organizational structures. Nevertheless, up until now there is no consensus about what the concept of PPC comprises. It is referred to as a multidimensional concept with a considerable overlap of principles.

2.2.2 Models of PCC

Despite the lack of conceptual clarity, there are a few models of PCC that have gained overall acceptance. The most influential ones are described in this section.

2.2.2.1 The Six Interactive Components of Stewart et al. (1995)

Stewart et al. was one of the first to recognize that PCC requires a change in mindset of clinicians towards a shared relationship and more empowered patients (Stewart et al., 1995; Yoder & Morgan, 2011). Their study includes the following six components:

> *"(1) 'exploring both the disease and the illness experience' (eg, patients' feelings, ideas, expectations); (2) 'understanding the whole person' (eg, social context, life history, developmental stage); (3) 'finding common ground' (ie, on problems, priorities, goals, and roles); (4) 'incorporating prevention and health promotion'; (5) 'enhancing the patient–doctor relationship' (eg, compassion, healing, self-awareness); and (6) 'being realistic' (as to resources and time constraints)."* (Levesque, Hovey & Bedos, 2013)

2.2.2.2 The Five Conceptual Dimensions of Mead and Bower (2000)

The following five dimensions model of Mead and Bower was one of the first to consider interpersonal care aspects such as "humanness", empathy, mutual trust and respect as well as the passing on of sufficient information, among others, as key determinants of good care and patient satisfaction (Mead & Bower, 2000; Yoder & Morgan, 2011). It includes the following 5 dimensions:

(1) "The biopsychosocial perspective" takes into account the psychological, social and medical aspects of a disease. (2) "The patient as a person" seeks to address the experience of an individual with his illness. (3) "Sharing power and responsibility" considers that the necessary information is passed on to the patient to ensure that the health care provider and the patient share the responsibility in the decision-making

process. (4) “Therapeutic alliance” has the aim to establish a working relationship between patient and health care professional. (5) “The doctor as a person” considers that the doctors personality or subjective experiences influence the patient care. It is essential to be aware of this in order to provide PCC in a reflective manner (Mead & Bower, 2000; Yoder & Morgan, 2011).

The figure by Hudon et al. (2011) beneath demonstrates that the model of Stewart et al. largely corresponds with Mead and Bower’s model. Both are focusing on the patient-doctor relationship and the patient within the whole context of his disease including the bio-psychosocial perspective.

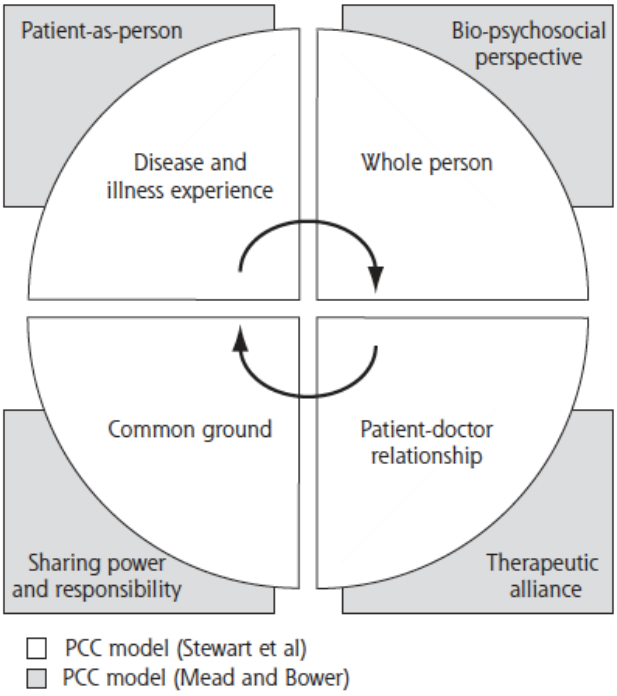

Figure 1: Conceptual Framework of PCC (Hudon et al., 2011)

2.2.2.3 The Common Wealth Dimensions of the Picker Institute

The below stated eight principles, developed by the Picker institute, were the first to recognize that PCC should also guide the organization and not only the interpersonal interaction between patient and the care provider (Yoder & Morgan, 2011). This model has gained popularity among the practical implementation of PCC and is often used as reference point throughout international research (Paparella, 2016). It encompasses:

> *"(1) Fast access to reliable healthcare advice, (2) Effective treatment delivered by trusted professionals, (3) Continuity of care and smooth transitions, (4) Involvement of, and support for, family and carers (5) Clear, comprehensible information and support for self-care, (6) Involvement in decisions and respect for patient's preferences, (7) Emotional support, empathy and respect & (8) Attention to physical and environmental needs."* (The Picker Institute, 2018)

2.2.2.4 Common Characteristics & Criticism

All of the above described models have had a significant influence on the implementation of PCC healthcare policies and practice and are still identified in recent research (Baron, 2014). Nowadays, PCC has reached persuasive acceptance by policy makers, health care providers and researchers who argue that "it represents a shift from a traditional, paternalistic, provider- driven and disease- focused approach towards one that fully integrates the patient's perceptions, needs and experiences, into every phase of medical consultation, treatment and follow- up" (Fix et al., 2017).

Groene, Tuzzio and Chorkin (2012) describe PCC as "a 'container concept' that envelops several different attributes and behaviors". They also argue that care can be patient-centered with or without adopted models. According to them an organization may operate very patient-centered "but one unpleasant interaction with a team member can leave its imprint—a perception that the patient was not put at the center." This suggests that in organizations patient-centeredness needs to be provided, implemented, evaluated and challenged by every patient, keeping in mind that to every patient PCC means something else. Moreover, as Groene et al. writes that PPC has to be

> *"applicable, and the attributes to be actionable, in any health care setting (…) 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."* (2012)

2.3 PCC in Organizations

The previously explained models and attributes of PCC have led to an increased recognition by focusing on benefits and values by higher engagement of patients. This chapter will go into more detail about the process of making PCC a part of the organizational culture.

2.3.1 Standardization of Norms - Common Culture

In order to be able to implement PCC successfully all levels of the organization should cooperate with each other to create a shared belief system and a common mindset. A cultural change is a dynamic process particularly in large organizations such as hospitals (Groene et al., 2012). The implementation of PCC "requires a fundamental change of culture – to turn the principle of 'working with' (not 'doing for') into a reality." The change has to come from within an organization and from its workforce. It "cannot be successfully imposed on them from outside." (Ahmad et al., 2014). Furthermore, they suggest that PCC

> *"...cannot be mandated, specified in a contract or designed into a pay-for-performance system: the participants need to have internalised the ideas and so change their behavior because they believe it is the right thing to do, not because they have been directed."* (Ahmad et al., 2014)

Mintzberg & Glouberman (2001) state that the current "health system hardly lacks for strong cultures. What it lacks is a single strong culture. Aside from all its specialized cultures". Villa, Barbieri & Lega (2009) write that healthcare organizations will not be able to

> *"sustain functional self-referential designs, where resources are duplicated, economies of scale are underexploited, clinical integration and clinical governance is nonexistent, and autonomy (in using the specialty's resources) prevails over accountability (on outcomes requiring the integration of different specialties in using fixed and shared resources, such as operating rooms, equipment, beds, and staff)."*

Traditional systems of hierarchies often stand in the way of achieving a cooperative approach of exchanging information within a health care network. Hierarchies are still more or less present in almost all hospital systems. The term “hierarchies” dates back to the 5th century where it denoted a model to command a course of action such as in the military. Hierarchical structures in organizations ensure a standardized work processes which will not be questioned due to a system that relies significantly on bureaucracy and control. In hierarchical organized systems communication usually “flows from the top to the bottom which means innovation stagnates, engagement suffers, and collaboration is virtually non-existent” and there is no, or little focus placed on the individual experience of employees. (Morgan, 2015).

Specialists need to coordinate their clinical operations as a network without dissociation of expertise. It would be beneficial that all levels of care including administration and community care are guided by understanding attitudes and mutual trust and respect (Mintzberg & Glouberman, 2001). A recent publication of the European Commission (2017) supports that “the introduction of very flat structures, with less hierarchy, is an interesting approach to building an ecosystem of trust and collaboration among involved stakeholders.”

In flatter organizations the structure seeks to open up in order to make collaboration and communication possible as the following figure by Morgan (2015) visualizes:

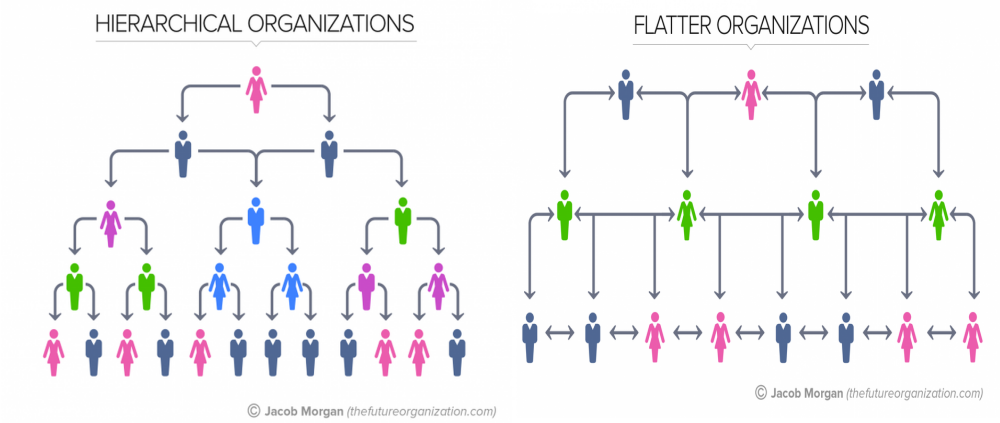

Figure 2: Moving away from Hierarchies (Morgan, 2015)

2.3.2 The Role of Management and Leadership

Management plays a crucial role in dealing with ongoing challenges such as safety and quality of care, financial pressures, meeting performance targets, local and national politics as well as in realizing PCC. Strong leadership can shape the organizational culture in a way that it requires the collaboration and integration of all involved parties (Taylor & Groene, 2015). In order to sustain and unify an organization, a common vision has to be conveyed by simultaneously engaged and committed leaders on the board and CEO level (Schaller, 2007). This should give direction for developing effective strategies and to align people necessary to produce change at an organizational level. People need to want to make it happen and the only way to overcome obstacles or barriers is that people feel motivated and inspired in the process of implementing PCC (Life Without Barriers, n.d.). Albert Cherns already stated in 1979 that

> *"Organizational objectives are best met (…) by the joint optimization of the technical and the social aspects, thus exploiting the adaptability and innovativeness of people in attaining goals instead of determining technically the manner in which these goals should be attained."*

A recent trend that can be observed in healthcare is to move away from universal guidelines and standardization to tailored strategies. The top down one-treatment-fits-all approach is becoming outdated (El-Alti et al., 2017). Successful institutions drive change from the bottom of the organization. These front-line experts or "bottom tier" have become practiced at managing pressures, often by working around innovations in dealing with the pressures that are put upon them. Effective change does not happen by measures and actions delegated and forced down from the top. Instead, it comes from the operations of personally engaged leaders or engaged managers (Mintzberg, 2012). Management needs to distance itself from standardized control mechanisms, detailed policy manuals and standardized processes that dictate to professionals how to do their job. The goal should be to work together collaboratively and adaptively with open communication beyond hierarchy, as "work becomes professional precisely because it requires nuanced judgment. It cannot therefore, be controlled technocratically." (Mintzberg & Glouberman, 2001)

2.3.3 Responsible Autonomy

Responsible autonomy can be defined as “the management technique of allowing employees more discretion and greater variety in their work” (Heery & Noon, 2008). It legitimizes the philosophy outlined above. Professionals self-organize their work by solving complex problems in a way that “responsible people respond to each other’s needs and ideas” to make the overall system perform better (Mintzberg & Glouberman, 2001). Palmer (2007) argues that institutions need to focus on humanization particularly when staff are facing significant pressures or time conflicts. Health professionals need to act as “a moral agent with the power to challenge and help change the institution” and be educated to have an “ethical autonomy and the courage to act upon it”. He furthermore states that:

> *“The education of the new professional will reverse the academic notion that we must suppress our emotions in order to become technicians. We will not teach future professionals emotional distancing as a strategy for personal survival. We will teach them instead how to stay close to emotions that can generate energy for institutional change, which might help everyone survive.”*

Autonomy “enables productivity through mastery and purpose. The logic is simple: if one creates a space in which staff pursue their own goals and are not paid by the hour, they will focus on their activities not the clock.” (Matt Black Systems, n.d.) Moreover, the researchers argue that:

> *“This approach allows the individual more freedom and encourages them to bring something to bear on the difficulties they face, something that is routinely withheld within the conventional command-and-control system. This special ingredient is the source of productivity improvements, yet it is something acutely personal and uniquely human.”* (Matt Black Systems, n.d.)

Managers can support their workforce by trusting them in doing their jobs, by maintaining positive dialogues and by setting clear directions (LWB, n.d.). The management should not be put in charge of solving a problem when being actually disconnected from the one doing the work (Mintzberg & Glouberman, 2001). Their role should be one of a coach, mentor or supervisor for good quality care whenever needed (LWB, n.d.).

2.3.4 Patients (individual) Autonomy

Patient-centered healthcare organizations view human interactions as a core pillar of their services and engage with patients as their partners (Newell & Jordan, 2015). This reinforces and validates the principle of responsible autonomy. By recognizing patients as individuals and by enabling them to take informed decisions with regard to their treatment, the responsibility, power, control and autonomy is increasingly ”shifted from government and collectives to the individual, such that the individual is now ‘responsible’ for his or her health or disease” (El-Alti et al., 2017).

Berwick (2009) argues that healthcare should be operating in a more consumer-oriented mode such as in the marketplace. The professional should not be the one to define excellence in the form of a “Trust us; we know best what will help you” approach but in a consumerist “Let us know what you need and want, and that is what we will offer” manner. The following examples by Berwick (2009) demonstrate how power can be shifted to the patient:

> *“(1) Hospitals would have no restrictions on visiting—no restrictions of place or time or person, except restrictions chosen by and under the control of each individual patient. (2) Patients would determine what food they eat and what clothes they wear in hospitals (to the extent that health status allows). (3) Patients and family members would participate in rounds. (4) Patients and families would participate in the design of health care processes and services. (5) Medical records would belong to patients. Clinicians, rather than patients, would need to have permission to gain access to them. (6) Shared decision-making technologies would be used universally. (7) Operating room schedules would conform to ideal queuing theory designs aimed at minimizing waiting time, rather than to the convenience of clinicians. (8) Patients physically capable of self-care would, in all situations, have the option to do it.”*

This suggests that future healthcare organizations delegate more power and authority to individuals and design the entire care process to giving the best experience to patients and their families.

2.4 Outcomes and Costs associated with PCC

The most common interpretation of cost efficiency in healthcare is “in terms of cost-reduction (Paparella, 2016). Coordination of health care by the standardization of work and output is extremely common across organizations and eventually has become its own disease. When institution fail to implement performance measurements, governments and insurance companies tend to control costs and measurements (Mintzberg & Glouberman, 2001) that cannot be standardized because they fulfill the needs of individuals and their individually tailored treatment. The saying “If you can’t measure it, you can’t manage it” is therefore obsolete (Mintzberg, 2012). The problem with this approach is that costs in comparison to benefits are more easily defined. This often leads to a cut back in costs without measuring the benefits. “Efficiency thus becomes confused with economy, and performance deteriorates” (Mintzberg & Glouberman, 2001). To be effective, medicine and management alike would need to balance “evidence-based” and “experience-based” healthcare. It is important to use judgment when it comes to measuring costs and outcomes because the reduction of “measurable costs at the expense of difficult-to-measure benefits” will not produce the desired outcomes (Mintzberg, 2012).

Larsson & Tollman (2017) state that the only way to achieve a more cost-effective system in health care is to give autonomy to professionals. Thus, teams and individuals should be able to judge about the right treatment/ solution without dictation of complex guidelines and rules. According to the two researchers (2017), an interplay of the following 3 factors (Figure 3) in the design of a work environment should lead to better outcomes and use of resources:

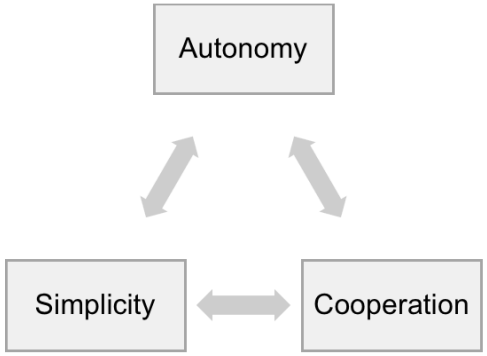

Figure 3: Work Environment – edited by the author (Larsson & Tollman, 2017)

More recently governments seek to spend money more efficiently by adding value in proportion to the costs of a treatment or by "achieving the best outcomes at the lowest cost" (Paparella, 2016). Research suggests that if PCC is realized it should lead to individual as well as economic benefits (Groene, 2011 & Paparella, 2016). The following figure represents the most important benefits according to research:

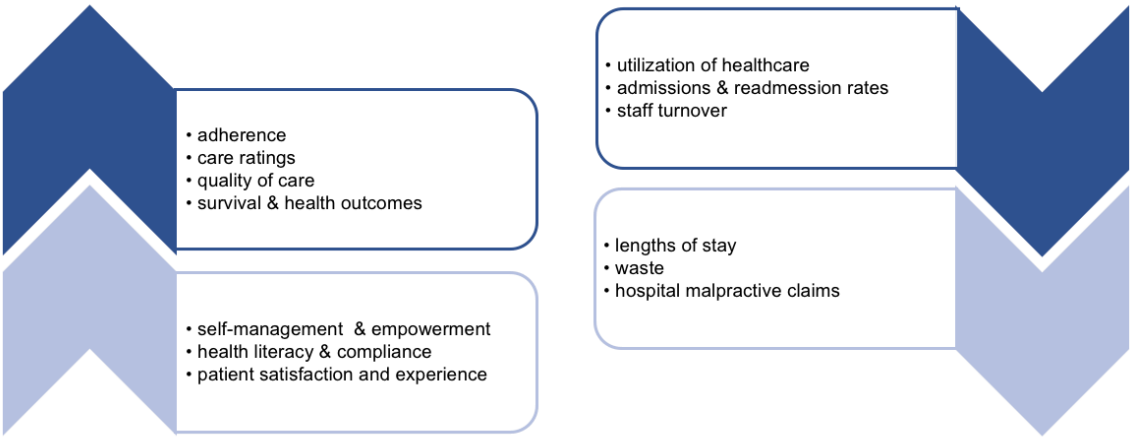

Figure 4: Individual & Economic Benefits of PCC - created by the author

The available evidence shows that an effective implementation of PCC reduces under- and over-use of health care services. Moreover, it can "reduce the strain on system resources and save money by reducing the number of diagnostic tests and referrals" (AHRQ, 2008). Ahmad and colleagues (2014) state that they have "better outcomes, follow appropriate drug treatments, avoid over-treatment, and are less likely to be hospitalized". According to them (2014)

> *"a recent study by Nesta estimated £4.4bn could be saved in the NHS through greater participation and self-management of long term conditions [when] patients are involved in decisions about their own care and treatment and have more knowledge and confidence."* (Ahmad et al.,2014)

Lindgren and Wahlin (2015) state that the "main objective for all health care systems is to maximize the health for the covered population with the limited resources available." They also argue that "payment has been tied to activities rather than treatment outcomes." Health care providers are struggling with the optimization and coordination of their processes to achieve better health outcomes at lower utilization

of resources. By redesigning reimbursement systems based on delivered value (health outcome of a patient per 'dollar' spent) patient outcomes can be improved. A positive example of a reimbursement method which delivers better outcomes for patients is the use of episodes payments. Episode payments are bundled payments that compensate multiple care providers through a single, negotiated payment for all episodic treatments (Lindgren & Wahlin, 2015). Providers and specialists need to define outcomes that should be measured based on the most important needs of patients (Larsson & Tollman, 2017).

Crucial for the effectiveness of PCC is the recruitment and education of health professionals in a satisfactory number which can represent an economic challenge for many healthcare institutions and systems. Besides medical innovation and ageing population, the national budget of many governments would be additionally pressured by the factors recruitment and training (Paparella, 2016). Nevertheless, new roles and new skills of physicians (communication skills in terms of cultural competence, team management, feedback) need to be developed. In the long term this can lead to more effective time management and reduced length of visit since physicians would be able to deal better with patients' concerns and with disadvantaged population groups (Fiscella & Epstein, 2008). The implementation of PCC can lead to a reduction in staff turnover (productivity loss) which in turn could offset the initial costs (Lowery, 2013).

2.5 Measuring of PCC

Measuring PCC is a critical and challenging issue because "fundamental to measurement is the notion that an observed change in a given indicator reflects something about the underlying care delivery and quality." (European Commission, 2017) Thus, the measurement "is problematic owing to the complexity of the relational processes involved as well as the lack of theoretical clarity of the PCC concept." (Levesque, Hovey & Bedos, 2013) Furthermore, Ahmed and colleagues (2014) highlight that without "this conceptual clarity, defining and measuring potential outcomes – and the logic which might link these outcomes – becomes" very difficult (Ahmed et al., 2014).

The following table reflects the complexity of factors that must be taken into account when measuring PCC on a system level (European Commission, 2017):

1. System-level measures (community/ population)	*2. Measures for population health outcomes*
• Amenable mortality (avoidable deaths) • Healthy lifestyles • Population health	• Hospital admissions & readmissions • Community-based care • Patient safety
3. Personal health outcomes	*4. Resource utilization*
• Quality of life • Independent living • Self-management	• Hospital utilization • Residential & long-term care utilization • Primary care utilization • Health care costs • Balance of care
5. Organizational process and system characteristics	*6. User and carer experience*
• Access to care • Hospital use • Care transitions • Care planning • Care coordination	• Experiences • Continuity of care • Supporting holistic goals & outcomes • Communication & information • Shared decision making • Care planning • Care delivery and transitions • Emergencies

Table 2: Complexity of measuring PCC – edited by the author

In a hospital setting, PCC is usually measured by looking at the perspective of the care receiver. According to Yoder & Morgan (2011) “measuring delivery of PCC in a post-acute, inpatient environment is critical for assessing and improving individualized care at the bedside.” In fact, PCC cannot be measured by looking at health outcomes alone. Effective communication throughout the care process is essential to “mitigate a patient’s distress associated with illness and uncertainty” and to make them feel involved, understood, respected, engaged and motivated for change. It is also problematic to measure as the health outcomes may be indirect. The condition might still worsen even though PCC is delivered (Epstein & Street, 2011). Due to the complexity of PCC, it is also important to measure not only the patient’s perspective, but also the opinions of relevant stakeholders such as families, carers or health professionals (Epstein & Street, 2011).

The table below identifies common measures at an organizational level:

	Examples of common measures
Self-efficacy	Patient knowledge; satisfaction with care; decisional conflict; empowerment; confidence to self-manage; responsibility for own care; self-efficacy scales
Behaviour change	Self-care behaviour; medication adherence; ability to cope; level of physical activity; diet; decision to screen; measures of patient and clinician involvement (eg the OPTION scale)
Clinical	Quality of life indicators (eg sickness impact profile, SF36); physical functioning; fatigue; locus of control; condition-specific measures
Health care utilisation	Consultation length; hospitalisations; emergency admissions; relapse rates; cost of training programmes; GP attendances

Table 3: Common measures of PCC (Ahmed et al., 2014)

It is important to recognize that there is no single tool that combines all relevant attributes, aspects and dimensions of PCC across different clinical contexts, populations and countries (Epstein & Street, 2011). The primary research shall indicate which measurements are used to evaluate the delivery of PCC and related factors.

2.6 Concluding Remarks

This chapter reflects the complexity of the study topic and the vast number of factors influencing the implementation and maintenance of PCC. Moreover, it analyzed the most prominent definitions and PCC models that gained overall acceptance according to literature. In the organizational setting the most significant enablers, according to the secondary research analysis, represent:

(1) An open culture that supports change from the bottom-up as well as responsible autonomy of patients and staff, (2) a united workforce that operates autonomous and is given the permission as well as the ability to drive change and (3) the integration of the patient in the design of processes and PCC strategies. (4) All surrounding this is an open and committed management that sets a clear direction, provides effective measuring strategies and makes the necessary resources available to support PCC.

The literature review guided the primary research part and aimed to identify relevant underlying theories and management strategies of PCC. The previously defined principles served as basis for the primary research analysis. The next section will assess whether they are applied in varying hospital settings as facilitators of PCC.

3 Research Setting: Case Studies

In this chapter background information on the study sites will be presented which is important for the context of this analysis. The data for the case studies was obtained using a variety of sources, including documents that were published by the organizations themselves, such as annual reports, and independent publications of country statistics or national health institutes/ systems. The selection was guided by the following two principles. Firstly, organizations that have demonstrated excellence regarding PCC or similar innovative approaches were identified. Secondly, final sites which offer a broad perspective of the diversity of European health systems, and organizational differences with regard to levels of decentralization and funding arrangements were chosen for the analysis. Finally, a total of four hospital organizations and health centers across Europe were included in this research. England, Austria, Finland and the Netherlands and Sweden have been selected as exemplars to illustrate rather than generalize the practice of PCC in the more developed countries within Europe. This inter-European comparison should provide a bigger picture of structures and strategies both within and across countries and cultural differences in order to identify areas for improvement as well as opportunities for the delivery of PCC (Garratt, Solheim & Danielsen, 2008).

The following table provides a more detailed overview about the researched hospital organizations. Hospital 4 in the Netherlands has been anonymized and the Karolinska University Hospital has been excluded:

COUNTRIES	*STUDY SITES*
England	Northumbria Healthcare NHS Foundation Trust
Austria	University Hospital Graz
Finland	COXA - Hospital for Joint Replacement
Netherlands	Hospital 4 (anonymized)
Sweden	Karolinska University Hospital (subsequently excluded)

Table 4: Study Sites

3.1 Northumbria NHS Foundation Trust (England)

The Northumbria Healthcare NHS Foundation Trust provides health care services for 500.000 people in the region North Tyneside and Northumberland from 11 sites (NHS, 2017). More detailed information on the different sites can be obtained from the figure below:

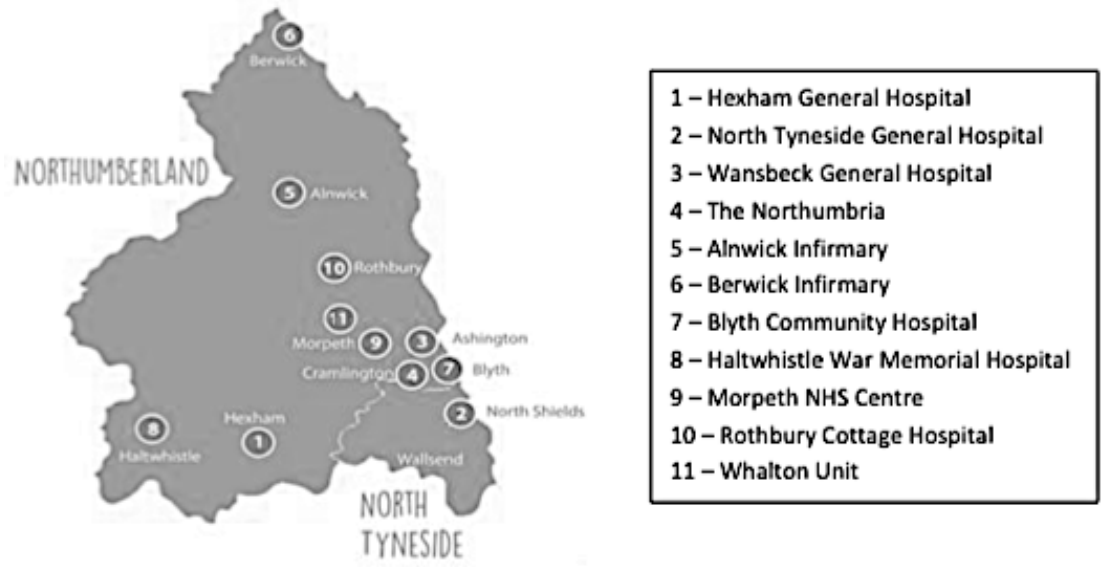

Figure 5: Northumbria NHS Foundation Trust – Sites (NHS, 2017a).

The Trust has been identified as an organization that demonstrated measurable excellence in creating value and outcome for patients. It has “what is seen as the most comprehensive patient experience programme in the NHS” (NHS, 2017a/b). A robust measurement framework exists including inpatient real-time surveys with a feedback to the wards within 24h, short questionnaires that are answered by patients when they leave the organization and detailed at-home surveys (NHS Improvements, 2017; NHS, 2017a/b). The Care Quality Commission has rated the Trust as “outstanding” and in 2016, “it was named as the most open and transparent organisation in the NHS in England” (NHS, 2017c). Moral concepts such as patient first, respect, “everyone’s contribution counts”, accountability, responsibility, and high quality and safe care are reflected throughout the organizational statement of values and structure. The Trust’s organizational culture recognizes the importance of staff wellbeing and supports their continuous commitment in dealing with increasingly rigorous performance targets (NHS, 2017a/b). Even though the pressure on budgets is continuously increasing, Northumbria was one of the few trusts to remain financially

balanced and achieved a surplus of £ 14.8 million for the financial year 2016/2017. The strong financial position reflects the financial strength of Northumbrias' management. In achieving these targets, it also creates confidence in its performance at national level thus allowing the organization to gain more space and flexibility to invest in its more direct patient services, such as patient-focused care. Northumbria used patient-focused care as a specific management strategy which enabled them to better balance its an organization's assessment of patient needs against national top-down performance targets. Nevertheless, financial challenges and concerns remain present in the current economic climate (NHS, 2017a).

3.2 University Hospital Graz (Austria)

The Austrian health system is characterized by the interplay of numerous stakeholders whose responsibilities are regulated by law. Healthcare in Austria is hospital-oriented, and according to a European comparison of 2010 the hospital frequency was much higher than EU average (BMG, 2013).

As one of three public university hospitals in Austria, the University Hospital Graz represents an important center of medicine (LKH-Univ. Klinikum Graz, 2017). The hospital's goals and priorities are the optimization of patient-related treatment processes, integrated patient care, humanity and respectful communication, quality assurance and control as well as the thoughtful use of financial resources. The major goal defined in 2009, is the implementation of integrated care in which the patient is seen as a unique human being with individual needs and in which a proactive, appreciative and respectful communication or interaction is realized (Brunner, 2009). This objective is also reflected by the mission statement saying that a modern treatment of the patient in its center includes a biopsychosocial concept with interdisciplinary and inter-professionally personalized medicine (University Hospital Graz, 2017). By taking into account the different responsibilities and by ensuring that professional groups work together constructively the above-mentioned goals should be realized. Achieving these goals involves a major organizational and logistical challenge, which is implemented by merging functional centers or organizational units (Brunner, 2009).

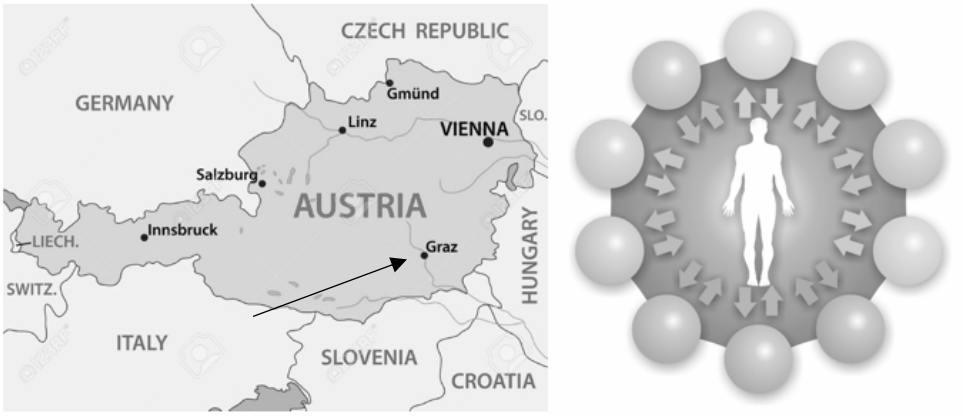

Figure 6: Map of Austria & Mission Statement (University Hospital Graz, 2017)

3.3 Coxa - Hospital for Joint Replacement (Finland)

In terms of accessibility, scope and quality the Finish healthcare system is internationally acclaimed (Finland Health, 2016; Coxa hospital, 2014). The system in Finland is highly decentralized and is mainly tax-financed (Coxa hospital, 2014).

Coxa was the first specialist facility at the campus of the Tampere University Hospital built as a “hospital within a hospital” (Coxa hospital, 2014). Principles of the new Coxa model include (Rechel et al., 2009):

- the creation of care pathways, amongst the first in Europe,
- the delegation of work process management to front-line staff to increase their motivation,
- the systemization of processes and
- the adoption and integration of lean management principles across all care pathways.

The aim is to achieve economies of scale and improved effectiveness by this process of systematized clinical practice (Rechel et al., 2009). Coxa is now the leading hospital in Scandinavia and Finland specializing in joint replacement operations. In terms of patient safety and outcomes, it is among the very best in international comparison and has a strong reputation as a leading center of excellence. As an illustration of its excellent patient outcomes it has complication rates below 0,2 % (FinlandCare, n.d.).

As a partly-private organization which provides predominately public services, and with its good rankings Coxa represents a valuable participant. Public-private partnerships are regarded as having great potential for the health and the business sector to strengthen innovativeness and competitiveness in healthcare (Nordic Council of Ministers, 2010). Coxa tends to demonstrate this effect.

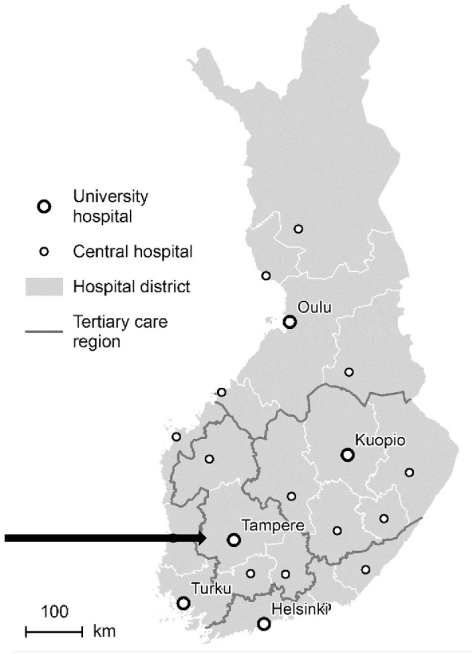

Figure 7: Hospital districts, Finland (Huotari et al., 2017)

3.4 Hospital 4 (The Netherlands) - anonymized

The healthcare system in the Netherlands differs from most other European countries. Approximately 90% of the hospitals in the Netherlands operate as non-profit, semi-public institutions. Hospital services are increasingly decentralized and medical specialists are getting more and more involved in hospital management. Tariffs are negotiated on a competitive basis between insurers and hospital organizations. Healthcare providers operate under the principle of efficiency and quality care to attract customers as well as insures by improving and by maintaining competitive advantage (Rechel et al., 2009). In general, the Netherlands is firmly moving towards an open market model of healthcare provision. The market system Is gradually shifting their focus on full patient experience instead of aiming at cost efficiency and clinical outcomes.

The hospital group in question was formed as a merger between an older established hospital and a new campus model hospital providing the basis for a care model that integrates primary, acute and social care, with a specific focus on elderly care and post discharge rehabilitation. In this context the central theme of the merger was a strong statement of values reflecting the importance of PCC. However, the initial incentive was a combination of better managing a difficult financial outlook and preparing for the rigors and risks of a market economy in healthcare. At the request of the hospital, references have been omitted that otherwise would have named the organization.

3.5 Karolinska University Hospital (Sweden)

The Karolinska University Hospital is the largest university hospital in Sweden and one of the biggest single-site hospitals in Europe (Rechel et al., 2009). It was created in 2004 by merging the Huddige University Hospital and the (old) Karolinska Hospital. In the first years after the merger the hospital was struggling at the financial as well as at the organizational and cultural level. A vertical clash of management and professional groups hindered the integration. Change was not accepted by the staff due to traditional managerial top-down approaches. Managers/ leaders were seen as formal actors who dictated formal mandates. This vertical conflict between clinical staff and top management was overcome through shared leadership, informal leaders and by the introduction of bottom-up management in order to drive change (Choi, 2011; Choi et al., 2010).

Today, it is known for its highly progressive medical care. Moreover, the hospital strongly focuses on enhancing patients' involvement in their care. With their new operating model, Value-Based Health Care (VBHC), it is trying to address challenges like a fragmented organization, inconsistencies in the quality of care and economic problems (Karolinska University Hospital, 2016). The concept of VBHC has become particularly established in healthcare organizations in Sweden and is one of the major approaches of the Karolinska Hospital (Nilsson et al., 2017; Porter & Lee, 2013). The value to the patient can be increased by a stronger focus on the patient's entire journey through the healthcare services. The patient's involvement in the decision-making process concerning their treatment should be enhanced and medical outcomes should be improved (Karolinska University Hospital, 2016).

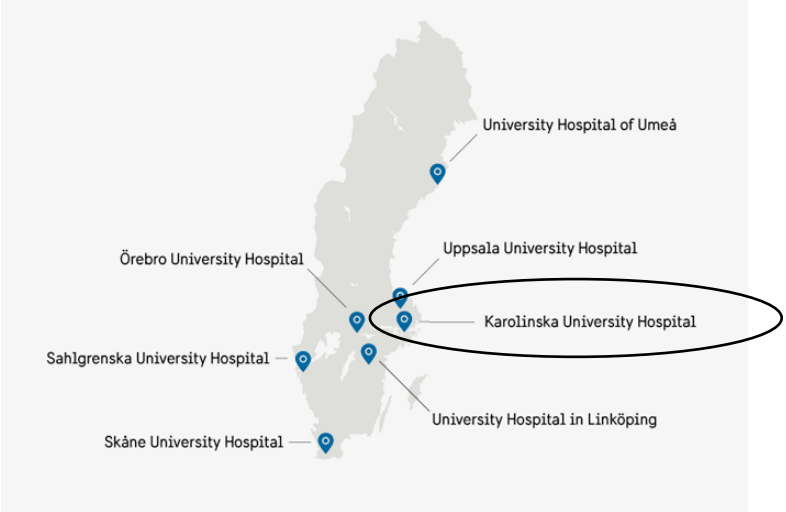

Figure 8: Karolinska University Hospital (Symbiocare, n.d.)

3.5.1 Criteria for Exclusion

The Karolinska University Hospital is successfully dealing with change and has gained a strong reputation with is preliminary VBHC approach. This is widely promoted as being an approach that shifts from a typical teaching hospital clinical focus to a more embracing 'patient experience' model. It has many similarities with PCC initiatives and the definitions used in this study. Its participation would have been very valuable for the aim of this survey. Initially there was a discussion of creating a synergy between this master thesis and a PhD thesis project on VBHC. Despite early discussions with entitled Karolinska staff they were unable to respond adequately within the timescale necessary. This is a disappointment as VBHC is developing quickly as part of the evolution of its patient focused care strategies. Nevertheless, its promotional literature and video presentations have been useful as background 'grey' resource material.

3.6 Concluding Remarks

The adaption of PCC models "has taken different shapes across Europe: it is interesting therefore to see how different health systems are pursuing their own value agenda" (Paparella, 2016). The relevance of the sites is given due to the following main characteristics:

- Northumbria is a prime example of how to implement person-focused care throughout the organization. PCC seems a critical factor in its success that is

reflected in the award one of the “outstanding” Trusts in the NHS. It is widely seen as an exemplar in this field as described later.

- The University Hospital of Graz represents the German speaking area and culture with a very different health system in comparison to, for example, England. An explicit patient-centered framework in Austria has not been developed. Graz defined as one of his goals the implementation of integrated care in 2009. Whether this goal has been successfully achieved or not will be further evaluated in the primary research part.
- The Scandinavian culture of Coxa is highly interesting with respect to this thesis as it represents a management style that is more motivating, empowering and value-focused and according to literature better suited to deal with the societal challenges. Coxa is operating with humanitarian priorities at its core that reflect the Scandinavian culture which is characterized by flatter less hierarchical structures and greater local front-line autonomy (IFM, 2006).
- Hospital 4, in the Netherlands, wished to be anonymized, therefore no further details about organizational structures and processes were shared above. The hospital director’s perspective represents an independent opinion of a leader operating in one of the most innovative health care systems within Europe and within a hospital noted for its commitment to quality.

Although the study sites represent different countries of Europe and their concepts, strategies and core drivers differ at first sight there are also significant similarities. All are dealing with challenges such as the ageing population and the rising levels of chronic illnesses and are continuously aiming to deliver value for the patient during a period of fiscal austerity. Additionally, all of the organizations seek to involve health care professionals as leaders to help overcome previously fragmented and bureaucratic organizational structures. Moreover, the new focus on PCC is perhaps the most promising way of involving the public and engaging them to contribute to more effective and innovative ways of providing healthcare.

The primary research aims to identify if enablers of PCC can be transferred to other health systems to enhance their services and to be able to deal with arising conflicts more effective. Collaboration and the sharing of experience can help to develop tailored set improvements. In addition, it will analyze the differences of PCC in terms of values, culture and corporate identity within the various settings in greater detail.

4 Methodology

The following chapter will provide a brief description of the research design, the data collection methods, and plans for the data analysis used for the primary research survey. Moreover, criteria for the selection and composition of the sample as well as for the inclusion and the exclusion are presented in this chapter.

4.1 Research Design

4.1.1 Mixed Method Approach

The mixed method approach was chosen for the following research. It combines the collection of quantitative and qualitative data. It is used when a researcher attempts to broaden understanding by incorporating both approaches in one single survey to offset the weaknesses of each and to gain a more in-depth understanding (Tashakkori & Teddlie, 2010). To put it in another way, it is an “opportunity to compensate for inherent method weaknesses, capitalize on inherent method strengths, and offset inevitable method biases” (Harwell, 2011).

Characteristic for the **quantitative research approach** is the belief that reality can be observed and measured objectively. This builds on the assumption that there exists one single “truths” that is independent of human beliefs and perceptions. Strengths include the minimization of confounding, replicability, objectivity and the generalization of findings if samples are representative and large enough (Harwell, 2011; Tariq & Woodman, 2013). The researcher aims to remain objective by setting aside his or her perceptions, biases and experiences when conducting the research. Common instruments include surveys or tests for data collection and statistical testing of hypotheses (Harwell, 2011). This research approach is less suited to explain complex cultural or social phenomena’s (Tariq & Woodman, 2013).

The qualitative research focuses on understanding and discovering thoughts, perspectives and experiences of the participants. The aim is to give meaning, make sense and interpret social constructs or “truths” (Harwell, 2011). It acknowledges that personal views and beliefs as well as the social context shape multiple realities (Tariq & Woodman, 2013) and therefore allows a detailed analysis of a topic by collecting data through interviews, ethnographic work and case studies, amongst others. The

research process is characterized by an open and flexible naturalistic setting that allows an interaction with few boundaries. The outcome of qualitative studies largely depends on the researcher and the given situation. Biases, perceptions and experiences of the researcher cannot be set aside and therefore the generalization and replication of the results are not the general goals of this research approach (Harwell, 2011).

By combining the two methods it is possible to obtain more synergistic and complete data within one investigation than by separating the collection and analysis of qualitative and quantitative data (Wisdom & Creswell, 2013). The following definition of Johnson et al. (2007) is used for the purpose of this thesis:

> *"Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e. g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration."* (Johnson et al., 2007)

According to Wisdom & Cresswell (2013) the characteristics described below should be included into mixed methods studies:

1. Collection and analysis of close-ended quantitative and open-ended qualitative data.
2. Using appropriate methods and procedures for the collection and analysis of both methods e.g. appropriate size of the sample.
3. Integration of the data during the analysis or discussion.
4. Implementing procedures concurrently (with the same sample) or sequential (with a different sample).
5. The procedures should be framed in a way that they seek to gather different perspectives to one topic within theoretical or philosophical research models.

4.1.2 The Explanatory Sequential Design

An Explanatory Sequential Design, was chosen in the present research, which is composed of two research phases: “(1) an initial quantitative instrument phase, followed by (2) a qualitative data collection phase, in which the qualitative phase builds directly on the results from the quantitative phase.” (Wisdom & Cresswell, 2011)

This means that both datasets (quantitative and qualitative) are analyzed initially separately, followed by another phase when both data sets are combined, related and compared (Cresswell & Clark, 2011; Harwell, 2011). Typically, one data is embedded into the other and therefore given more weight (Harwell, 2011). The following study will be a predominantly qualitative study with a small quantitative component (Tariq & Woodman, 2013). The weight is given to the qualitative approach since the aim is to analyze perceptions and viewpoints of individuals. The initial quantitative research phase is followed by a second phase of qualitative data collection with the same (concurrent) sample (Clark & Cresswell, 2007). In the interpretation phase, both methods are integrated into each other by merging both datasets and discussing them (Tashakkori & Teddlie, 2010; Cresswell, 2007). The aim is to analyze and understand the theoretical background and different perspectives of participants and to gain a deeper understanding of the underlying processes of PCC (Cresswell, 2007). This research design allows to analyze complex models as it is the case in the present research. Other strengths of the research design are that multiple perspectives can be derived from one data set and the data collection period is shorter. Weaknesses represent the amount of time needed to analyze the data and available resources (Harwell, 2011).

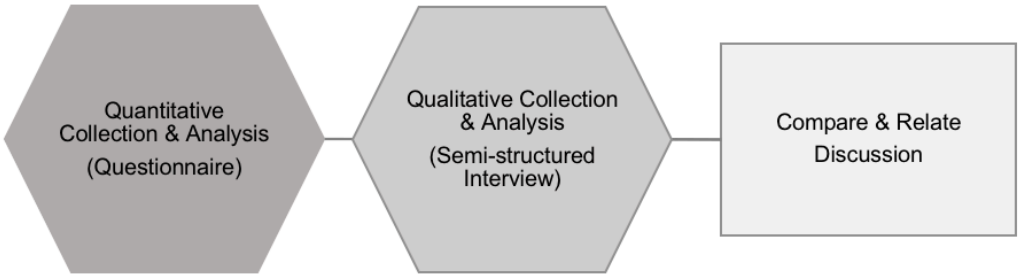

Figure 9: Explanatory Sequential Design - edited by the author (Sauro, 2015)

4.2 Sample and Sampling Plan

The goal of this thesis is to gain a deeper understanding of the healthcare leaders' and professionals perspectives regarding PCC efforts and strategies. Conflicts, solutions and common success factors between top-down directed management and local autonomy should be reviewed.

The participants received an introductory email with the main outline of this thesis and a request for participation. Their participation required being part of a two-part survey: the first part comprised the completion of a questionnaire, including a confidentiality clause as required by the thesis guidelines, and the other part involved a short semi-structured personal interview.

After the participants' agreement was received, an interview guide was delivered (Annex 1 & 2), including the questionnaire and the confidentiality agreement. The questionnaire (n=8) and confidentiality agreement were completed in the first phase. After the analysis of the questionnaire, a series of semi-structured telephone interviews (n=9) was conducted with the same sample. At this point, it is relevant to note that one interview partner did not want to participate in the questionnaire. The timeframe for the data collection, quantitative and qualitative, was April to June 2018.

4.2.1 Criteria for Sample Selection, Study Inclusion and Exclusion

Due to the diverse fields of activity in hospital organizations, it was initially necessary to determine areas of work that might represent the state of PCC in the organization. For this purpose, four fields of work were determined in order to select suitable participants, who are capable of providing information about PCC. The defined target group were managers, nurses, clinicians and other health care professionals. The deliberate selection of participants from different fields enables a more detailed review of PCC. In the next investigation step, it was necessary to select persons who have proven experience with PCC. CEOs, directors and managers were directly contacted and asked to participate. They were selected based on their recognized expertise, either as organizational leaders or as experts working to develop or implement new strategies. They received an introductory email and a main research outline which explained the content and scope of this study. Moreover, the selected target group

was asked to provide advice on the selection process of staff for the purpose of this study. Preferably the participant group of one hospital site should consists of one manager, one clinician and two nurses.

In total twelve departments or organizational units of the selected health organizations (Annex 4) were contacted to link this research with the appropriate staff who might participate. The goal target size was 15 interviews. Four from each of the main study sites in Austria, Finland and England and three additional external perspectives of Hospital 4 or the Karolinska University Hospital. Due to time constraints, the goal target size could not be reached in Coxa and Northumbria despite an early start to the process. Karolinska was excluded for reasons previously given.

4.2.2 Nature & Sample Size

Eight people completed the questionnaire and nine people participated in the interview. Two nurses were interviewed in Coxa, Two managers with nursing background in Northumbria (one for the quantitative research), one Hospital Director in Hospital 4 and four participants of all professions in Graz (two managers, one manager with nursing background and one clinician). The table below provides more information on the included sites and the number of participants for the quantitative and qualitative research:

ORGANIZATION	TARGET POPULATION		QUANTITATIVE RESEARCH SAMPLE	QUALITATIVE RESEARCH SAMPLE
Northumbria	Nurse	X		
	Manager*	X	1	2
	Clinician			
Graz	Nurse			
	Manager*	X	4	4
	Clinician	X		
Coxa	Nurse	X		
	Manager		2	2
	Clinician			
The Netherlands	Nurse, Manager or Clinician	X	1	1
In Total			**8**	**9**

**manager with nursing background*

Table 5: Study sites/ sample for the master thesis

In table 6, background information about the included professions as well as their identifications for the qualitative research analysis is provided:

PROFESSION	NUMBER
Manager with nursing background (M/N)	3
Manager (M)	2
Clinician (C)	1
Nurse (N)	2
Hospital Director (HD)	1
Other Health Care Professionals	0
In Total	**9**

Table 6: Working areas/ professions of the sample

4.3 Part 1: Quantitative Research Design

A questionnaire was developed as a basis for the qualitative research tool (interview) to evaluate the state of PCC in the different contexts, care settings and professional groups. The European Commission (2017) recommended using a set of indicators to measure a concept as complex as PCC. As a starting point, 11 variables (Table 7) were defined which were then underpinned with statements based on the literature review. The participants were asked to rate their level of agreement with the statements/ operational definitions below using a Likert-scale from one, “strongly disagree”, to five “strongly agree”. Likert scales are used to measure views, attitudes or perceptions of people and provide a range of possible responses to a given statement (Jamieson, 2004). For the purpose of this thesis, the following operational definitions were used:

VARIABLE	OPERATIONAL DEFINITION
Patient autonomy	1) “Healthcare professionals take patients’ preferences regarding the treatment options into account” (Berghout et al., 2015*). 2) “Patients are supported in setting and achieving their own treatment goals” (Berghout et al., 2015).
Teamwork	1) “Healthcare professionals work as a team in care delivery to patients across departments and professional disciplines” (Babiker et al., 2014; European Commission, 2017*).

	2) “Organizational units work together in teams to manage and educate patients about their disease and to give patients the autonomy to exercise judgment concerning their treatment” (Larsson & Tollman, 2017*).
Coordination of care	“Patients experience coordinated care based on clear and accurate information exchange between relevant healthcare professionals” (NICE, 2012).
Involvement of family members/carers	“Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care” (NICE, 2012).
Healthcare professional education	“Adequate training and education concerning PCC is provided by the organization” (Schaller, 2017*).
Commitment of management & leadership	1) “The senior leadership at the level of the CEO and board of directors is committed to implement PCC” (Schaller, 2017*). 2) “A strategic vision is clearly and regularly communicated to every member of the organization” (Schaller, 2017*).
Openness of management	“A primary aspect of the management of the organization is openness, transparency and accountability in all their operations and communications” (Newell & Jordan, 2015*).
Local autonomy	1) Healthcare professionals have the ability to initiate the implementation of PCC strategies (Larsson & Tollman, 2017). 2) “Authority is devolved to professionals to find other innovative and creative responses to patient needs” (Mintzberg, 2012*).
Standardization of procedures	1) “Procedures are highly standardized and a high level of control of measurements exists” (Mintzberg, 2012*). 2) “Managers use traditional organizational mechanisms such as detailed rules and guidelines and key performance indicators (KPIs) to regulate work processes of employees” (Larsson & Tollman, 2017*).
Financial resources	PCC leads to improved health behavior of patients and therefore to a decreased use of resources (Groene, 2011 & Paparella, 2016*).

Table 7: Operational Definitions PCC (*edited by the author)

4.3.1 Data Collection (Questionnaire)

The aim of this questionnaire was to obtain additional information about the organization' values, the managerial strategies and the state of PCC in the organization. The same type of survey was conducted in all countries. All organizations received English language questionnaires, except Austria. In the case of Austria, the questionnaire was translated into German following a retranslation into English. The target group was not a sufficiently large sample to make a generalization about the organization which was not the purpose of this questionnaire. The aim was to gain an idea and to collect additional data in feasible way previous to the main method of expert interviews. The data collected by means of the questionnaire should later on help to build the conversations on these findings.

4.3.2 Data Analysis

Typically, as in the present research, Likert-type-rating offers 5 response categories. It is a type of ordinal data collection since the statements have a rank order. The intervals or ranks can't be presumed as having equal value since they express a feeling or a perception. Therefore, the mean and standard deviation aren't appropriate measurements for ordinal data which represents statements (as numbers). In the statistical analysis ordinal data should be analyzed with the median or mode as a measurement of the central tendency. Response frequencies and percentages can be used to describe ordinal data. The Mann–Whitney U-test or the Spearman's Rho are also considered as appropriate measurements for the statistical analysis of ordinal data because they measure data of ratio or interval level (Jamieson, 2004).

The analysis was done using Microsoft Excel 2016 (macOS) and IBM SPSS Statistics 25. For the variables with two definitions the means were calculated per variable and also per organization to provide an overall picture of the situation in different hospital settings. The mode and the Mann–Whitney U-test were not calculated due to the small target size. The detailed analysis of the SPSS calculation is attached (Annex 5 & 6). For the aim of the present research, as previously stated, it was not relevant to do an extensive quantitative statistical analysis, due to the fact that the target size was not large enough to make a generalization and the answers required highly nuanced judgements of the participants. The major goal of the quantitative research part was to collect additional information on the state of PCC in the respective organizations from the participants' point of view prior to the interviews.

4.4 Part 2: Qualitative Research Design

The target group was the same as for the quantitative survey. A semi-structured personal interview was conducted via telephone. Due to the widely geographically distribution of the organizations and the busy target group it was not possible to conduct face-to-face interviews. According to Mathers, Fox & Hunn (2007) it is an equally effective method and an economical way to conduct a qualitative study via telephone. The questions to be covered were attached to the interview guide (Annex 1). A semi-structured interview approach was chosen to provide some sort of structure, but also the flexibility to go deeper into to details when needed (Keller & Conradin, 2018). The individuals were given the opportunity to ask questions beforehand. Furthermore, they were able to prepare for the interview to provide more comprehensive and valuable data about their organizations.

4.4.1 Data Collection (Interview)

The interviews were conducted between April and June 2018 by one single researcher. They were audio-recorded and transcribed. The interviews conducted in German (Austria) including the related transcripts were translated into English. To protect the anonymity of the participants the recordings, transcripts, translated versions and the confidentiality agreements are attached in a supplementary folder. The individuals agreed that their participation was on a voluntary basis and that all their contributions will be anonymized. By arrangement, it was also possible to anonymize the organization, as it was the case in Hospital 4. Participants had the opportunity to withdraw at any time or refuse to answer any question without any consequences of any kind.

4.4.2 Data Analysis

The interviews were recorded by means of a digital recording device and were then transcribed according to the transcription rules of Kuckartz (Dresing & Pehl, 2018). Transcription rules determine how the spoken language is transferred into written form. Unfortunately, information losses are inevitably associated with this transformation. Depending on the research matter and analysis, it varies widely which losses are considered acceptable and which are not. There are plenty of transcribing methods that mainly differ in terms of “if” and “how” nonverbal or verbal features, such

as pauses, laughter, stretched speech, dialects or facial expressions, are transcribed (Kuckartz, 2014). Deliberately simple and quick transcription rules that clearly smooth the language and focus on the (semantic) content of the speech were applied for this thesis (Dresing & Pehl, 2018).

A content-reductive evaluation was conducted for the evaluation of the transcripts using a multi-level method of classifying and coding (Dresing & Pehl, 2018). Therefore, by means of the grounded theory dimensions and common data or themes were identified and then codes (conceptual labels) were developed to group similar responses. The purpose was to look for common characteristics that were addressed by the individuals and also described as “sorting out the structures of signification” (Draper, 2004). In the first coding process the main text passages from the transcripts were deductively reduced and in the next step assigned to the main categories (Kuckartz, 2014). The aim was to reduce the material in a way so that only essential significant and essential passages which are related to the topic of this work would remain (Schmidt, 2003). In the next step, data was collected and interpreted adequately so that meaning was given to the result as well as to adopt explanations about the findings (Draper, 2004). On the request of one of the participants (N-M/N2), an additional step was required to validate the study findings. The key statements that were included in this thesis were sent back to the participant to make changes if considered necessary. The revised version is included in the supplementary folder.

The following figures represent how the various organizations and individuals working for it can be identified in the result section:

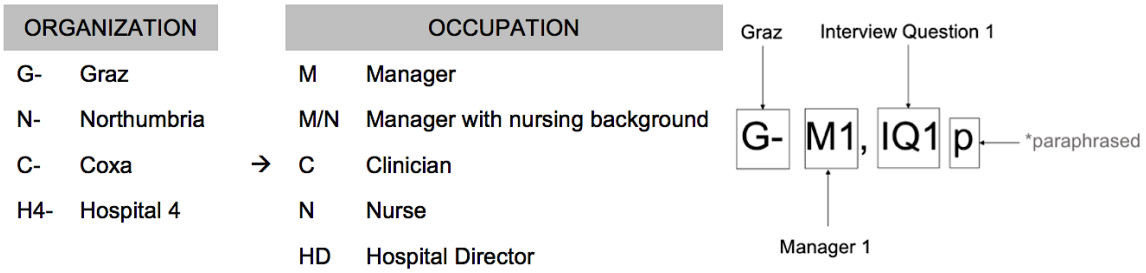

Figure 10: Identification of participants (organization, position, interview question)

5 Results

5.1 Quantitative Research

5.1.1 Demographic Analysis

Twenty people from twelve different organizational units (Annex 4) were contacted and asked to participate and/ or to recommend suitable staff for this survey. Four participants from Graz, two from Coxa and one person respectively from Northumbria and Hospital 4 returned the completed questionnaires. A total sample of eight people was achieved in the survey resulting in a correspondence rate of 40%. The participation included mainly managers, nurses or managers with nursing background. Six of the participants work in leading positions within their organizations, four of them were or are still occupying a clinical-oriented role. Six of them received specific training in regard to PCC.

The following table summarizes the detailed data of the quantitative sample:

QUANTITATIVE SAMPLE SIZE	
Managers with nursing background (Graz/ Northumbria)	2
Managers (Graz)	2
Nurses (Coxa)	2
Clinician (Graz)	1
Hospital Director (Hospital 4)	1
In Total	**8**

Table 8: Quantitative Sample

The quantitative research aimed to evaluate the state of PCC within the organization prior to the conducted interviews. The aim was to enable the researcher to gain a broader perspective of the participants' opinions concerning the state of PCC within the organizations. The dimensions used for the quantitative research (questionnaire) are illustrated in figure 11 below. The respective definitions can be obtained from Table 7 in chapter 4.3 (Part 1: Quantitative Research Design).

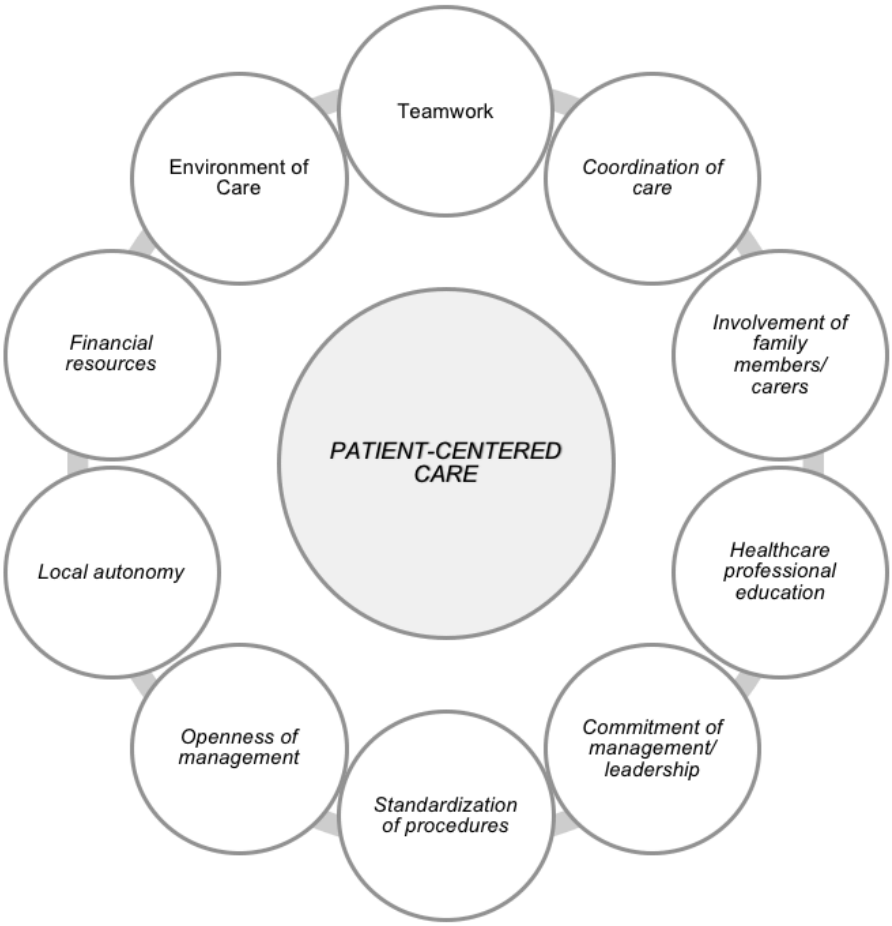

Figure 11: Dimensions of PCC - created by the author

5.1.2 Quantitative Results

The participants were asked to rate their level of agreement on a Likert Scale from one, “strongly disagree”, to five, “strongly agree”. An average or mean score was calculated for the all the individuals per organization and for the respective dimensions (Table 9). Higher values are assigned to stronger agreement and lower scores reflect the level of disagreement (Colosi, n.d.). Of a maximum of 50 points Northumbria scored the highest with 42.5 and Graz the lowest with 36.1. points. Coxa and Hospital 4 had similar results, as illustrated in the following table:

ORGANIZATION	*NUMBER*	SCORE
Northumbria	1	42.5
Graz	4	36.1
Coxa	2	39.4
The Netherlands	1	40.0

Table 9: Study Sites (Questionnaire)

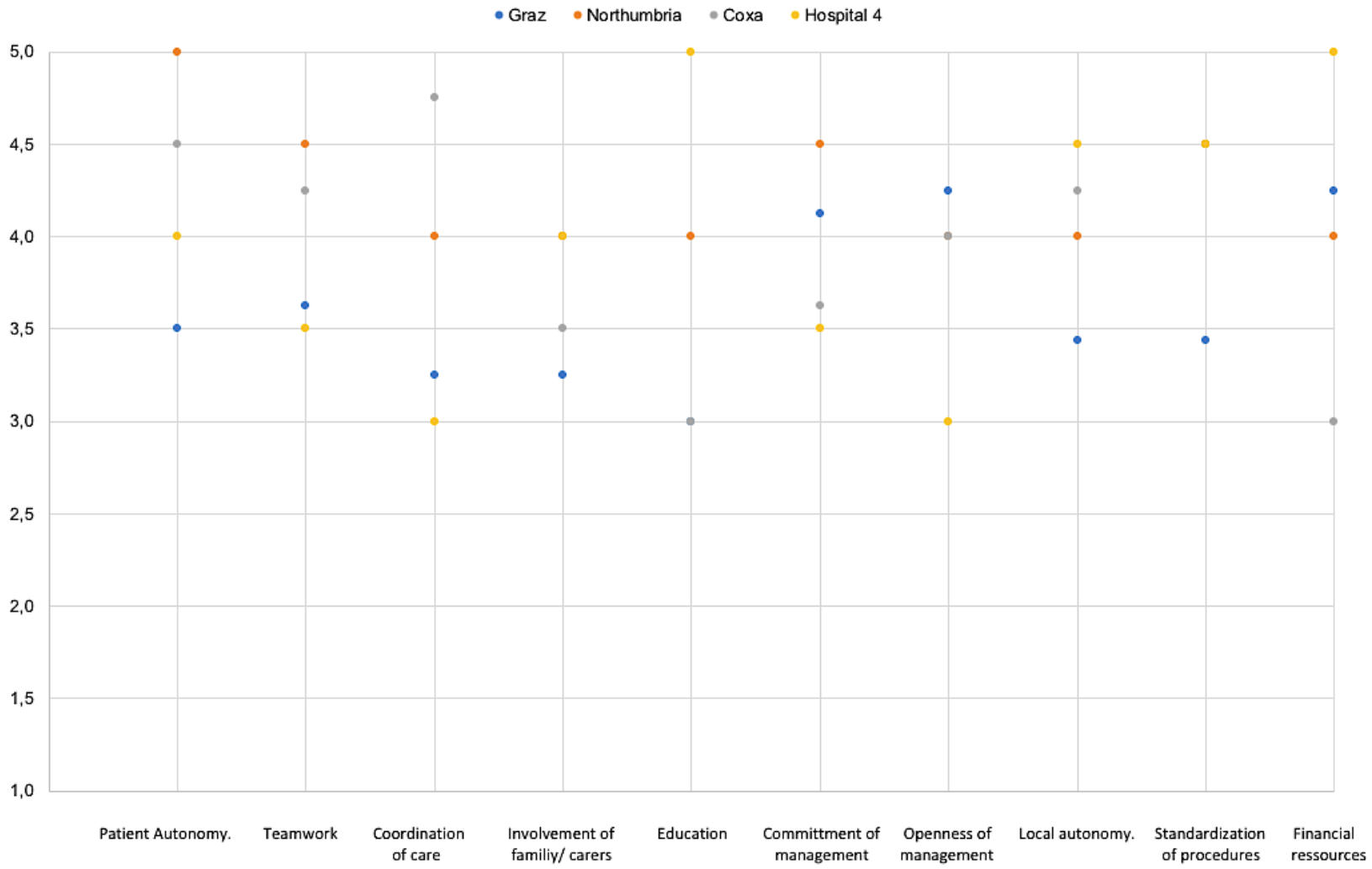

Figure 12: Level of agreement (Dimensions PCC)

Figure 12, on the previous page, shows that the mean scores for the respective dimensions are between “3 – neither agree nor disagree”, “4 – agree” and “5 – strongly agree”.

Starting with the result of Northumbria, it can be seen that the participants assigned the highest level of agreement to the dimension of “patient autonomy”. “Teamwork”, “a committed management” and “standardization of resources” were ranked between four and five, thus given a high level of agreement. All of the other dimensions were rated with four, “agree”. Northumbria was the organization with the highest total score.

The second hospital questioned, the University Hospital Graz, rated most dimensions with three, “neither agree nor disagree”. The participants agreed on “an open and committed management”. Furthermore, “financial resources” can be decreased by the implementation of PCC according to them. Graz was the organization with the lowest total score.

Thirdly, the Finish hospital site Coxa evaluated the dimension of “education of healthcare professionals“ and “the decrease of financial resources” by the implementation of PCC rather neutral, with “three”. A high level of agreement was assigned to the variables “coordination of care”, “patient autonomy” and “the standardization of resources”. The other dimensions achieved scores between 3.5 and 4.5.

Hospital 4, in comparison to the other organizations, reached a strong level of agreement on the “financial resources” variable with five. Moreover, “the education of health care professionals” was given the highest score. “Local autonomy” and “the standardization of resources” also received high levels of agreement with 4.5. “Coordination of care” and “the openness of management” were rather neutral.

To summarize, it can be said that all of the organizations ranked “the involvement of family members and carers” between three and four. Three of the organizations, except Graz, assigned a strong level of agreement to the variable “standardization of resources”.

5.1.3 University Hospital Graz

Graz was the only organization that met the goal target size of four participants. As figure 13 demonstrates, a larger variance of views was observed in comparison to the picture above. In fact, no conclusions can be drawn about the state of PCC as the sample size was not sufficient to be significant. In addition, the fact that the questioned participants differ in their profession also influences the results. However, the observed high degree of variation between the participants reflects the secondary research as well as the qualitative research outcome of a high fragmented organization and different levels of integration.

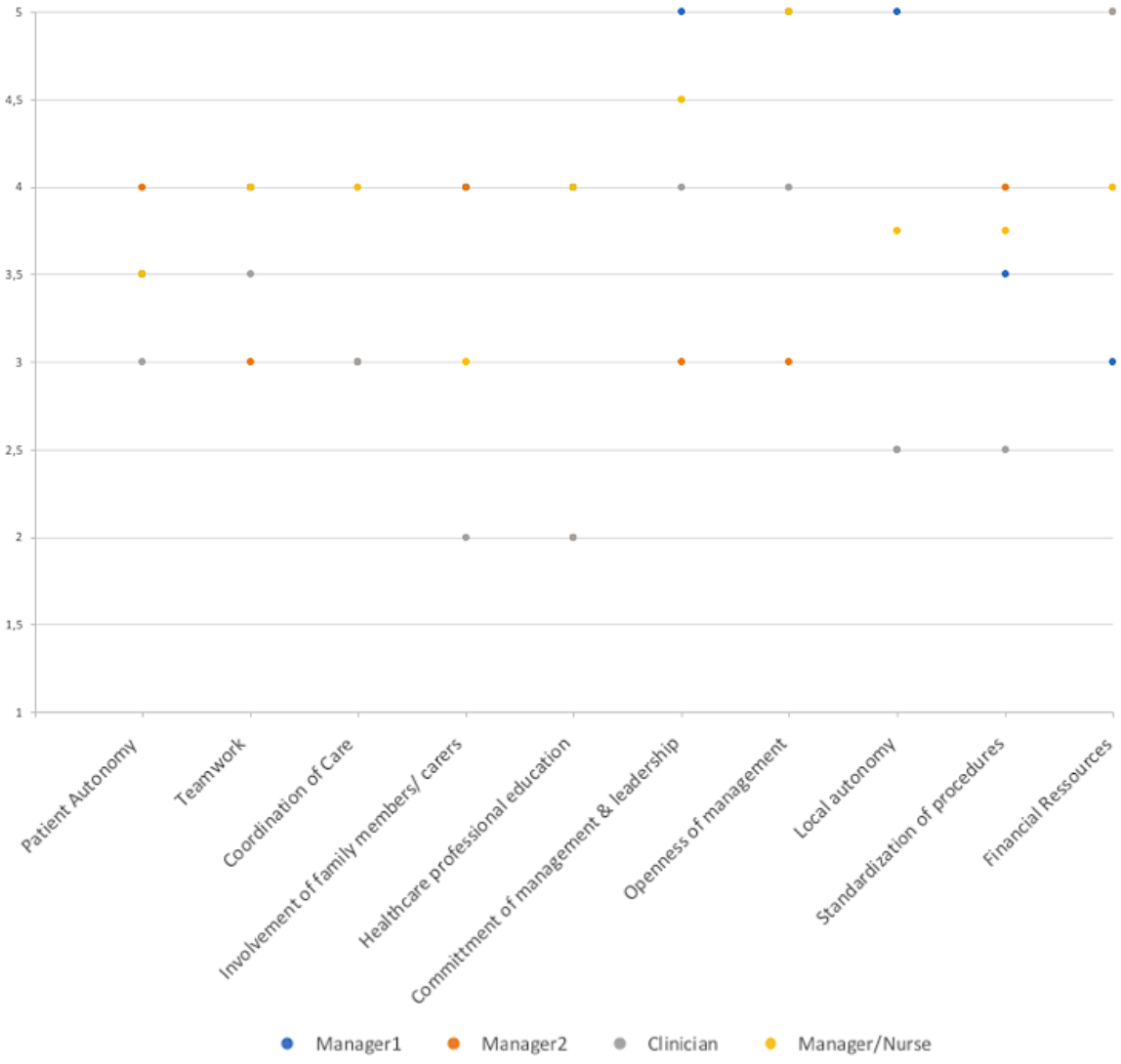

Figure 13: Dimensions of PCC in Graz

5.2 Qualitative Research

The interview results will be analyzed in the following qualitative research section. Firstly, a clarification of the personal definitions of PCC and the state of PCC in each of the study sites will be reviewed. Secondly, the relevance of performance and financial targets within the study context will be evaluated. Finally, the main obstacles and enablers for the implementation of PCC will be provided.

5.2.1 Personal Definitions of PCC

As in the secondary research explained, personal as well as operational definitions might greatly differ between professionals, organizations and countries. Therefore, the participants were asked to give their own definition, opinion or interpretation of PCC. According to the participants, additional factors that have to be taken into account when implementing PCC on an organizational level are represented and integrated in the following figure below from Hudon et al. (2012) and described subsequently:

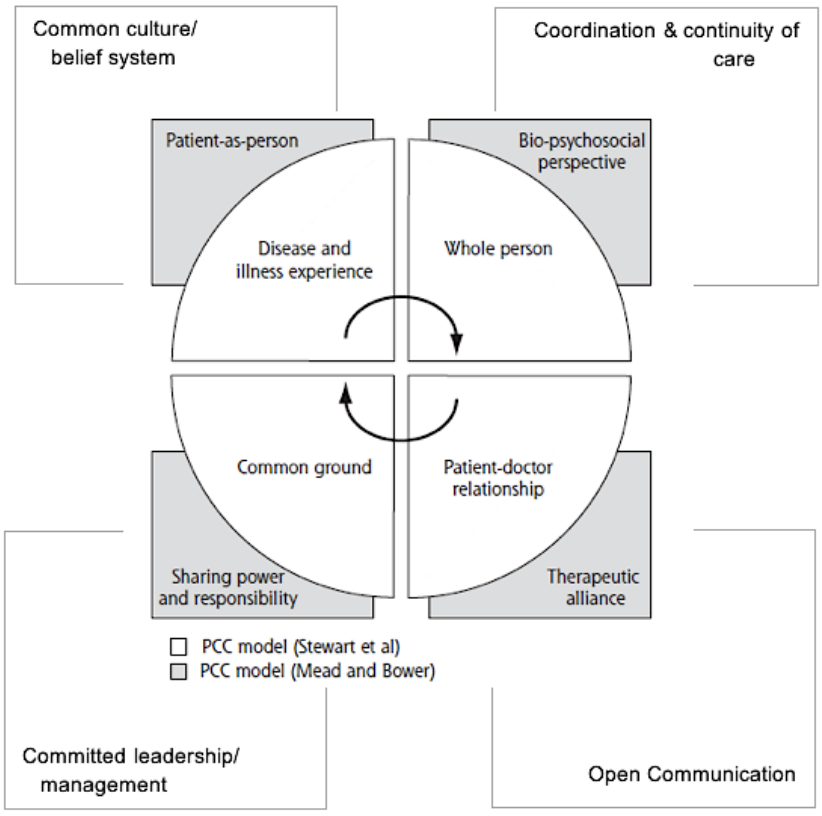

Figure 14: PCC model - edited by the author (Hudon et al., 2012)

The majority of participants stated that PCC emphasizes that the patient is at the center of care *(N-M/N, C-N1, C-N2 & G-M1, IQ4; G-M2, IQ5;* G-M/N4, *IQ1).* The patient has to be seen as a human being and not as an "an object that gets a diagnosis and a therapy" (G-M/N4, IQ1; C-N1, IQ4). Another factor that needs to be promoted is self-management or "helping people to help themselves". Self-management facilitates to provide people with the power the and autonomy of having more direct control over their health and to get a better understanding of their own skills, resources and capabilities. Meaningful partnerships between patients and staff as well as the involvement of families or carers was mentioned in this regard (N-M/N2, IQ4; G-C1, Q6, N-M/N1, IQ2; IQ4). Moreover, they indicated that this may lead to better life quality and more independence and consequently to less need for care (G-C1, Q6). Informed-decision making has to be supported. Furthermore, the patient needs to be given the feeling that he or she can influence and challenge decisions. Personal preferences also ought to be taken into account (G-M1, IQ4p). For the successful delivery of PPC it is crucial to foster the enhancement of a positive dialogue between staff and to reflect on the care process together with the patient in a way that it adds value to the individual person (G-M1, IQ4p). It is fundamental that patients experience the care process in a safe and trustful environment, in which they act and feel like themselves (N-M/N2, IQ10; C-N1, IQ4). The entire process has to be based on respectful and equal partnership "rather than a traditional analytic we know best, and we tell you what's right for you kind of approach" (N-M/N2, IQ4). Or as one of the participants put it:

> *"It is care that is personalized, and needs to be tailored around individuals' needs, wishes and values. (…) It's a system of service where information is passed on reliably, that transitions of care aren't resulting in gaps of service delivery or of quality. That people feel that they are in a joined up coordinated system from the time they access care to the time they are transferred home. It is essential that the fundamental rights around involvement, dignity, compassion and respect are always evident in our practice."* (N-M/N2, IQ4)

A trustful committed leadership that encourages open communication and good coordination of care were defined as critical when delivering patient-centeredness (N-M/N1, IQ9a; G-M/N4, Q9a). Skills and capabilities of healthcare leaders and healthcare professionals need to be developed to move towards a patient-centered organization. The only way to do this is by providing adequate training and support during the

education as well as advanced training for people who already are in the profession (N-M/N2, IQ4ap; G-M/N4, Q5p; G-M1, IQ2; G-M2, IQ4b).

Healthcare organization have to move towards a corporate culture that supports people to develop critical thinking skills and appropriate solutions by themselves in a self-managing behavior. A workforce that holds the same set of values and beliefs was mentioned in this regard (N-M/N1, IQ7; N2, IQ7b & IQ7c). Professionals sharing the same set of values, norms and beliefs within and across departments, disciplines and professions are likely to lead to an enhancement of communication, coordination and continuity of care (G-M2, Q4p). In the design of processes, it is recommendable to integrate the patient in the best possible way (C-N1, IQ4, H4-HD, IQ4). Even though, there was a significant variance between the different interpretations overall the participants have a good knowledge about what PCC should encompass, whether it is defined as PCC, integrated-care or just compassionate care out of an inner feeling what is right for the patient.

5.2.2 State and Quality of PCC

The participants were asked whether they consider their organization as patient centered in its aims and service delivery and to elaborate their opinion. The state of PCC was rated “better than expected” by all the participants (one outlier – G-C1) at a closer look the results were not consistent and major differences exist between the organizations.

5.2.2.1 Northumbria NHS Foundation Trust

The Northumbria NHS Trust places a major focus on person-centeredness on all levels of the organization. They have a particularly comprehensive framework that constantly tries to put the “patient first” (M/N1 & M/N2, IQ3). A major focus is making their care “as personal as it can be” as well as on measuring their efforts reliably (M/N1, IQ1; M/N2, IQ1). Northumbria is an integrated trust that is continuously striving to improve by looking at the quality of their information provision, their shared decision making and the level of integration between their services (M/N2, IQ6p; M/N2, IQ1p).

As main success factor in the provision of high and safe quality care and in enabling a contribution from the bottom-up staff in the organization Northumbria identified to hold the same set of values and beliefs (M/N1, IQ4ap). By using an application technique

called “value-based recruitment”, people who share the “right attitudes, beliefs and behaviours that allow them to deliver person-centred care” are integrated in the organization (M/N2, IQ4a). An encouraging and empowering working environment “where people feel psychologically safe about raising concerns and addressing those concerns” is realized in Northumbria (M/N1, IQ4a). According to them (M/N2, IQ4a),

> *“Staff can’t give what they don’t have. That means that if what we want is respectful, enabling, safe, compassionate and person-centred care for patients then staff too needs to feel safe, enabled, developed, respected and cared for themselves.”*

The participants stressed that it is absolutely important to be focused on measuring the performance to enable the implementation of “things that really matter to people, when they are lying frightened in our hospital beds’” (M2, IQ6). According to a conducted survey within their organization the feedback “around patient experiences is directly linked to clinical effectiveness and to safety.” In Northumbria, “a more compassionate and person-centred approach to orthopaedic care, for example, has saved a lot of lives and also reduced costs with reduced length of stay for my organization.” (N-M/N2, IQ10) Real-time feedback loops are in place that allow the clinical teams to respond in accordingly and immediately to the received information. It has proven not very effective to provide professionals with feedback about how person-centred their care is in retrospect (M/N2, IQ4a) The way feedback is communicated is important. It has to be improvement-focused and not judgmental for the fact that it increases the likelihood of professionals to identify problems as well as opportunities (M/N2, IQ4a). Northumbria places a major focus on a collaborative way of working without dictating rules that state, “what has to be done” (M/N1, IQ4a). This leads to a greater staff satisfaction which automatically improves the patients experience and thus creates a win-win situation for everybody (M/N1, IQ7b).

All surrounding is a management culture that enables people to come up with their own solutions, because “change comes from within” when people want it to happen (M/N1, IQ7a). The management of Northumbria encourages “an improvement asset from the bottom.” They highlighted that it is the people on the ground floor that are carrying out the work and drive the improvements. Moreover, one staff member claimed that only “if they get they get the support and the encouragement from the top they are going to feel valued enough to carry out the improvements” (M/N1, IQ9a).

“The commitment of a board who deeply see the values in this kind of work” has been defined as a main enabler for patient-centeredness. This is realized in Northumbria. The board level supports PCC by tracking patient-related factors and by being constantly in touch with what is happening on the ground floor (M/N1, IQ9a).

5.2.2.1.1 Personal Empirical Experience with Northumbria

Although the number of respondents was lower that initially planned the authors’ own experience as an intern in the Northumbria Healthcare Foundation Trust within the Medicine and Emergency Care Business Unit matches the above described results. In forming this judgement, the author applied the central tenets of the survey methodology to more adequately reflect on and analyze the experience within the Trust. During the internship, the author was involved in the preparations for meetings and helped with work concerning the Trust’s high priority strategies and visualization of the patient’s journey throughout the hospital (“patient stories”). The author also spent time observing and shadowing different teams and services within our Trust and Community Services. For this reason, it was possible to observe the commitment of staff to deliver excellent care and to involve the patient in everything they do at first hand. Northumbria places considerable focus on enhancing patients’ experiences and continuously seeks to improve their care model. Their quality commission reports are largely outstanding and define the “inspirational leadership and strong clinical engagement” with fully informed staff as major enablers for the successful change to a new model of patient pathways (Care Quality Commission, 2015).

Communication is very open and flows from the bottom up, from the simple ward to the board level. There is little evidence of hierarchal structures or attitudes and there is a strong emphasis on “making everyone’s contribution count”. The management style with a low (almost absent) level of bureaucratic control and a shift of power to the professionals, patients and publics is very progressive. This is a factor of the clinical led management model that ensures unity of purpose and shared values between the Board and front-line clinical, nursing and professional staff. In such an environment the emphasis is manifestly on engaging the patient and the public in all dimensions of care planning and management. This was a stand-out feature of the authors’ experience. The consistency of the viewpoint of the survey respondents and the author of this paperwork compensates for the slightly lower response rate. The reasons are given in section 7 (Limitations).

5.2.2.2 University Hospital Graz

The overall perception of the participants in Graz is that they think and operate patient-centered or at least try to do so (M1, IQ1; M2, IQ1; M/N4, IQ1). According to them, the management is open and engages in patient-centered activities by fostering, for example, the lean management approach on improving patient-centeredness and patient flow which is supported by the secondary research of this master thesis (M1 & M2, Q9, IQ9a). Several guidelines that try to shift the focus to the patient and that include patient-centered elements are in place (M1 & M2, Q9, IQ9a). In addition, the primary nursing approach is currently implemented in which one person is responsible for one patient over the duration of the stay. This should lead to an optimization of the information flow and in turn to greater patient satisfaction (M1, IQ3p).

In practice, however, the PCC approach is difficult to implement due to the complexity of hierarchal and organizational structures, bureaucratic attitudes, and the financial framework (M2, Q1; M2, IQ1; M/N4, IQ1). There is still a situation in Austria in which professional groups maintain very strong hierarchies among and between each other which contributes to a fragmentation of care (M2, Q2). A certain "central" resistance to moving to a more patient-centered approach was highlighted by the participants. Challenges around power, influence and around attitudes about "who knows best" can get in the way of a successful implementation of PCC (M2, Q2). One of the participants stated that:

> *"Wherever people work there are old-established patterns of behavior. And no matter what you try in health care or elsewhere moving in a different direction always leads to a certain resistance. But that doesn't have to be negative. It also has a positive aspect that you simply deal with the topic considerably more intense."* (M1, IQ4b)

It was highlighted that to overcome barriers an open and transparent hospital wide communication with less emphasis on hierarchal attitudes needs to be established. A communication in which healthcare professionals accept and recognize the other expertise regardless of level of education and without strict hierarchical understanding has to be fostered (N/N4, Q11p; C1, Q7a). To achieve this the management/ hospital board and the "bottom tier" (e.g. nurses, doctors, other health care professionals) have to be aligned throughout the organization (M2, Q4a; M/N4, Q4ap). As soon as personal disagreements arise, these issues have to be discussed in a way that it is

not influencing the care process (M2, Q2). Moreover, trust of the management, the ability to "try out, pilot and measure ideas" and the opportunity to intervene in things that were always different have been identified as crucial in order to deliver better care (M1, Q9a). One of the participants stated (M/N4, Q4a):

> *"The human being, the patient with all the values that we have in our organization must always be in the center. And all the people around, have to focus, hierarchically independent to share and cooperate as best as they can."*

The University Hospital Graz is in a transition phase in which there are some self-starter areas that are operating patient-centered with strong, open and committed local management, but others that are still struggling with top down task-oriented care. To some extent it is still the case that there is a working environment in which: "The doctor is the center of the earth and everything has to gather around him." In these latter settings little responsibility is passed on to the patients and meaningful partnerships between professionals are proving difficult (M/N4, Q11; C1, Q2).

Some of the obstacles are the size and complexity of the organization, the repetition of communicational problems and hierarchical structures (M2, Q4b; C1, Q9 & Q9ap). Due to the fact that the University Hospital in Graz is a huge organization it is not feasible to change everything at once. It requires a change of mindset as well as culture which naturally requires time. The national and local context need to be considered in the implementation process. Furthermore, the future direction of care has to be discussed politically with the communities. The different parties and stakeholders need to be united and a shared commitment has to be created (M/N1, Q10p).

Moreover, the result of this organization indicated that measuring PCC is of tremendous importance for determining the benefits for the patient (M1, IQ4, N/M4 Q8, M2, Q8) and that "there is certainly progress in this direction" (M1, IQ6). In- and out-patient surveys exist and the patient experience as well as the doctor-patient conversation are constantly evaluated. Feedback loops to the respective units are in place. Nevertheless, there is room for improvement as a certain need for more effective measurements was expressed by the participants. According to one of them, a great variety of surveys to evaluate the patient experience exist "that can be quite tiresome". There is a certain risk that information gets lost, is not passed on reliably or not used effectively due to the sheer amount of assessments (M1, IQ6p).

5.2.2.3 Coxa

The Coxa model is slightly different to the one in Northumbria and Graz as it focuses on the technical process of joint replacements. Thus, the patient usually leaves the organization the same day he or she received surgery. As mentioned in the secondary research (chapter 3.2) the Coxa model focused on the creation of care pathways, the delegation of processes to staff for increasing their motivation, the systemization of processes and the integration of lean management principles. This is reflected by the participants and within the organization. Care pathways and specific goals for the patient are designed according to the patients' needs in order to place the patient in the center (N1, IQ1p; N2, IQ1p). Even though no specific PCC framework or training is provided in the organization staff seem to be working in a very patient-centered way (N1, IQ1p; N2, IQ1p; N1, IQ7p). The participants stated that it is a part of their culture (N1 & N2, IQ3). The workforce in Coxa operates very independently and can decide by themselves how they to reach the desired goal. The crucial part is that the "patients are satisfied with their treatment and well taken care of" (N2, IQ10a).

The Finish culture is very open with a transparent and supportive style of communication in which problems as well as areas for improvements can be addressed without inhibition (N1 & N2, IQ3; N2, IQ7b & IQ7c).). Professionals at Coxa recognize the importance of honest information-giving and empowerment as well as participation of the patient to exercise judgement about different treatment options. A great deal of responsibility is thereby passed on to the patient by educating and informing them how to self-manage their disease, one of the critical success factors highlighted in secondary research of this study (N1, IQ7p & IQ4p). Management might consider implementing education programs with regard to PCC. However, further local research would be needed so that PCC can be promoted as enhancing local values and autonomy instead of identifying it as simply another management target (N2, IQ7a).

According to the participants the performance is very high at Coxa and patient volumes are steadily increasing. The measurement framework is focused on the patient's perception, expectation and satisfaction within the hospital. Financial targets are mainly related to lengths of stay and an increase or decrease in patient volumes. It was emphasized that performance and financial targets can negatively impact the work (N1, IQ10ap). To be open and to adapt to change was mentioned as being critical

to deliver PCC in the context of the performance and financial targets (N1, IQ10ap). Effective, well-balanced and managed processes are essential to guarantee a successful implementation of PCC within this context (N1, IQ10ap).

5.2.2.4 Hospital 4

The focus in Hospital 4 is on added value for the patient by organizing care around patient groups and focused patient care centers. The streaming and pooling of patients serves the purpose of getting them in and out of the hospital as smoothly and fluently as possible (HD, IQ7p). In management, it is important to "be aware of different clinical processes and organize it around patient culture." (HD, IQ5)

Clear processes have to be defined and related to the patient. According to the hospital director of the respective organization: (1) Patients have to be organized in organizational units in treatment and in functionality. (2) They need to be provided with all essential information prior to, inside and after the hospital stay. (3) In order to achieve this staff has to be organized as well within the organization. (4) Information needs to be passed on reliably within the organization and also to the outpatient area (GP, nursing homes and other health care institutions) (HD, IQ5p; IQ7p; IQ10ap)

A problem that can arise in management is that other issues can come in between and use up the limited time and focus. These issues might be, for example, organizational change, mergers, financial problems or new buildings. There are "so many issues [that] can take the priority of the agenda". It was highlighted that in practice, 70% of the management agenda is not focused on PCC. Even though issues are indirectly connected to PCC the focus is not sufficient. At least 50% should be placed on patient centeredness (HD, IQ1; IQ2). A responsibility to change this exists according to the interviewed hospital director. It was stressed that professionals that "are into leadership have all the ability to change it. Who else should? What are you paid for?" (HD, IQ7b). As the other organizations already emphasized the entire process can be carried out by measuring it and reacting according to the feedback (HD, IQ7a).

> *"The main thing if you are really connected to this to this issue then you have elements that allows you to go down into the process and measure what you are doing and to connect: 'That is what we think we deliver. Are we delivering that?'"* (HD, IQ7a)

An electronic system gathers a vast amount of information, such as the time of arrival, the time it takes to get an appointment, the time it takes to answer a phone call, the lengths of stay, the pathway within the hospital and the corresponding waiting times, etc. This information can be used to improve the patients experience and to design pathways in their best interests (HD, IQ7a).

5.2.3 Performance and Financial Impact on PCC

The study suggests that performance and financial targets can play a significant role in the delivery of PCC (G-M/N4, IQ10p; H4-HD, IQ4p) and that "targets can divert [one] away from person-centeredness" (N-M/N2, IQ10). In Northumbria, for example, national targets around "infection control and single sex accommodation resulted in people being moved around the system particularly older people". It was also mentioned that the NHS in wider terms, is struggling with severe pressures on emergency care services due to years of financial austerity and underinvestment. This resulted, for example, in patients waiting excessive times on trolleys for bed availability. In such cases "there is no element that we can classify as person-centred care and none of the staff working in our system wants to see their patients in that environment but that definitely happens". Centrally imposed targets with unintended consequences might impact negatively on person-centeredness (N-M/N2, IQ10). By dictating a certain amount of time or limiting/ optimizing time, which goes as far as calculating the minutes per patient or service, the patient is not in the focus of care (G-C1, Q10).

Time and resources are a key factor in the delivery of PCC (N-M/N2, IQ10). Staffing is a critical factor that allows people to operate patient-centered (G-M/N4, IQ10; C-N2, IQ2p). Insufficient time and resources to build relationships that underpin PCC might threaten the provision of PCC (N-M/N2, IQ4b, G-M/N 1, Q10p). The sustainability of PCC can be threatened "if financial pressures mean that there are fewer resources to support safe practice or PCC and if people have less time to listen and less resources to invest." Furthermore, it means that there are "fewer resources that could, for example, support shared-decision making, training, development of staff or patients, or paying for a room, a place to meet and to discuss." (N-M/N2, Q10b) Being intelligent about the working area is critical in this regard as it is not necessary about having more staff, but also about intelligent time and resource management. Wards have to be organized in the same standard fashion to reduce walking distances and to enable staff to work on every ward within an organization. As a direct consequence, time and

staff gets used more efficiently (N-M/N1, IQ10p). Nevertheless, the delivery of PCC does not depend on money alone or as one of the participants stated (N-M/N1, IQ10b):

> *"I think we are in healthcare that we attract people who are delivering the care. You can't be paid to be compassionate. You either are or you don't come into this profession to be like that. I don't think that has anything to do with money."*

Nevertheless, a robust measurement framework and "being absolutely focused on performance" is crucial to determine effective PCC strategies and to abandon ineffective ones. Everything can be measured if it is tied to specific goals. Those goals have to be articulated together and in agreement with patients about whether these aims have been achieved or not (N-M/N2, IQ8). A variety of measurements were addressed by the participants which are represented in the table below:

MEASUREMENTS AND TARGETS OF PCC	
Performance Measurements	• Quality of care, access time and the cost-performance (H4-HD, IQ10a) • In- and out-patient surveys about the care experience (G-M1, IQ6p) • Health literacy before/ after the intervention (G-M1, Q10) • Reputation (C-N1, IQ10a) • Patient/ staff experience & satisfaction (C-N1, IQ10a; N-M/N2, IQ4b)
Financial Targets	• Appropriate staffing (G-M/N4, IQ10) • Monitoring of waiting times (G-M2, Q10a, N-M/N2, IQ10) • Rise/fall in patient's volume (C-N1, IQ10a) • Re-admissions and lengths of stay (G-M1, Q10; C-N1, IQ10a)

Table 10: Performance and financial targets

On a system level, the financial framework and the future direction of care needs to be discussed politically with the population of a country because it is not feasible to provide PCC when the resources are not made available (G-M/N4, IQ10p). According to Northumbria, it is not unusual to encounter anxiety about involving patients, families or communities in the development, improvement, delivery and design of new services because people think that their expectations will exceed the resources that are available, but that is not necessarily the case. The experience of one of the participants in Northumbria suggests that patients, families and communities "are incredibly respectful about the publics purse and about the demands on staff" (N-M/N2, IQ7b). This imposes that citizen empowerment may help to solve obstacles

systematically by moving towards a process of social learning on a local, national and regional context. The sense that people want every treatment available no matter how expensive might not be true. An open dialogue between the different stakeholders and public could make healthcare more effective also in terms of value per money. Northumbria, for example, places a great focus on the patients' voice and the involvement of the community. In fact, they are highly successful with it also in terms of financial stability.

5.2.4 Enablers and Barriers of PCC

In the current economic climate challenges (e.g. public finances, pace of change) and opportunities (e.g. innovation, digitalization, personalization) have never been greater. Obstacles certainly do exist. By addressing them systematically the organization as well as the system can move towards a more patient-focused care. The main conflicts or obstacles that were addressed by the participants are

(1) hierarchical structures and high levels of control and standardization,
(2) power imbalances and personal disagreements (distance, distrust, lack of empathy & tolerance),
(3) challenges around teamwork and the recognition of expertise between professionals (mutual respect),
(4) a lack of willingness to address challenges and
(5) a high fragmentation of the organization and a discontinuity in the care process.

Main enablers to achieve the wide-spread implementation and to overcome barriers of patient-centeredness represent:

(1) An open communication between all levels of care that is based on trust, empathy and understanding attitudes (management, healthcare professionals, patients).
(2) A strong focus on value-oriented care based on the outcome of measurements including the provision of real-time feedback directly to the professionals on the respective wards.
(3) A sharing of information that is simplified in terms of language and passed on reliably within the system (e.g. e-records, leaflets, discharge documents).

(4) The willingness to address challenges (leadership) and to give patients/ staff the power to address and carry out the change is crucial in this respect (responsible autonomy).
(5) A simplification of processes and design of care/ working environment (pooling of patients, standardized design of wards, use of new technologies etc.).
(6) The involvement of patients and citizens in the design of processes, pathways and strategies.
(7) A shared commitment of relevant stakeholders (public, providers, patients, staff, policy makers etc.) to implement it systematically.

The above described facilitators of PCC have to be harmonized on a system, organizational and patient level, visualized in the following figure:

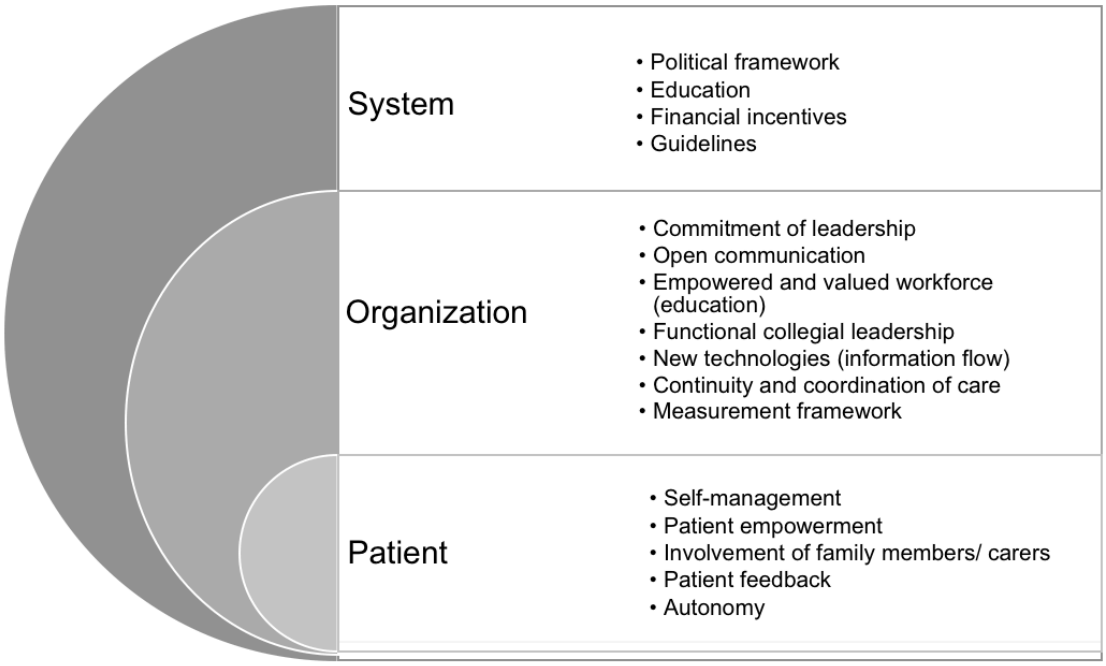

Figure 15: Enablers of PCC on different levels - created by the author

6 Discussion

The findings confirmed that patient-centeredness can serve as a core driver for the alignment of professionals and organizational change. The establishment of a culture of improvement from the top-down to the “bottom tier” of the organization enables professionals to initiate and implement PCC strategies independently according to the patients’ needs. Nevertheless, consideration must be given to different corporate cultures and driving forces of organizations in regard to the implementation of PCC. The study showed that major differences exist within the evaluated organizations, particularly in terms of care models and organizational strategies.

The findings of Northumbria support the secondary research which suggests that a major focus lies upon patient-focused care on all levels of the organization. Distinctive factors that influence PCC positively include value-based recruitment, a robust measurement framework, the clinical led management model and the exceptionally large focus on the engagement of patient, staff and the public. Local community relationships present another major difference between the organizational strategies in the compared hospitals. A consistent theme within the Northumbria hospital is the importance of a sophisticated staff and public communication strategies. This cannot only be seen by the organizations open and accessible website, but also by its focus in staff meetings, team events, induction processes and essentially in all forums where there is discussion about patient care and quality of service. The rhetoric strategies of Northumbria match with the practical implications. Additionally, a remarkable consistency was observed between the author’s empirical observations and personal perspective gained as an intern and that of the participants in the survey.

The University Hospital in Graz, on the other hand, operates in a system which is hierarchal in nature with a high degree of fragmentation. According to Brunner’s ideals (2009), the vision for Graz is to become an organization that sees patients as human beings and realizes a proactive, appreciative and respectful communication among professionals is not fully realized. Strategies to do so exist, but they are not implemented in a consistent manner. There is considerable potential for improvement within Graz. To put theory into practice the “bottom tier” needs to be enabled to implement strategies regarding PCC and all processes need to be defined in a way that they add value to the patient and also to the staff. The Northumbria approach can

serve as starting point for Graz to adopt strategies that have already proven effective in practice to overcome challenges such as strict hierarchical settings and a high fragmentation of care.

Coxa was the originator of the whole systems integrated pathway model. This is a very comprehensive and innovative framework that links all players in the patient pathway from primary care to post discharge rehabilitation and social care. However, the organization does not specifically address PCC as such. Nevertheless, it is very successful and has a good reputation because they implicitly respond to patient sensitivity. The study implies that a key factor in the effective PCC delivery is the Finish culture with humanitarian principles at its core.

New innovative approaches in terms of reimbursement systems have been mentioned as a means to achieve a wider implementation of PCC. Bundled payments (episode payments), for example, might encourage staff to “keep patients healthy” and therefore reinforce PCC. Healthcare is increasingly getting more competitive and new financing models such as public-private partnerships (e.g. Coxa) are also arising in other countries of Europe. Hospital 4 in the Netherlands, for example, tries to adapt to the increasing competition and to payments being negotiated on a tariff base between insurer and provider. The organization strives to achieve this goal with a better design of the built environment, systemization of processes, pooling of patients and higher involvement of communities. Incentives on a system level were identified to help implement PCC on a large scale, but they are still quite controversial in healthcare. Even though it was mentioned by the participants as a related factor of PCC delivery a minor focus was placed on new financing models as it would exceed the scope of this thesis. Further research would be needed in this regard.

In general, a gradual shift towards PCC in its different forms can be observed in the examined organizations. Nevertheless, there is no “best model”. The balance or bias towards central direction or local autonomy is a consequence of different management styles and values and the extent of convergence between these two factors. The movement towards local staff initiatives is a result of the vocational drive evident within the front-line staff and their relationships to local communities. In other words, the most effective PCC models derive from the close alignment of values, cultures and processes throughout the whole organization. As a result, effective leadership is a necessity in order to include all these factors. Healthcare organizations

that wish to move forward in healthcare need to implement strong leadership strategies because changing and/ or developing a culture is a complex task which requires the alignment of heath care professionals and leaders with a common vision.

Patient-focused aims and objectives have been proven achievable and maintainable under the increasingly tightened fiscal and operational performance targets. Nevertheless, some differences in perspectives and priorities between managers and staff still exist. This is naturally given due to different accountabilities of managers in the varying organizational settings. The effective delivery of PCC is supported in organizations which define processes that seek to combine financial, performance and patient standards. Progress in healthcare including the financial sustainability also depends on the nature of management in understanding and supporting the principle of responsible autonomy regarding their front-line staff.

On an organizational level, financial constraints play a significant role as they can negatively impact the provision of PCC, particularly at times of scarce resources or when there are more urgent issues to be dealt with. Nevertheless, the findings of this survey support the notion that in a healthcare setting it is especially difficult to detect if financial pressures affect PCC negatively or not. Clear definitions, measures and means of monitoring PCC at all levels (organizational, local and national) need to be developed, but these metrics barely exist at the moment (Robertson et al., 2017). The current health care systems do not only lack a consistent and clear definition of PCC, but also a validated measurement tool to systematically assess PCC on a cross-county level and to enable a large-scale comparison between organizations. Within the organizations, a great support for the importance of measuring and utilizing feedback was addressed by the participants and there are certainly efforts to do so reliably. Nevertheless, measuring PCC proved to be difficult and vague in its realization. Even though most of the evaluated hospitals conduct patient surveys, they are not always gathered systematically. Thus, the information is not used effectively. Reasons for the ineffective use of patient surveys are professional, organizational and data-related barriers demonstrated by a lack of supporting infrastructures, change resistance, skepticism of staff, discrimination and not timely or unspecific feedback (Groene, 2011). For this reason, the author of this thesis argues that measurements should reflect the social changes in medicine. This includes patient involvement in the care from the very beginning to the very end of the health journey as it is the case in Northumbria.

Well-coordinated health policy strategies and guidelines as well as the political support were identified as crucial to communicate changes in a consistent way to staff, patients and also the public. This research supports the idea that the government plays a central role in the delivery of PCC on the grounds that patient-centeredness cannot be realized if the government tries to reduce the financial burden by impeding the access to care with longer waiting times or by restricting certain services. This might lead to better financial performance, but to lower quality (Robertson et al., 2017).

Throughout this research, the most striking and consistent factor to achieve PCC was the shift away from top-down managerial approaches towards flatter organizational structures. This would involve the integration of local as well as patient autonomy in the design of patient flows and processes that can help in reshaping organizations to deal with the enormous financial and operational pressures that are put upon them.

The study reinforces that when the workforce is given the autonomy and permission to initiate change, without awaiting approval of the management, staff and teams are able to adapt flexibly and immediately to pressures and unexpected incidences in terms of a self-managing behavior. Inter-personal skills or human dimensions such as trust, empathy and mutual respect are essential prerequisites in this respect. The argument of Mintzberg & Glouberman that shared norms of managers, nurses, physicians, among others are likely to maintain and hold the system together by adapting to unexpected complications or unanticipated pressures can thereby be supported. Internalized attitudes can replace externalized controls. Consequently, people “just know what they have to do” and can coordinate their care efforts more effectively (Mintzberg & Glouberman, 2001). These attitudes are then likely to become embedded as core values of an organization.

The results illustrate the all-embracing complexity of PCC that basically involves all processual, structural and cultural dimensions of patient care. Despite relevant systematization of PCC, the ultimate variable remains the patient and their perception which will always be subjective to some degree. A more in-depth analysis including a quantitative analysis of indicators and a sufficient sample size could definitely be considered to enable a more comprehensive and extensive comparison of European healthcare organizations.

7 Limitations

There are naturally variables or limitations which need to be addressed and acknowledged for the purpose of this thesis. This study was not intended to provide an extensive analysis on PCC in every European nation. It rather focused on addressing common characteristics and enablers of four European hospitals located in England, Austria, Finland and Netherlands. The aim was to foster learning from their experience and efforts designed against an all pervasive and consistent set of pressures deriving from demographic, epidemiological and financial changes. The totality of these pressures contributes to the complexity and difficulty of building and sustaining patient focus in all dimensions of healthcare delivery.

This study is illustrative in nature and it is not possible to generalize since each country has its own individual policies, legislative frameworks and ideological beliefs. There is also a lack of comparable indicators (performance, access and efficiency), which makes it almost impossible to quantitatively compare PCC (Paparella, 2016). As Ericikan and Roth (2014) stated “generalization is a critical concept in all research designed to generate knowledge that applies to all elements of a unit (population) while studying only a subset of these elements (sample).”

The thorny issue of generalization is intensified by the sample size which was rather small particularly for the quantitative analysis (n=8). Due to the above-mentioned reasons, it was not possible to carry the statistical analysis any further without risking a misleading interpretation of the results. Therefore, the included data should be reflected critically due to the small sample size. Or as Mead & Bower (2000) said the “utility of any measure depends on its validity, reliability, sensitivity and feasibility, and a trade-off between these criteria is often necessary”.

In fact, this is rather irrelevant for the qualitative research part (n=9) as the goal “is not to generalize but rather to provide a rich, contextualized understanding” of the experiences, beliefs, attitudes and expertise of the participants (Polit & Beck, 2010). It is important in this regard to select individuals who are able to provide a meaningful representation of the study context (2004) which is the case in the present study.

The aim of mixing both approaches was to get a more comprehensive picture of the situation in the different hospital settings. Due to conflicting work pressures at the time

of the interviews, it was not possible to reach the target sample size in Northumbria. This limitation was partly offset by the empirical observations of the author of this thesis.

Another limitation is reflected upon the research design. The reviewed scholars and studies noted that it is quite problematic to mix qualitative with quantitative research methods since it requires skills and experience in both methods (Tariq & Woodman, 2013). Qualitative research is often criticized for being subjective and reflecting only the personal interests and biases of the researcher. To exclude personal biases the research process was made transparent and clear links between the data were provided (Draper, 2004).

Due to the complexity of the health systems, organizational structures, the topic and the timeframe of this thesis, it was extremely difficult to provide an intense analysis of all the factors influencing PCC. A major focus was placed on organizational and corporate culture as well as on the relationship between local staff initiatives and top-down directed management strategies. Financial incentives and payment systems were addressed but only to a manageable extend. Thus, further research would be of relevance in this regard.

8 Conclusion and Recommendation

All of the study sites are engaged and committed to implement PCC or at least elements of patient-centeredness within their systems. The major message is that a cultural foundation is the key to patient-centeredness. Thus, successful PCC requires more than simply setting another set of targets or prescribed guidelines. The study outcome supports the hypotheses that healthcare organizations that support the alignment of patients and healthcare professionals in a partnership have better outcomes in terms of patient and staff experience. Moreover, they are better able to sustain and maintain against the increasing fiscal and performance pressures, as the Northumbria example demonstrated.

However, the real-world application of PCC shows that fragmentation and hierarchical structures, such as in Graz, are still present and limiting the potential of PCC. Barriers such as fragmentation of organization, information loss, hierarchies and poor communication between professionals as well as patients need to be addressed systematically in order to make PCC a successful practice. The only way to move beyond this is to establish an open and proactive cooperation of professionals including the recognition of the skills of everyone within a team. Soft-skills such as respect, trust and empathy are particularly important in this regard and must be demonstrated as well as practiced by the board and management level.

The study validated that the patient always has to be in the center. Their variability of perspective and circumstance is simply a dimension of PCC that irrevocably must be accommodated. Processes and pathways need to be guided and designed from this point of view and in the context of this study needs to be seen as the new foundation for an organizational, structural and cultural shift to improve patient responsiveness. Furthermore, this study showed that a culture of innovation and improvement needs to prevail, in which professionals feel able to raise or address concerns as well as to suggest beneficial organizational change without being afraid of consequences that may be critical in nature of the status quo.

Based on the outcome of this survey, the author proposes the following recommendations to move forward in healthcare, facilitate PCC and to deal more effectively with arising conflicts, obstacles and barriers.

Future oriented healthcare organizations need to

- address and systematically solve power imbalances and hierarchies.
- foster intrapersonal and communicational leadership skills that allow a passing on of power and responsibility to the professionals.
- distance themselves from standardized control mechanisms and instead focus on a strong set of values (leadership, relationships, processes).
- unite all the different parties (patients, staff, public) to create a shared commitment that is based on trust and inter-connectedness. This has to be reinforced by a strong, common and consistently communicated vision.
- move away from a “permission culture” towards one that enables healthcare professionals to initiate change by themselves.
- focus to the value created for the patient in the care setting as well as in the design of processes, pathways and strategies based on a robust measurement framework including a reliable, real-time and improvement-focused feedback.
- provide education of health professionals to allow patient-centered skills, attitudes and behaviours to emerge.
- simplify access to care, language, the information flow, the design of working environments, pathways and information giving, among others.
- consider the regional, local and national context and be open to adopt transferable improvements to their systems.

Summarizing, it can be said that there is no “one-size-fits-all” organizations answer to the successful implementation of PCC. Healthcare is a business that is very complex in terms of given goals, targets and standards that should be achieved and in turn might create huge pressures on staff. In many ways PCC is all about patient empowerment. Once underway, this type of engagement will change healthcare irrevocably from a paternalistic ethos (from the past) to a partnership in care (for the future).

“Culture does not change because we desire to change it. Culture changes when the organization is transformed. The culture reflects the realities of people working together every day.”
by Frances Hesselbein

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Annexes

Annex 1: Interview Guide (English)

INTERVIEW FORM – MASTER THESIS

THE COST AND IMPACT OF PATIENT-CENTERED CARE

A Comparison of the Perception of Hospital Managers towards Patient-Centered Care under the Evaluation of Financial and Performance Pressures

TABLE OF CONTENT

GENERAL INFORMATION

My name is Melanie Hartl. I am currently completing a double degree master's program addressing International Business at the University of Economics in Prague and International Health and Social Management at the Management Centre Innsbruck. The aim of my thesis is to understand the balance between centrally planned strategies and local initiatives regarding patient-centered care and whether the adoption of this principle is being challenged by the financial and operational pressures evident in many health systems across Europe.

Definition of Patient-Centered Care

The term patient-centered care is a widely used concept that underlies a considerable variation across Europe and across health organizations. For the purpose of my master thesis, I have defined my own short definition stating that:

> *Patient-centered care is an approach that tries to ensure that all clinical decisions and patient interactions are guided by a respectful, understanding, supporting and encouraging collaboration between patients and all members of the organization with the aim to improve clinical outcomes, to achieve greater involvement of patients and their families, to accomplish better allocation of resources, and to increase overall patient satisfaction.*

However, in the present study I am particularly interested in your own definition, interpretation and perspective of patient focused care.

CONFIDENTIALITY AGREEMENT (A REQUIREMENT OF MY THESIS STUDY)

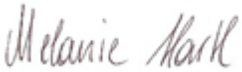
Title of the Research Project: The Cost and Impact of Patient-Centered Care

I agree to participate in a research project conducted by Melanie Hartl from the MCI Management Center Innsbruck, Austria. By accepting this agreement, I confirm that:

- My participation as an interviewee in this project is voluntary. There is no explicit or implicit coercion whatsoever to participate.
- I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind, and if I feel uncomfortable in any way during the interview session, I have the right to withdraw from the interview.
- All contributions will be anonymized. By arrangement, it is also possible to anonymize the organization.
- I allow Melanie Hartl to take notes during the interview. I also allow the recording of the interview and subsequent dialogue by audio tape. It is clear to me that in case I do not want the interview and dialogue to be taped I am fully entitled to withdraw from participation.
- I have been given the explicit guarantee that the researcher will not identify me by name or function in any reports using information obtained from this interview, and that my confidentiality as a participant in this study will remain secure.
- Excerpts from the interview may be cited anonymously in the master's thesis and any resulting publications.
- I have read and understood the points and statements of this form. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.
- I have been given a copy of this consent form co-signed by the interviewer.

By clicking **I Accept,** you confirm that you have been informed about the research project and that you agree to participate.

I Accept: ☐



Melanie Hartl, 14.04.2018

NCPI, Sample Informed Consent Form. Retrieved from: http://web.stanford.edu/group/ncpi/unspecified/student_assess_toolkit/pdf/sampleinformedconsent.pdf

PROFESSIONAL BACKGROUND

Occupational group	*Term of occupation in this role*	*Level of seniority*	*Have you had any specific training in patient-centered care:*
Managerial position			
Clinical background (doctor, nurse, other health professionals)			

PART 1: QUANTITATIVE STUDY

In the first part of this research you are asked to rate your level of agreement with the following statements using the scale below (1 strongly disagree – 2 disagree – 3 neither agree nor disagree – 4 agree – 5 strongly agree). You are now kindly asked to fill this out by yourself:

STATEMENTS*:*	*Strongly Disagree*				*Strongly Agree*
	1	2	3	4	5
Healthcare professionals take patients' preferences regarding the treatment options into account.	☐	☐	☐	☐	☐
Patients are supported in setting and achieving their own treatment goals.	☐	☐	☐	☐	☐
Healthcare professionals work as a team in care delivery to patients across departments and professional disciplines.	☐	☐	☐	☐	☐
Organizational units work together in teams to manage and educate patients about their disease and to give patients the autonomy to exercise judgment concerning their treatment.	☐	☐	☐	☐	☐
Patients experience coordinated care based on clear and accurate information exchange between relevant healthcare professionals.	☐	☐	☐	☐	☐
Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.	☐	☐	☐	☐	☐
Adequate training and education concerning patient-centered care is provided by the organization.	☐	☐	☐	☐	☐

The senior leadership at the level of the CEO and board of directors is committed to implement patient-centered care.	☐	☐	☐	☐	☐
A strategic vision is clearly and regularly communicated to every member of the organization.	☐	☐	☐	☐	☐
A primary aspect of the management of the organization is openness, transparency and accountability in all their operations and communications.	☐	☐	☐	☐	☐
Healthcare professionals have the ability to initiate the implementation of patient-centered care strategies.	☐	☐	☐	☐	☐
Authority is devolved to professionals to find other innovative and creative responses to patient needs.	☐	☐	☐	☐	☐
Procedures are highly standardized and a high level of control of measurements exists.	☐	☐	☐	☐	☐
Managers use traditional organizational mechanisms such as detailed rules and guidelines and key performance indicators (KPIs) to regulate work processes of employees.	☐	☐	☐	☐	☐
Patient-centered care leads to improved health behavior of patients and therefore to a decreased use of resources.	☐	☐	☐	☐	☐

PART 2: INTERVIEW GUIDE

*In the second part of this research a short semi-structured interview via phone or Skype will be conducted based on the following questions. This guide serves as pre-information for the interview. Therefore, you are kindly asked **not** to fill in the second part yet.*

1. Do you consider your organization as patient centered in its aims and its service delivery?
    - If yes/no: why?
2. Can you identify potential areas for improvement? If so in which way?
3. Please rate the quality of patient-centered care in your organization on a scale from 1-5:

Poor	Unremarkable	Meets expectations	Better than expected	Outstanding
1	2	3	4	5

4. What does patient-centered care mean for you?
    - In your opinion, what are the principal success factors in delivering patient-centered care?

- What are the major barriers that stand in the way of achieving patient-centered care?

5. How can being patient-centered help in the aim of delivering greater value to patients?
6. Do you use patient-centered care strategies? If yes: Which approaches, or strategies do you use? (e.g. service integration, greater self-help support for patients)
7. Do you have suggestions concerning the improvement of patient-centered care, if so which ones?
    - Are you able to implement these suggestions?
    - Are there potential conflicts when trying to implement new strategies/suggestions?
8. How can you know whether interventions intended to improve patient-centered care have achieved their goals? (e.g. patient feedback)
9. To which extent is the management/ head of the department open to suggestions concerning new strategies or initiatives according to your experience?

Not at all open	Slightly	Moderately	High	Very open
1	2	3	4	5

    - How could the management/leadership help you with providing patient-centeredness?

10. In your opinion, what role do performance and financial targets play when it comes to patient-centered care?
    - Are there performance targets setting specific performance metrics for patient-centered care, if so can you provide an example?
    - Is the provision and sustainability of patient-centered care being threatened by financial pressures, if so how?
    - At which level do they influence patient-centered care:

Not at all	Slightly	Moderately	Very	Extremely
1	2	3	4	5

11. Do you have any final personal views regarding patient-centered care?

Once again, I am extremely grateful for your contributing your valuable time, your honest information, and your thoughtful suggestions.

Annex 2: Interview Guide (German)

INTERVIEW FORM – MASTERARBEIT

THE COST AND IMPACT OF PATIENT-CENTERED CARE

A Comparison of the Perception of Hospital Managers towards Patient-Centered Care under the Evaluation of Financial and Performance Pressures

INHALTSVERZEICHNIS

HINTERGRUND INFORMATION

Mein Name ist Melanie Hartl. Ich absolviere momentan ein Double-Degree Masterstudium mit den Schwerpunkten International Business an der Wirtschaftsuniversität in Prag und International Health and Social Management am MCI Managementcenter Innsbruck.

Das Ziel meiner Masterarbeit ist es, das Gleichgewicht zwischen zentral geplanten Strategien und lokalen Initiativen in Bezug auf patientenzentrierte Versorgung zu verstehen und zu klären ob die Umsetzung dieses Prinzips durch den finanziellen und operativen Betriebs- und Arbeitsdruck in Frage gestellt wird.

Definition von patientenzentrierter Versorgung

Der Begriff patientenzentrierte Versorgung ist ein weit verbreitetes Konzept, das in Europa und in Gesundheitsorganisationen erheblichen Schwankungen unterliegt. Für meine Masterarbeit habe ich eine eigene kurze Definition definiert:

> *Patientenzentrierte Versorgung ist ein Ansatz, der versucht sicherzustellen, dass alle klinischen Entscheidungen und Patienteninteraktionen von einer respektvollen, verständnisvollen, unterstützenden und ermutigenden Zusammenarbeit zwischen Patienten und allen Mitgliedern der Organisation geleitet werden. Das Ziel ist es klinische Ergebnisse zu verbessern, stärkere Patienten- und Familienbeteiligung zu erreichen, eine bessere Allokation von Ressourcen zu schaffen und die allgemeine Patientenzufriedenheit zu erhöhen.*

In der vorliegenden Studie interessiere ich mich jedoch besonders für Ihre eigene Definition, Interpretation und Perspektive der patientenzentrierten Versorgung.

VERTRAULICHKEITSERKLÄRUNG

Titel des Forschungsprojekts: The Cost and Impact of Patient-Centered Care

Ich, Melanie Hartl, studiere am Management Center Innsbruck und führe im Rahmen meiner Masterarbeit eine Studie zur patientenorientierten Versorgung durch. Sie stimmen der Teilnahme unter folgenden Bedingungen zu:

- Meine Teilnahme als Interviewpartner in diesem Projekt ist freiwillig. Es gibt keinen expliziten oder impliziten Zwang zur Teilnahme.
- Ich habe mir den Zweck und die Art der Studie schriftlich erklären lassen und hatte Gelegenheit, Fragen zur Studie zu stellen.
- Ich verstehe, dass ich während des Interviews jederzeit Fragen stellen kann, mich weigern kann irgendeine Frage ohne irgendwelche Konsequenzen zu beantworten und wenn ich mich während der Interview-Sitzung in irgendeiner Weise unwohl fühle, habe ich das Recht, das Interview abzubrechen.
- Alle Beiträge werden anonymisiert. Unter Absprache, ist es möglich auch die Organisation zu anonymisieren.
- Ich erlaube Melanie Hartl, sich während des Interviews Notizen zu machen. Ich erlaube auch die Aufzeichnung des Interviews und den anschließenden Dialog per Tonband. Es ist mir klar, dass ich das Recht habe, von der Teilnahme zurückzutreten, falls ich nicht möchte, dass das Interview und der Dialog aufgezeichnet werden.
- Ich habe die ausdrückliche Garantie erhalten, dass sämtliche im Rahmen des Interviews erhobenen Daten streng vertraulich behandelt und anonymisiert werden.
- Ausschnitte aus dem Interview dürfen in anonymisierter Form in der Masterarbeit und eventuell daraus hervorgehenden Veröffentlichungen zitiert werden.
- Ich habe die Punkte und Aussagen dieses Formulars gelesen und verstanden. Ich habe alle meine Fragen zu meiner Zufriedenheit beantwortet bekommen und stimme freiwillig der Teilnahme an dieser Studie zu.
- Ich habe eine Kopie dieses Einverständnisformulars erhalten, welches vom Interviewer unterzeichnet wurde.

Wenn Sie dieses Kästchen ankreuzen, stimmen Sie zu, dass Sie über das Forschungsprojekt und über Ihre Rechte aufgeklärt wurden. Außerdem erklären Sie sich dazu bereit, an diesem Interview teilzunehmen.

BITTE hier klicken: ☐

Melanie Hartl

Melanie Hartl, 14.04.2018

BERUFLICHER HINTERGRUND

Berufsgruppe	*Beschäftigungsgrad in dieser Funktion*	*Dienstgrad*	*Spezifische Ausbildung im Bereich der patientenorientierten Versorgung (wenn zutreffend):*
Führungsposition			
Klinischer Hintergrund (Arzt, Krankenschwester, anderes Gesundheitspersonal)			

TEIL 1: QUANTITATIVE STUDIE

Im ersten Teil dieser Untersuchung werden Sie gebeten, Ihre Zustimmung zu den folgenden Aussagen zu bewerten, indem Sie die folgende Skala verwenden (1 stimme überhaupt nicht zu - 2 stimme eher nicht zu - 3 stimme weder zu noch nicht zu – 4 stimme eher zu - 5 stimme voll und ganz zu). Bitte füllen Sie das jetzt selbstständig aus:

AUSSAGEN:	*Stimme überhaupt nicht zu*				*Stimme voll und ganz zu*
	1	2	3	4	5
Fachkräfte des Gesundheitswesens berücksichtigen die Präferenzen/ Vorstellungen/ Wünsche in Bezug auf die eigene Entscheidungsfindung im Behandlungsprozess des Patienten.	☐	☐	☐	☐	☐
Die Patienten werden dabei unterstützt, ihre eigenen Behandlungsziele festzulegen und zu erreichen.	☐	☐	☐	☐	☐
In der Patientenversorgung arbeiten Fachkräfte des Gesundheitswesens als Team über Abteilungen und Fachdisziplinen hinweg.	☐	☐	☐	☐	☐
Organisationseinheiten arbeiten zusammen in Teams um Patienten über ihre Krankheit zu informieren und ihnen dadurch ein eigenständiges Urteil über die Behandlungsmethode zu ermöglichen.	☐	☐	☐	☐	☐
Die Patienten erhalten eine koordinierte Versorgung basierend auf einem klaren und genauen Informationsaustausch zwischen den zuständigen medizinischen Fachkräften.	☐	☐	☐	☐	☐

Die Präferenzen der Patienten für den Austausch von Informationen mit ihren Partnern, Familienmitgliedern und/ oder Pflegepersonen werden während ihrer gesamten Betreuung respektiert und reflektiert.	☐	☐	☐	☐	☐
Angemessene Ausbildung und Schulung in patientenzentrierter Betreuung wird von der Organisation angeboten.	☐	☐	☐	☐	☐
Die oberste Führungsebene ist überzeugt von der Notwendigkeit einer patientenorientierten Versorgung.	☐	☐	☐	☐	☐
Eine strategische Vision wird jedem Mitglied der Organisation klar und kontinuierlich mitgeteilt.	☐	☐	☐	☐	☐
Für das Management der Organisation sind „Offenheit, Transparenz und Verantwortlichkeit“ handlungsleitend.	☐	☐	☐	☐	☐
Gesundheitsfachkräfte sind in der Lage, die Umsetzung patientenorientierter Versorgungsstrategien zu initiieren.	☐	☐	☐	☐	☐
Die Fachleute haben die Autorität eigene innovative und kreative Antworten auf die Bedürfnisse der Patienten zu finden.	☐	☐	☐	☐	☐
Abläufe sind hoch standardisiert und werden ständig durch Mess- und Analyseverfahren analysiert.	☐	☐	☐	☐	☐
Manager nutzen traditionelle organisatorische Mechanismen wie z.B. detaillierte Regeln und Richtlinien oder Leistungsindikatoren (KPIs) um Arbeitsprozesse von Mitarbeitern zu regeln.	☐	☐	☐	☐	☐
Patientenzentrierte Versorgung führt zu einem verbesserten Gesundheitsverhalten der Patienten und trägt damit zu einem geringeren Ressourcenverbrauch bei.	☐	☐	☐	☐	☐

TEIL 2: INTERVIEW GUIDE

Im zweiten Teil dieser Arbeit wird ein kurzes semi-strukturiertes Interview zu folgenden Fragen via Skype- oder Telefongespräch durchgeführt. Sie werden gebeten den zweiten Teil jetzt noch ***nicht*** *auszufüllen. Er dient lediglich als Vorinformation für das Interview.*

12. Betrachten Sie Ihre Organisation in Bezug auf ihre Ziele und die Erbringung von Dienstleistungen Ihrer Meinung nach als patientenzentriert?
    - Wenn ja/ nein: Warum?
13. Gibt es Ihrer Meinung nach Verbesserungspotenzial? Wenn ja, auf welche Weise?
14. Bitte bewerten Sie den Zustand der patientenzentrierten Versorgung in Ihrer Organisation auf einer Skala von 1-5:

Gar nicht zufriedenstellend	Eher nicht zufriedenstellend	Mittelmäßig	Eher zufriedenstellend	Zufriedenstellend

1	2	3	4	5

15. Was bedeutet patientenzentrierte Versorgung für Sie?
    - Was sind Ihrer Meinung nach die wichtigsten Erfolgsfaktoren für die Umsetzung von patientenorientierter Versorgung?
    - Erkennen Sie Hindernisse für eine patientenorientierte Versorgung? Welche?
16. Wie kann Ihrer Meinung nach, eine patientenzentrierte Pflege dazu beitragen, den Patienten eine hochwertigere Versorgung zu bieten?
17. Verwenden Sie patientenzentrierte Pflegestrategien? Wenn ja: Welche Ansätze oder Strategien verwenden Sie? (z. B. Serviceintegration, Förderung der Patientenselbsthilfe)
18. Haben Sie Vorschläge zur Verbesserung der patientenzentrierten Versorgung, wenn ja welche?
    - Sind Sie in der Lage diese Vorschläge umzusetzen?
    - Gibt es mögliche Konflikte beim Versuch, neue Strategien oder Vorschläge umzusetzen?
19. Wie können Sie wissen, ob Interventionen zur Verbesserung der patientenzentrierten Versorgung ihre Ziele erreicht haben (z. B. Patientenfeedback)?
20. Inwieweit ist das Management bzw. der Leiter der Abteilung Ihrer Erfahrung nach offen für Vorschläge bezüglich neuer Strategien oder Initiativen?

Gar nicht offen	Eher wenig offen	Mittelmäßig	Eher offen	Sehr offen
1	2	3	4	5

    - Wie könnte Ihnen das Management bzw. die Führungsebene bei der Bereitstellung von Patientenzentriertheit helfen?
21. Welche Rolle spielen ihrer Meinung nach Leistungs- und Finanzierungsziele bei der patientenzentrierten Versorgung?
    - Gibt es Leistungsziele, die spezifische Leistungskennzahlen/Messgrößen für die patientenzentrierte Versorgung festlegen, wenn ja, können Sie ein Beispiel geben?
    - Wird die Bereitstellung und Nachhaltigkeit der patientenorientierten Versorgung durch finanziellen Druck bedroht, wenn ja, wie?
    - In wie weit beeinflussen diese Ziele die patientenzentrierte Versorgung:

Gar nicht	Eher wenig	Mittelmäßig	Eher viel	Sehr viel
1	2	3	4	5

22. Haben Sie abschließend noch persönliche Anmerkungen in Hinblick auf das Thema patientenzentrierte Versorgung?

Annex 3: Measurement Tools (PCC)

The most common instruments to measure PCC according to literature are illustrated below (Yoder & Morgan, 2011; *Epstein & Street, 2011):

Instrument	Author	Description of Instrument
Person-Centered Climate Questionnaire (PCQ)	Edvardsson, Koch & Nay, 2009	"17-item instrument used to measure the extent to which the climate (ambiance, culture, and safety) of the inpatient setting is person-centered"
Individualized Care Scale (ICS)	Suhonen, Leino-Kilpi, & Välimäki, 2005	"40-item instrument used to measure how nursing interventions support a patient's individual characteristics, personal life situation, and decisional control over care during a hospital stay"
Patient-Centered Inpatient Scale (P-CIS)	Coyle & Williams, 2001	"20-item instrument developed to capture the client's experience of 'personal identity threat' in the health care setting"
Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ)	Laschinger, Hall, Pedersen & Almost, 2005	"19-item instrument designed to measure satisfaction with the quality of nursing care"
Short Form-36 (SF-36)	Gandek, Sinclair, Kosinski & Ware, 2004	"36-item survey that measures eight domains of health that fall into two categories (physical health and mental health): physical functioning, role limitation due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health"
Functional Independence Measurement (FIM)	Unsworth, 2001	"10-item scale used by the staff to measure independent performance in self-care, sphincter control, transfers, locomotion, communication, and social cognition at admission and discharge"
Consumer Assessment of Health Plans Survey (CAHPS)*	Solomon, Hays, Zaslavsky, Ding, & Cleary, 2005.	A survey that measures the "overall quality of interpersonal care across health care settings." "To provide actionable feedback to individual clinicians or health systems about what needs to be changed to achieve patient-centered care".

Annex 4: Contacted Organizations/ Units

Organization	Organizational Units	Linked with Number of People (in total)
Northumbria Healthcare NHS Foundation Trust	General Manager of the Medicine Unit Development Lead Director of Patient Experience and Research	5
Coxa Universitätsklinikum Graz	Management Director Medical Directorate Nursing Directorate Quality and Risk-Management Comprehensive Care Center	3 8
Hospital 4	CEO	1
Karolinska University Hospital	Senior Consultant Clinical Management Medical Management	 3
In total	12	20

Annex 5: SPSS Analysis for Variables (Mean)

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Patient Autonomy	4	1,5	3,5	5,0	4,250	,6455	,417
Teamwork	4	1,625	3,375	5,000	4,09375	,786441	,618
Coordination of Care	4	1,75	3,00	4,75	3,7500	,79057	,625
Involvement of family members/ carers	4	,75	3,25	4,00	3,6875	,37500	,141
Healthcare professional education	4	2	3	5	3,75	,957	,917
Committment of management and leadership	4	1,000	3,500	4,500	3,93750	,462106	,214
Openness of management	4	1,25	3,00	4,25	3,8125	,55434	,307
Local autonomy	4	1,0625	3,4375	4,5000	4,046875	,4546490	,207
Standardization of procedures	4	,562500000000000	3,437500000000000	4,000000000000000	3,691964285714285	,241841802596229	,058
Financial Ressources	4	,766369047619050	3,483630952380950	4,250000000000000	3,850074404761905	,356645186901551	,127
Valid N (listwise)	4						

Annex 6: SPSS Analysis for the Quantitative Analysis

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Patient Autonomy	8	2	3	5	4,00	,756	,571
Patient Autonmy	8	2	3	5	4,00	,756	,571
Teamwork	8	3	2	5	3,75	1,035	1,071
Teamwork	8	0	4	4	4,00	,000	,000
Coordination of Care	8	2,0	3,0	5,0	3,688	,7990	,638
Involvement of family members/ carers	8	2	2	4	3,50	,756	,571
Healthcare professional education	8	3	2	5	3,38	1,188	1,411
Committment of management & leadership	8	3	2	5	3,88	1,246	1,554
Committment of management & leadership	8	2,0	3,0	5,0	4,063	,5630	,317
Openness of management	8	2	3	5	4,00	,756	,571
Local autonomy	8	3	2	5	3,87	1,126	1,268
Local autonomy	8	3,0	2,0	5,0	3,813	,9234	,853
Standardization of procedures	8	3	2	5	3,63	,916	,839
Standardization of procedures	8	2,0	3,0	5,0	4,313	,7039	,496
Financial Ressources	8	2	3	5	4,00	,926	,857
Valid N (listwise)	8						