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Measuring person-centred care in the mission, vision, and core value statements of Canadian healthcare organizations

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Abstract

Background Person-centred care (PCC) has been shown to improve health outcomes. The inclusion and incorporation of person-centredness in care has been a growing priority for healthcare organizations across Canada.

Methods Person-Centred Care Quality Indicators (PC-QI) evaluate to what extent various PCC elements have been integrated into healthcare organizations. Using the first PC-QI, content analysis was performed on the mission, vision, and core value statements of 54 healthcare organizations to assess whether PCC is being included as a strategic and decision-making priority in the Canadian healthcare system.

Results Fifty-three healthcare organizations (98%) included at least one domain of PCC in their statements. The three most frequent were compassionate care (85%), trusting relationship with providers (70%), and co-designed care (56%). There was no presence of affordable care.

Conclusion Canadian healthcare organizations are working towards promoting and implementing a culture that prioritizes some elements of PCC in the care of patients.

Keywords Patient-centred care, Person centred care, Quality indicator, Mission, Vision, Value, Healthcare organization

Background

Person-centred healthcare practice is important both for overall patient experience and health outcomes. Healthcare lacking person-centredness can lead to a greater risk of mortality and increased healthcare utilization and cost [1]. As described in a 2001 report from the Institute of Medicine, person-centred care (PCC) is "healthcare that respects and responds to the preferences, needs and values of the individual patients throughout all healthcare decisions". Implementing PCC has become a growing priority in healthcare since the turn of the century [2] due to its applications in providing higher quality patient care and improved job satisfaction for providers [1].

Healthcare provision in Canada differs by province. Some provinces have province-wide health systems, while others – as an effort in the 1990s to improve service delivery while managing cost – decentralized health care delivery to regional entities [3]. Operating regionally, health authorities plan and deliver healthcare that maintains and reflects the key priorities of the provincial and territorial ministries of health [3, 4]. Health authorities play a crucial role in the development and

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implementation of policy that promotes and enables PCC at the organizational level.

PCC, while highly beneficial for improving healthcare delivery, can be difficult to put into practice. To meaningfully assess the success of PCC strategies, a team of Canadian researchers and patient partners developed the Person-Centred Care Quality Indicators (PC-QIs) as part of a thorough, multi-phase process [5] to measure and assess PCC at the healthcare system level [6]. This set of indicators has been shown to be associated with health outcomes and care experiences, such as unplanned healthcare use following hospital discharge [7], various aspects of the treatment of serious illness [8] and community pharmacy services [9]. The development of the 26 PC-QIs are described in our previous publications [5, 10]. Using these indicators to assess PCC can help to improve health care quality,this paper focuses on the first of these indicators regarding the existence of policy on person-centred care [5].

The first PC-QI is called "Policy on Person-Centred Care" and seeks to make PCC an organizational priority by identifying if healthcare organizations have created a culture of PCC through measurement of structures that supply PCC [5]. This PC-QI measures whether there is policy (or policies) in place to provide the strategic direction and support needed for healthcare organizations to achieve their goals related to PCC [11]. This can include PCC protocols, education programs and the use of metrics for quality improvement and public reporting [11].

The decision-making, behaviours, actions, and overall culture of health authorities are guided by mission, vision, and core value statements [12–14]. Mission statements describe an organization's direction,communicating its purpose for existing, ongoing strategic plan for survival and growth, and how the organization will achieve its goals [12]. Vision statements concisely describe an organization's aspirations [14]. Core value statements are embodiments of the standards of care of an organization [13]. Every individual in the organization is responsible for adhering to the mission, vision, and value statements of the entity they represent. There are few studies that have examined the content of health organizations' mission, vision, and core value statements. One study examined the content of the world's 'top 5 hospitals' for their mission, vision, and core value statements [15], and one of the hospitals identified was a Canadian hospital (Toronto General Hospital- University Health Network).

Evaluating the mission, vision, and core value statements for the presence of person-centred care can provide insight into whether the Canadian healthcare system is implementing strategic direction for PCC at their highest level. A survey conducted by Doktorchik et al. [16] highlighted the need for a "standard of quality for patient-centered care" which can be executed through consistent use of PC-QIs for evaluation. The objective of this study is to assess the application of PC-QIs to evaluate the person-centredness of policy of health authorities across Canada.

Methods

Developed by Dalgish et al. [17], the READ (Ready materials, Extract data, Analyze data, Distil findings) approach is a four-step systematic process used in health policy research when conducting a review or evaluation of both print and electronic documents. It involves identifying the parameters of the document review (Ready materials), how data will be collected and organized (Extract data), the methods for data analysis (Analyze data), and refinement of the findings (Distil findings).

Step 1: ready materials

To address the research objective and define the study's parameters, the definition of the policy PC-QI was reviewed. The following five-part definition was established by Santana et al. [5] for organizations to use to assess whether a foundation for PCC is being provided through policy and culture:

1. Establishment of an operational definition for PCC
2. Inclusion of PCC in the organization's Mission and Vision
3. Inclusion of PCC as part of the organization's Core Values
4. Allocation of resources to support and implement PCC
5. Evaluation of PCC protocol and program implementation with the perspective of patients.

This study is focused on whether a PCC definition is present in the mission, vision, and values, and does not include an assessment of how PCC may be operationalized or evaluated. As such, assessment of the presence of PCC in a policy is only based on the first three components of the definition. No ethics approval was required for this study.

The study's inclusion criteria was healthcare organizations based in Canada that were responsible for delivering health services in a given region. After a current list of organizations that met the inclusion criteria was compiled, a search strategy was employed to find each authority's mission, vision, and core value statements. Each organization had a publicly available website, and these were searched to identify a page describing their mission, vision, and value statements. The most recent publicly available strategic plan was also consulted to see if it aligned with the mission, vision, and value described on the website. In the cases where there were discrepancies between the website and the strategic plan, the

strategic plan's version of the mission, vision, and core value statements were used instead.

Step 2: extract data

The statements of each health authority's mission, vision, and core values were then compiled into an excel spreadsheet to be prepared for content analysis of the data. For statements provided in French, the website's English version was used. In the case that an English version was not provided, the French mission, vision, and/or core value statement was translated into English and the translated version was then coded and analyzed.

The definition of PCC present in the person-centred care framework developed by Santana et al. [11] was used to guide step 2 and 3: a "holistic approach to care that incorporates the various dimensions to whole well-being, including a person's context and individual expression, preferences and beliefs". Thirteen key domains from the person-centred care framework were identified as potential components of PCC that might be mentioned in mission, vision, and core value statements:

1. Person-centred care,
2. Culturally competent care,
3. Co-designed care,
4. Compassionate care,
5. Equitable care,
6. Trusting relationship with providers,
7. Communication,
8. Coordination of care,
9. Patient involvement in decisions,
10. Timely access to provider,
11. (Use of) Patient-reported outcome measures,
12. Patient experience, and
13. Affordable care.

Step 3: analyze data

Using these thirteen PCC-related domains, content analysis – an approach used to identify meaning and interpret themes from recorded communication [18] – was performed on the mission, vision, and core value statements included on the websites as of August 31st, 2023. Content analysis allows for the use of a framework such as the PCC definition and domains to interpret broad strategic policy such as mission, vision, and core value statements [18, 19]. Each organization's available mission, vision, and core value statements were compiled into an excel spreadsheet and coded according to the domains. The mission, vision, and value statements of each organization were coded by the first, second, and third authors. All terms were coded independently. Afterwards, the research team discussed and came to a consensus on the decisions made regarding coding.

Step 4: distil findings

Through a review of the mission, vision, and value statements of health organizations, the PC-QI "Policy on Person-Centred Care" was able to guide an exploration of how PCC is embedded in healthcare authorities in Canada.

Results

Data was collected from 54 healthcare delivery organizations. Four of the institutions were provincial health authorities (Alberta, Nova Scotia, Prince Edward Island, and Saskatchewan) and four were territorial health authorities (Northwest Territories and Nunavut). British Columbia, Manitoba, New Brunswick, and Newfoundland and Labrador further regionalized their province's health system resulting in sixteen regional health authorities being recorded in this study.

Ontario, Quebec, and Yukon do not use provincial/territorial and/or regional health authorities. Integrated health systems that operated in similar functions were used instead to broaden the study's scope. Seven institutions were regionalized hospital networks (six from Ontario and one from Yukon). For Quebec, 21 of these integrated health systems were identified as the CISSS (integrated health and social services centres/centre intégré de santé et de services sociaux)/CIUSSS (integrated university health and social services centres/centre intégré universitaire de santé et de services sociaux). An additional two regional boards relating to indigenous health from Quebec were included.

In Appendix 1, we present the 54 organizations whose mission, vision, and value statements were extracted for this study. This list considers the province/territory, name of the organization and the type of organization included (e.g., provincial, regional, or territorial authority, or regionalized hospital network (RHN)).

Figure 1 demonstrates that compassionate care, trusting relationship with providers, and co-designed care were the three most present PCC domains. There was no mention of affordable care in the mission, vision, value statements of any health authorities.

Table 1 contains examples of the PCC domains from the mission, vision, and core value statements of the included organizations.

Discussion

This paper assesses the presence of PCC in the mission, vision, and core value statements. While without conducting full-scale evaluations this analysis cannot conclude whether the health authority has effectively implemented person-centred care, it does provide insight into whether elements of PCC were highlighted in organizational guiding statements.

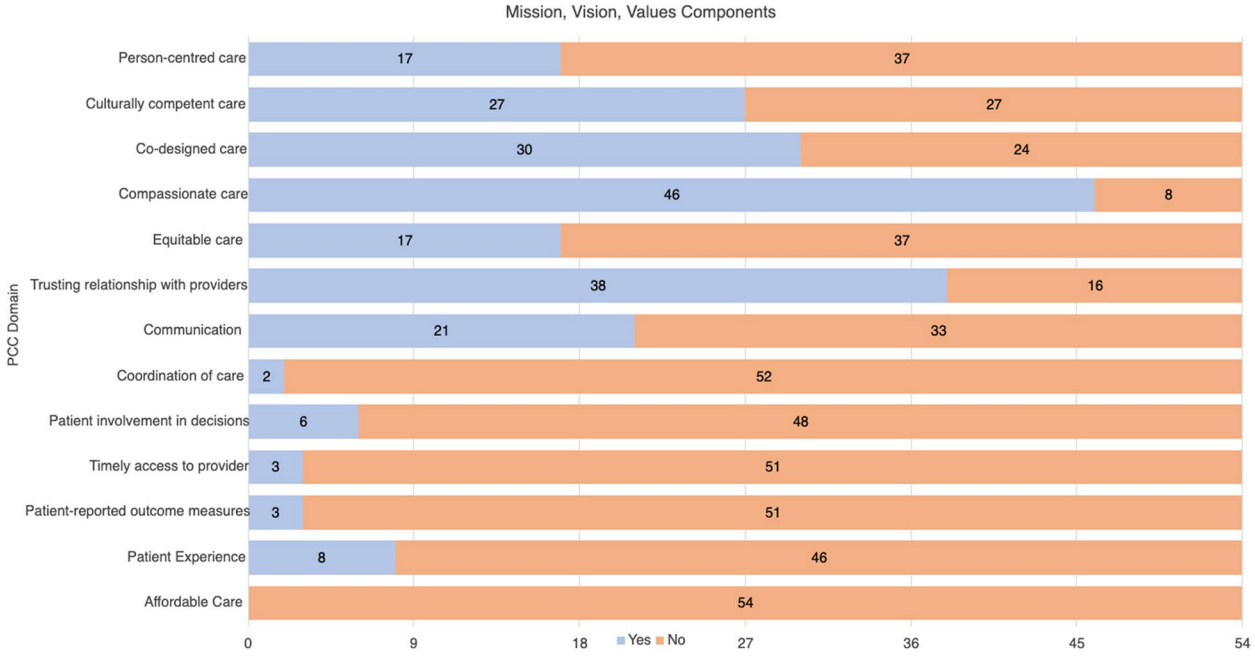

Fig. 1 PCC domains presence in mission, vision, core value statements

The inclusion of person-centred care ensures that healthcare received by Canadians is respectful and responsive to their needs, preferences, and values, which in turn has been shown to improve healthcare outcomes.

Assessing the inclusion of person-centred care in the mission, vision, and core value statements illustrates whether healthcare organizations across Canada are promoting a culture that prioritizes PCC in the care of patients. 53 out of the 54 institutions included at least one of the thirteen domains included in our operational definition of PCC. Therefore, suggesting that person-centred care values, at least in some form, are present in Canadian health authorities. Compassionate care, trusting relationship with providers, and co-designed care were the three most common domains present in Canadian organizations' policies and are key components of PCC.

Compassionate care is empathetic, kind, and mindful of the individual needs of patients. It recognizes the suffering of patients and drives the motivation of providers to act to provide quality care [20]. Compassionate care allows for relationship building and effective communication to take place between patients and providers [11], this, in turn, leads to the establishment of trusting relationships with providers [21].

Trusting patient-provider relationships are a necessity for PCC. Patients who experience distrust, or overall lower levels of trust in their healthcare provider, have been found to delay seeking care [22], are less likely to adhere to treatment, and overall report greater dissatisfaction with their care [23]. Quality patient-provider relationships are marked with trust, respect, accountability, and integrity. Taking the time to establish these relationships can increase effective and equitable communication and respect between patients and providers [23].

Co-designed care focuses primarily on the need for collaboration/partnership between providers and patients/communities. By communicating openly with patients about their care, compassionate care shines through as a beacon of reassurance, empathy, and responsiveness to patient needs [2, 24]. This can improve patient adherence to treatment/care, satisfaction with care, and health outcomes [25].

These domains all play a critical role in ensuring that organizations create and promote a PCC culture. Organizations placing a focus of culture rather than establishing structures (e.g. programs, training) is consistent with literature, which suggests that promoting a PCC culture derived from patients and providers is essential for laying a sustainable foundation for the arrival of PCC structures, such as programs, protocols, and additional PCC resources [11]. To improve health outcomes, a supportive, accommodating, and trusting environment between patients and providers must be built. This allows co-design with patients to take place and for patients to feel dignified and respected in the choices being made about their health.

It is significant to note that none of the organizational documents reviewed included affordable care as part of their PCC policy. Affordable care as a domain exists to improve health outcomes by using PCC as a foundation

Table 1 PCC domains in mission, vision and core value statements

PCC Domain	Examples	% mentioned (N)
Culturally competent care	• "We will respect the diversity of our region and ensure care is provided in ways that are fair and reflective of the knowledge, values, beliefs and cultures of the people we serve." o Labrador-Grenfell Health • "We are committed to providing care and services that are safe, and to ensuring people feel culturally, socially, emotionally, spiritually and physically safe." o Interior Health • "Ensure accessible and efficient health care and social services, which adapt to the needs of the population of the Laurentians." o CISSS des Laurentides	50% (27)
Co-designed care	• "We work with the communities we serve, and partner with others who share a commitment to improving health and well-being…" o Eastern Health • "Include and acknowledge the contributions of employees, physicians, patients, families and partners." o Saskatchewan Health Authority • "It delivers care and services in keeping with best practices and innovation and promotes the participation of users, their families and the personnel of the CIUSSS de la Capitale-Nationale." o CIUSSS de la Capitale-Nationale	55.56% (30)
Compassionate care	• "We show kindness and empathy for all in our care, and for each other." o Alberta Health Services (AHS) • "Being empathetic—genuinely seek to understand each person's experience." o Northern Health Region (NHR) • "We empower hope for the whole person, being there along the journey with kindness, generosity, and empathy for another's reality." o Southern Health-Santé Sud	85.19% (46)
Equitable care	• "Excellent health and care for everyone, everywhere, every time." o Vancouver Island Health Authority (Island Health) • "We work together to promote conditions and remove barriers so every person can achieve their full health potential." o Winnipeg Regional Health Authority • "… the adaptation and fair distribution of resources, with flexibility and in consistency with individual and collective needs." o CISSS de Chaudière-Appalaches	31.48% (17)
Trusting relationship with providers	• "To value each individual and bring trust to every relationship." o Vancouver Island Health Authority (Island Health) • "Respect, caring and trust characterize our relationships." o Fraser Health • "Accountability is answering to the people we serve and each other for our decisions and actions." o Nova Scotia Health Authority	70.37% (38)
Communication	• "Open, truthful and clear communication." o Northern Health Region • "We show openness and willingness to listen and we promote dialogue." o Vitalité Health Network • "We connect, listen, and work together." o Prairie Mountain Health	38.89% (21)
Coordination of care	• "…improve their health through information, education and partnerships." o Central Health • "The quality of the care and services offered, which implies that they are effective (that is, likely to improve health and well-being) and safe. We must also be able to adapt them to the expectations, values and rights of users (responsiveness) and provide them in a coordinated and integrated manner (continuity)." o CISSS de la Gaspésie	3.70% (2)

Table 1 (continued)

PCC Domain	Examples	% mentioned (N)
Patient involvement in decisions	• "…engaging others in discussions and decisions affecting them…" ∘ Central Health • "Collaboration is demonstrated by our personnel's commitment to work in teams and to integrate users and their families, along with our partners from the community, as full members of those teams, all working towards a common goal." ∘ CIUSSS de la Capitale-Nationale • "…involves them in the decisions that concern them so that they have a care and service experience that meets their needs." ∘ CISSS de Chaudière-Appalaches	11.11% (6)
Timely access to provider	• "…providing timely access to reliable care in a culturally safe manner that respects diversity." ∘ Interlake-Eastern Regional Health Authority • "…we strive to bring timely, equitable access to healthcare for the North." ∘ Northern Health Region (NHR) • "We provide quality care and services while ensuring the greatest possible access." ∘ Vitalité Health Network	5.56% (3)
Patient-reported outcome measures	• "…actively engage our population for feedback and direction." ∘ Central Health • "We strive for outcomes that are measured, assessed and reported on." ∘ Northwest Territories Health and Social Services Authority (NTHSSA) • "Systematically question user-patient satisfaction to improve." ∘ CIUSSS de l'Est-de-l'Île-de-Montréal	5.56% (3)
Patient experience	• "Exceptional Care. Every person. Every day." ∘ Horizon Health Network • "…deliver an exceptional care experience for all." ∘ Vancouver Coastal Health (VCH) • "Acting with benevolence means anticipating in a spirit of indulgence and understanding, so that the process of care or services goes as smoothly as possible." ∘ CISSS de la Gaspésie	14.81% (8)
Affordable care	• N/A	0% (0)

for addressing cost as a barrier and social determinant of health [26]. Not being able to afford quality essential care, such as pharmaceutical costs, ambulance, and emergency care, can have a negative impact on patient safety [26], which can reduce health outcomes. Although universal coverage exists for basic healthcare (i.e. physician services and hospital-based services), costs for patients in many forms other than direct payment for care exist [10]. The lack of presence of affordable care in the statements indicates that there is still a gap in knowledge as to the extent of PCC and potential barriers to access to care.

Strengths and limitations

This is the first study to use a PC-QI to assess the presence of PCC policies across Canadian health systems. This study identifies gaps in PCC that could be used to inform future strategies for health authorities looking to include a greater focus on PCC in their policy reflected in their mission, vision, and core value statements. At the same time, it is hopeful that at least some elements of PCC are reflected in the core values of healthcare organizations across Canada.

One limitation of this study lies in the diversity of health systems across Canada; making it difficult to find a common healthcare organization that could be easily compared across the country. For example, Ontario and Quebec steered away from the health authority model to regionalize their delivery of care as hospital networks [27, 28]. In Yukon, there was limited information publicly available about the healthcare system at the time of data collection. As most of the data collected from Quebec was translated from French to English, there's an increased risk that the English version which was analyzed may not have been fully representative of the original French version. Another limitation is that the findings of this study may not be generalizable to other countries. However, the findings suggest promising direction regarding international interest in PCC as well as areas of PCC that may require additional focus with regards to health policy.

Future research

Additional research is also required to understand not only whether PCC is a goal of the system, but also whether it is effectively implemented as well. As this study focused on evaluating the presence of PCC, a future direction would be to investigate using the lens of the two additional components of the PC-QI definition to further assess whether health authorities are allocating resources to support and implement PCC and evaluating

PCC protocol and program implementation from the perspective of patients. This may include the use of PC-QIs as tools to equip health systems with standardized metrics to identify gaps in PCC and to make the needed improvements that reflect patient needs, values, and priorities.

Conclusion

This study describes the PCC policy landscape in Canada, by exploring whether health authorities incorporate PCC into their organizations' strategic policy. The findings suggest that Canadian healthcare organizations are working towards promoting and implementing a culture that prioritizes some elements of PCC in the care of patients. These findings can guide development of policy and elevate the standard of PCC in Canada by identifying areas that need to be addressed to improve patient experiences and outcomes.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12582-3.

Supplementary Material 1.

Authors' contributions

All authors (II, SA, PF, MLS, KM, MS) take responsibility for the reported research, and have participated in its concept and design, analysis and interpretation of the underlying data, and drafting of this manuscript.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

N/A.

Consent for publication

N/A.

Competing interests

The authors declare no competing interests.

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