



# Shaping tomorrow's healthcare systems: key stakeholders' expectations and experiences

Stephen J. O'Connor<sup>1</sup>, Nancy Borkowski<sup>1</sup>, Katherine A. Meese<sup>1,2</sup>

<sup>1</sup>Department of Health Services Administration, School of Health Professions, University of Alabama at Birmingham, Birmingham, AL, USA;

<sup>2</sup>Office of Wellness, UAB Medicine, Birmingham, AL, USA

Correspondence to: Stephen J. O'Connor, PhD. Department of Health Services Administration, University of Alabama at Birmingham, 557 School of Health Professions Building, 1705 University Blvd., Birmingham, AL 35294, USA. Email: [sjo@uab.edu](mailto:sjo@uab.edu).

Received: 24 May 2022; Accepted: 03 August 2022; Published: 25 December 2022.

doi: [10.21037/jhmhp-22-60](https://doi.org/10.21037/jhmhp-22-60)

View this article at: <https://dx.doi.org/10.21037/jhmhp-22-60>

Enhancing the experiences and meeting or exceeding the expectations of important healthcare stakeholders such as patients, healthcare workers and organizations, informal caregivers, communities, payors, and government is the focus of this special series, "Shaping Tomorrow's Healthcare Systems: Key Stakeholders' Expectations and Experiences." Much attention over the past two decades and from around the globe has been given to the patient stakeholder and the patient experience. For example, the Organization for Economic Cooperation and Development (OECD) suggests that its member countries assess and consider the patients' perspective as a key element of any healthcare quality improvement initiative (1). Likewise, the Commonwealth Fund supports research in a variety of countries to better comprehend the patients' experience as a means to fundamentally improve healthcare delivery (2). At the same time, there has been an emerging realization of the vital importance of other stakeholders in terms of improving patient experience. See for example, Spiegelman and Berret's book: "*Patients Come Second: Leading Change by Changing the Way You Lead*" (3), and recent research identifying mistreatment from patients and visitors as the largest source of mistreatment for physicians at work (4). The coronavirus disease 2019 (COVID-19) pandemic has especially brought into sharp focus the true value of the healthcare workforce as well as other areas in need of improvement within our broader health systems.

This special series examines a wide and diverse range of healthcare stakeholders that interact in ways that support and enhance the patient experience. These stakeholders range from the broader macro level such as an entire

country's health system to micro level delivery aspects of workflow processes and care standardization. At the macro level, it is necessary to examine those broader components of our national health systems, the physical facilities in which care is delivered, and the organizational leadership designs relative to how well they are serving our patients, workforce, and communities. Macro level topics addressed in this series include: (I) the revitalization of the Italian National Health Service (NHS); (II) healthy building designs and features, and (III) the value and sustainability of the Chief Experience Officer (CXO) role.

In Italy, Vendramini and Lega describe the severe stresses faced by the Italian National Health Service (NHS) during the early part of the COVID-19 pandemic. The pandemic, coupled with the decentralized nature of the Italian Health System (organized by regions), an insufficient governance structure, and less than adequate national coordinating mechanisms among the country's 20 regions served to hamper NHS performance. The authors describe specific challenges for the NHS that have been heightened by the pandemic and the revitalization plan (Next Generation EU Plan) approved by the Italian Parliament and the European Union to address those challenges. The prospects for recovery plan implementation success and financing are discussed.

At the facility level, Marberry *et al.* examine "healthy buildings" and their potential to improve the health of patients, staff, and communities. Moreover, they describe how building design can significantly affect pollution levels, such as carbon emissions, that are associated with climate change. The authors note that approximately 25% of global

healthcare greenhouse emissions derive from the U.S. healthcare system (5). They further discuss the benefits of healthy buildings in terms of organizational and community stakeholders as well as return on investment. The article concludes with specific action steps for healthcare leaders to motivate and guide the creation of healthy buildings. This article is particularly useful for health care leaders who almost continuously find themselves responsible for building renovations, retrofits, and new construction. It is a concise guide for how to create healthy buildings for the benefit of not only the people who use it, but for the entire planet as well.

Choi and colleagues explore the sustainability of the Chief Patient Experience Officer (CXO) role over time in U.S. hospitals. The principal findings, consistent with earlier work, is that hospitals that maintain a formal CXO role demonstrated significantly higher Hospital Consumer Assessment of Healthcare Provider and System (HCAHPS) ratings for patient overall experience and willingness to recommend. The U.S. Centers for Medicare & Medicaid Services (CMS) and other payers have been moving away from traditional fee-for-service payment methods towards a value-based purchasing (VBP) approach that rewards higher clinical quality, lower costs, and improved patient experience. As the authors note, attention to patient experience can improve clinical quality and lower costs (6), and lead to improved patient safety, employee satisfaction, physician engagement, resource utilization, and readmission rates (7). Furthermore, greater patient experience can serve to positively differentiate a healthcare organization from competitors. The results of this study demonstrate the positive return on investment associated with the creation of a CXO role and the reasoning for sustained investment in this role.

Meso or mid-level topics presented relate to: (I) the association of patient experiences to clinical outcomes in a trauma center; (II) factors associated with well-being among healthcare workers; (III) how an Accountable Care Team (ACT) model relates to reduced stress among healthcare workers during the COVID-19 pandemic; (IV) the role of informal caregivers on healthcare teams; and (V) strategies for improving physician (resident, fellow, and faculty) experience and well-being.

In their article, Oberle *et al.* investigate whether or not patient experience is associated with important clinical outcomes in a Level I trauma center in the U.S. Using HCAHPS data to assess patient experience, the authors demonstrate the reliability and validity of the HCAHPS

domains in the trauma setting. For the entire sample of trauma patients, a significant negative association was found between the nurse communication HCAHPS domain and hospital-acquired complications. For the severely injured subgroup, significantly lower rates of 30-day readmissions were observed for subjects reporting positive nurse communication, positive physician communication, positive overall hospital rating, and a willingness to recommend the hospital to others. The authors discuss these results in terms of improving the structures and processes that enhance nurse communications and ensuring trauma patients receive high quality care and best outcomes.

Colón-López and colleagues report on a mixed methods approach to studying factors linked with distress among specific types of healthcare workers – physicians, nurses, advanced practice providers, clinical support staff, and non-clinical support staff. Employing a sample of 1,037 subjects and a 9-item Well-Being Index (WBI) dependent variable, stepwise and multivariate regression analyses were performed to examine the relationship of decisional involvement, work control, resiliency, preferred organizational support, moral distress, and other stressors (non-work, general work, and clinical work stressors) to well-being. Additional qualitative analyses of the open-ended responses were conducted using NVivo 11. The authors found that nurses reported highest distress scores among the types of workers studied. They also found correlates of well-being applicable to all worker categories and uncovered unique correlates associated with specific worker subgroups. These results can assist healthcare leaders by concentrating interventions on particular occupational categories.

Meese *et al.* describe the Accountable Care Team (ACT) model used in a large academic medical center and the extent to which working in such a team was related to reduced stress during the COVID-19 pandemic. In other words, can the ACT model serve as a form of “psychological personal protective equipment” (PPE) that can help protect the well-being of healthcare workers during a crisis event such as the COVID-19 pandemic? The ACT model invites traditional hierarchical healthcare teams to adopt a flatter, more collaborative configuration for shared decision making. Common components of the ACT model include: (I) designated unit-based leaders, generally a physician-nurse leadership dyad, (II) cohorting of patients, physicians and team members to the unit as much as possible, (III) high-performing daily interprofessional team care planning rounds, (IV) proactive leadership dyad assessment of

patient experience, and (V) access to unit-level data for use by the team in performance improvement (8,9). Study results indicate that ACT members felt less lonely and socially isolated, leading to a sense of belongingness and connectedness at work; however, ACT membership was not associated with improvements in overall distress scores.

Stephenson and colleagues explore the role, considerations, and implications of including family and friend caregivers of older adults in healthcare teams. Despite the fact that more than 80% of these caregivers are responsible for coordinating care with providers, effectively incorporating them into the care delivery process is typically hampered by a lack of acknowledgement and coordination. The authors discuss important reasons to better incorporate caregivers on healthcare teams including caregiver engagement, team dynamics, professional identity and status, and the boundaries between formal and informal work. Health care management and policy implications are addressed for effectively incorporating caregivers to leverage improvements in care delivery for older adults and those caring for them.

In a New York City healthcare system, Peccorale *et al.* report on physician (faculty and trainees) needs assessments and subsequent interventions. Faculty physicians placed greatest value on opportunities for mentorship, leadership skills, enhanced teamwork, and appreciation. Graduate trainee physicians valued wellness day policy enforcement, workspace improvements, and appreciation. In response, five primary interventions were established and deployed. These included: (I) creation and enhancement of a Well-Being Champion Program; (II) development of well-being plans; (III) efforts to reduce electronic health record (EHR) and clerical work burden; (IV) wellness days; and (V) leadership development programs for faculty. This research expands our understanding of the elements associated with physician well-being and burnout and means by which these elements can be counteracted.

At the micro level, article topics include: (I) diversity signaling in nurse recruitment and (II) the use of Discrete Event Simulation (DES) to explore visualization (work performed at a remote location) of magnetic resonance (MR) imaging procedures for improved efficiencies, scanner utilization, patient experience, workflow, and care standardization.

Cole and colleagues examine Diversity Value Signaling (DVS), an extension of Signaling Theory, in nursing job advertisements at 100 leading hospitals in the U.S. Their findings indicate that inclusion of DVS in nurse job

advertisements at these leading hospitals relates to higher performance in terms of both hospital ranking and patient experience scores. Additional analyses show that the use of compliance-based DVS language—language explicitly stating the hospital’s compliance with the law to not discriminate—was associated with lower U.S. News ranking and patient experience scores. The research is particularly relevant as the percentage of the U.S. population identifying as racial and ethnic minorities exceeds 40% and is predicted to surpass 50% by the mid-2040s (10). Juxtaposing this trend on to a nursing workforce that has been persistently comprised of mostly white females (11), one can see how this workforce does not mirror the diversity observed in the general population. Moreover, nursing represents the single largest healthcare profession in the U.S. and has presented significant challenges to recruiting a diverse workforce; a challenge which has been exacerbated since the onset of the COVID-19 pandemic.

Using DES, Lun *et al.* explore virtualization of MR imaging procedures as a means to improve efficiency, lower cost, lower patient times, and enhance overall utilization. Results showed that a model suitable for virtualization (work performed at a remote location) that offloaded the ‘checking unreported implants’ and ‘acquiring image’ to expert technologists lowered time per exam by 12.73 minutes and the average wait time by 6.89 minutes compared to the traditional MR workflow. Benefits of these virtual MR procedures include improvements in efficiency, scanner utilization, patient experience, workflow development, and care standardization.

In summary, the articles in this special series demonstrate the many ways by which the expectations and experiences of patients and other healthcare stakeholders can be understood and improved. Stakeholders’ expectations and experiences must be carefully considered and adequately addressed to strengthen the responsiveness and performance of our health systems.

## Acknowledgments

*Funding:* None.

## Footnote

*Provenance and Peer Review:* This article was commissioned by the editorial office, *Journal of Hospital Management and Health Policy* for the series “Shaping Tomorrow’s Healthcare Systems: Key Stakeholders’ Expectations and Experiences”.

The article did not undergo external peer review.

*Conflicts of Interest:* All authors have completed the ICMJE uniform disclosure form (available at <https://jhmhp.amegroups.com/article/view/10.21037/jhmhp-22-60/coif>). The series “Shaping Tomorrow’s Healthcare Systems: Key Stakeholders’ Expectations and Experiences” was commissioned by the editorial office without any funding or sponsorship. All authors served as the unpaid Guest Editors of the series. SJO serves as an unpaid editorial board member of *Journal of Hospital Management and Health Policy* from August 2021 to July 2023. The authors have no other conflicts of interest to declare.

*Ethical Statement:* The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated or resolved.

*Open Access Statement:* This is an Open Access article distributed in accordance with the Creative Commons Attribution-NonCommercial-NoDerivs 4.0 International License (CC BY-NC-ND 4.0), which permits the non-commercial replication and distribution of the article with the strict proviso that no changes or edits are made and the original work is properly cited (including links to both the formal publication through the relevant DOI and the license). See: <https://creativecommons.org/licenses/by-nc-nd/4.0/>.

## References

1. OECD Health Ministerial Statement – The next generation of health reforms. 201701/18.
2. Schoen C, Osborn R, How SK, et al. In chronic condition: experiences of patients with complex health care needs, in eight countries, 2008. *Health Aff (Millwood)* 2009;28:w1-16.
3. Spiegelman P, Berrett B. *Patients Come Second: Leading Change by Changing the Way You Lead*. New York, United States: An Inc. Original, 2013.
4. Rowe SG, Stewart MT, Van Horne S, et al. Mistreatment Experiences, Protective Workplace Systems, and Occupational Distress in Physicians. *JAMA Netw Open* 2022;5:e2210768.
5. Eckelman MJ, Huang K, Lagasse R, et al. Health Care Pollution And Public Health Damage In The United States: An Update. *Health Aff (Millwood)* 2020;39:2071-9.
6. Manary M, Staelin R, Kosel K, et al. Organizational characteristics and patient experiences with hospital care: a survey study of hospital chief patient experience officers. *Am J Med Qual* 2015;30:432-40.
7. Meyer MA. Qualifications and skills required for patient experience positions. *J Patient Exp* 2020;7:1535-42.
8. Marrone SR. Perioperative accountable care teams: Improving surgical team efficiency and work satisfaction through interprofessional collaboration. *J Perioper Pract* 2018;28:223-30.
9. Kara A, Johnson CS, Nicley A, et al. Redesigning inpatient care: Testing the effectiveness of an accountable care team model. *J Hosp Med* 2015;10:773-9.
10. Mizrahi I. The minority-majority shift. Two decades that will change America. The surge of multiracial families. *Forbes* 2020. Available online: [www.forbes.com](http://www.forbes.com)
11. Bonini SM, Matias CE. The impact of Whiteness on the education of nurses. *J Prof Nurs* 2021;37:620-5.

doi: 10.21037/jhmhp-22-60

**Cite this article as:** O’Connor SJ, Borkowski N, Meese KA. Shaping tomorrow’s healthcare systems: key stakeholders’ expectations and experiences. *J Hosp Manag Health Policy* 2022;6:31.