What Should Leaders Do When Inefficiency Is Perceived as a Cost of Inclusivity in Strategic Planning Processes in Health Care?

Commentary by Aveena Kochar, MD, and Alia Chisty, MS, MD

Abstract

During the development of new health care policies, quality improvement teams can face the challenge of weighing differing opinions within the group that can hinder progress. It is essential in such cases to refer to the four keys principles of quality improvement (QI) as a guide to enhance group cooperation and promote development of the mutual objective. Co-production is a model that emphasizes the participation of the patient—a service receiver—in the production of services being rendered by the health care professional. By putting into practice the QI principles and using the model of co-production, quality improvement teams can improve efficiency of health systems and clinical outcomes.

Case

Dr. Stevens chairs her institution's quality improvement council, a group dedicated to implementing hospital policies and procedures that promote optimal resource utilization and best possible clinical outcomes for patients. Every month, a multidisciplinary group of clinicians and administrators meet to discuss progress of recent quality improvement efforts. A particular area of concern has to do with reducing falls among inpatients. Falls can be catastrophic for some patients and can result in increased morbidity. Once they've happened, they can be difficult and costly to manage, and they can influence reimbursement.

The quality improvement council hopes to implement and optimize fall prevention initiatives to reduce patients' risk. After several months of planning, Dr. Tarib, a hospitalist, and Mr. Collins, a nurse informaticist, propose a plan that seeks to better integrate the roles of nurses, physical therapists, occupational therapists, medical assistants, and medical students into rehabilitation programs devoted to facilitating patients' walking. A goal of this plan is to integrate effective fall prevention strategies throughout patients' rehabilitation programs.

Dr. Stevens notices that the quality improvement council represents many organizational stakeholders whose input is regarded as necessary for implementing new initiatives but does not include former patients. She has read in a recent article that patient

involvement in strategic planning can contribute to improved health system efficiencies, improved health outcomes for patients, increased trust between clinicians and patients, increased satisfaction among patients, and reduced costs for health care organizations. She regards the absence of former patients' perspectives as a shortcoming in the quality improvement council's strategic planning processes. Several council members agree that former patients' views should be incorporated, and a small group of former patients who have recovered from falls in health care settings have now been invited to deliberate with the council about developing fall prevention initiatives.

Some members of the group of former patients suggest that they are not comfortable with the roles proposed for medical assistants and medical students in the fall prevention plan proposed by Dr. Tarib and Mr. Collins. While they express respect for the professional experience that informs Dr. Tarib's and Mr. Collins's fall prevention proposal, they also express suspicion about entrusting critical parts of implementing the fall prevention protocol to assistants and students. They cite their own experiences, recalling how their walking rehabilitation efforts required intense physical exertion and also aroused feelings of anxiety about how their bodies would be handled by those upon whom they depended to help them try to keep stable and upright when they felt weak and needed more help during their rehabilitation sessions.

One former stroke recovery patient says, "I relied on a masters-prepared physical therapist who understood how a body like mine could fall. She trained me in how to do these micro-movements that were critical to my progress. I just can't imagine a medical student or medical assistant having the index of experience, expertise, and patience to help me like she did. They're not trained like physical therapists at all. Why would you expose a vulnerable postoperative patient, for example, to that kind of risk? Is it to save money?"

While initially eager about welcoming former patients to the council deliberation, Dr. Tarib and Mr. Collins now feel frustrated. This former patient's comment and a few others like it during the most recent meetings of the council prompts some clinician members to complain about how former patients' participation requires longer and more frequent meetings, partly due to the need to explain clinical concepts with which clinician members of the council are already familiar and comfortable. They openly express their aggravation privately to each other and to Dr. Stevens, declaring, "The patients have raised some important points, but they don't always know what they're talking about. The conversation is now full of complexities we didn't worry about before. How will we ever come to a decision? I just can't keep taking time away from my other duties to attend meetings that are full of inefficiencies, obstacles, and questions. We're not making progress anymore."

As chair of the council, Dr. Stevens must decide what to do.

Commentary

As seen with Dr. Stevens and the quality improvement council, incorporating patients into the process of developing a new policy can be challenging and met with resistance by health care professionals who, though well-meaning, have competing interests. Moreover, time pressures often cause clinicians to revert back to traditional paternal roles. In this paper, we first examine the simultaneous development of patient-centered care and co-production to understand the centrality and importance of patient engagement to co-production initiatives. We then show that, by adopting the Health Resources and Services Administration's four pillars of quality improvement (QI)—a focus on patients, on being part of the team, on the use of data, and on quality improvement as a system and process [1, 2]—Dr. Stevens can guide the members of the group to remain true to the purpose of co-creating QI projects.

The Development of Patient-Centered Care and Co-Production

Over the last two decades, society has seen a monumental transformation in the patient-physician relationship. Traditionally, the relationship was paternalistic. Similar to the manner in which a parent instructs a child to complete a task without discussion, physicians would dictate the care of patients without knowledge of their patients' preferences. The SUPPORT study of end-of-life care of hospitalized patients, published in 1995, showed that physicians were not well informed about their patients' preferences and that less than half of physicians knew that their critically ill, hospitalized patients preferred to avoid resuscitative measures and that half of the advance directive orders were written within two days of death [3]. Following the publication of this revolutionary study, the necessity for a new approach to patient-physician interaction became apparent. In 2001, the Institute of Medicine stated that "patient-centered care," defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions," would become a core goal of the US health care system [4]. In the following years, further studies showed that patient-centered care improved patient satisfaction with physicians, quality of care, and health utilization [5, 6].

As the approach to care changed at the level of individual patient-physician relationships, there was a parallel shift in health care systems and policy. When approaching broader health care systems, the concept and development of co-creation becomes important as first implemented in the commercial world, with its "production" and "services" divisions. Businesses began incorporating individual customer preferences into the production division over half a century ago [7], and the concept of co-creation—the joining of the consumer and producer to jointly influence the development of a product—was developed. Two marketing professors pushed this concept of customer involvement into the service industry in 2008 [8]. Co-creation in the health care system, similar to the concept of patient-centeredness at the level of individual patient-physician

relationships, encourages the involvement of the patient in care but at the level of developing new health care policies that are broadly implemented [9]. Patients thus have an opportunity to aid in the development of policies based on their own experiences.

The Relevance of QI Principles in Implementing Co-Creation Projects
Focus on the patient. Incorporation of patient preferences and ideas into the development of health care policies can be challenging in a system that only recently has encouraged a shift away from its traditional paternalistic roots toward patient centeredness. Physicians and other clinicians often feel more knowledgeable and superior to their patients, thereby undermining patients' opinions, as is evident from the remarks of clinician members of the council about the "complexities" and "inefficiencies" of patient involvement in this case. As mentioned earlier, one of the four essential pillars for successful QI projects is the focus on patients [1, 2]. Instilling in and reminding the QI council team members that involvement of patients is an important and founding principle can help further the project. When there is a focus on the patient, understanding the patient's concerns becomes paramount. This focus also allows for acknowledgement of issues, ideas, and shortcomings, such as recognition of the need for patient education, which might not have been previously considered. In this case, Dr. Stevens has an essential role to play in facilitating patient involvement. The patients should be counseled on the importance and advantages of early mobility in fall prevention, and the QI group will need to evaluate the population of patients for which the intervention is relevant.

Focus on being part of a team. Physicians and other medical staff team members can often feel that the inclusion of patients in the involvement of QI projects hinders and slows the progress of the project, creating a tension between efficiency and inclusivity. In these cases, the second of the four QI principles becomes important: the need to focus on being part of a team. It is essential for members of the team to acknowledge that each of the other team members is an asset. Each team member has different knowledge and experience that informs his or her ideas and principles [1]. For example, Dr. Tarib can provide information about the medical physiology behind a fall, Mr. Collins can attest to barriers in patient mobility on the floor, and the patients can relate personal experiences of falling and rehabilitation. Development of an intervention for QI projects is multifaceted and involves multiple disciplines. Taking advantage of individuals' and divisions' unique characteristics in a multidimensional approach will allow the council to view falls from multiple vantage points. It is each individual's responsibility to listen and be open to new ideas [1].

In this case, Dr. Stevens should not capitulate to the demands of the clinician members of the QI team by removing the patient members of the team. Their input is invaluable in the QI process. However, as the team leader, she can hold herself accountable for promoting team efficiency by setting meeting agendas, a clear plan for communication,

and a process for decision making. By reducing the tension between efficiency and inclusivity, Dr. Stevens can hope to address the concerns of the clinician members while still incorporating the viewpoints of the patient members of the team.

QI as a system and process. QI is divided into two major components: what is done and how it is done. Process mapping can help evaluate or redesign a current process to meet the specific needs of the health service delivery system [9] by allowing an organization to better understand what and how care is provided and if that care is congruent with evidence-based guidelines. It is imperative that those who implement policies and practices in health care systems be both responsible and accountable to patients who are the recipients of service delivery, which often involves communication, education, and explanation of the details of the service. In the case of Dr. Stevens, accountability would involve integrating the opinions of the patients who would be the recipients of the fall prevention program into the QI process to produce the most effective program possible.

Focus on data. QI strives to allow the care team and the patient to interact productively and efficiently to achieve optimal health outcomes. We measure these outcomes by focusing on data, whether it is quantitative or qualitative [1]. Using standardized performance measures and focusing on existing data, people can identify opportunities for improvement and monitor the improvement over time. Since Dr. Stevens's team members are concerned about time, she can suggest implementing the best co-produced version of the fall prevention program with a clear timeline for evaluating its efficacy and promptly incorporating changes based on feedback from actual patients experiencing the program. This would be another way to engage patients in the development of the fall prevention program by responding to data.

Conclusion
In conclusion, co-production is valuable and necessary for the development of effective quality improvement projects. In this case, Dr. Stevens should not limit patient involvement at the request of the clinician members. Instead, she can refer to the four principles of QI—focus on patients, focus on teamwork, focus on use of data, and understanding QI work as systems and processes [1, 2]—to remind physicians of the purpose of QI programs and to emphasize the need for patient participation in order to truly provide patient-centered care. By keeping in mind these four principles, QI teams can co-produce services that enhance the quality of care provided to patients, utilize patients' knowledge in service delivery, integrate patients' opinions to enhance the quality of the system or process, and finally generate solutions that are more effective and efficient.

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