

# High-Performing Patient and Family-Centered Academic Medical Centers

*Cross-Site Summary of Six Case Studies*

Prepared for  
The Picker Institute



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## Executive Summary

This report summarizes key findings and lessons learned from a series of six case studies of high-performing patient and family-centered academic medical centers.

The centers included for study were selected on the basis of several criteria, including mix of geographic location, recommendations of project advisory panel members, diverse approaches to achieving patient and family-centered care documented in previous studies, and performance on selected quality metrics such as HCAHPS.

The six centers profiled for this project are:

- Harborview Medical Center in Seattle, Washington
- Medical College of Georgia Health (MCGHealth) in Augusta, Georgia
- State University of New York (SUNY) Upstate in Syracuse, New York
- University of Colorado Hospital in Aurora, Colorado
- University of Pittsburgh Medical Center in Pittsburgh, Pennsylvania
- Vanderbilt Medical Center in Nashville, Tennessee

Individual profiles with detailed information on the centers studied are available at: [www.pickerinstitute.org](http://www.pickerinstitute.org).

### *Cross-Cutting Findings*

A dominant theme that emerged across all six centers is that in order to achieve sustainable patient and family-centered care it is necessary to change the culture of the organization. Transforming the culture in each organization was uniformly described as a journey. While each center's culture change journey followed different paths, the following six core elements of sustainable change were observed in common across the centers:

- **Visionary leadership:** Each organization is characterized by strong, visionary leadership committed to achieving the goals of patient and family-centered care.
- **Dedicated champion:** A dynamic, dedicated champion must be responsible for driving necessary changes at the operational level.
- **Partnerships with patient and families:** Central to the change strategy is developing active collaboration with patients and families on multiple levels, including policy and planning, patient care, and medical education.
- **Focus on the workforce:** Principles of patient and family-centered care must be incorporated into human resource policies that determine the way staff are recruited, trained, and rewarded.
- **Effective communication:** Clear communication at every level, from board to management to front line workers to patients and families, is required to spread and reinforce patient and family-centered values and procedures.
- **Performance measurement and monitoring:** Continuous measurement and monitoring are needed to assess progress and identify new opportunities for improving performance.

Each of the academic medical centers included in this project provide useful operating examples of how these core elements of a successful change strategy can be implemented in different ways as part of an overall culture change journey. Selected examples are provided in this summary report. The individual profiles provide further information related to each center's journey.

Although not all of these centers are top performers on HCAHPS or other performance metrics, each has been aggressively implementing programs aimed at improving their scores, and most are making impressive progress in the specific departments or units they have targeted. While each center has made a significant organizational commitment to patient and family-centered care, professional and staff resistance remains an important obstacle in some realms of academic medicine. The strategies for overcoming these professional biases profiled in these case studies offer valuable guidance, but more work needs to be done to instill the importance of the patient and family experience as an intrinsically vital aspect of health care delivery in its own right.

## Introduction

Hospitals and health care systems throughout the United States are increasingly trying to make health care services more patient and family-centered. Forces contributing to the growing focus on patient and family-centered care (PFCC) include public reporting of patient experience survey scores through the Federal government's national HCAHPS program, public and private purchaser initiatives to build measures of the patient experience into performance-based payment programs, and the use of such measures in accreditation, certification, and recognition programs. A growing demand among patients for an enhanced service experience and greater participation in their health care is placing further pressure on health care systems to find ways to become more patient and family-centered.

As health care organizations strive to improve their performance, the experience of others that have developed and implemented successful strategies can provide valuable guidance and lessons. This report summarizes key findings and lessons learned from a series of six case studies of high-performing academic medical centers funded by The Picker Institute. Because academic medical centers face particular challenges of balancing patient care with their teaching and research missions, lessons learned through case studies of centers that have successfully implemented patient and family-centered care can benefit other academic as well as non-academic health care systems. Further information on the academic medical centers studied as part of this project is available through detailed individual profiles published on The Picker Institute Web site at: [www.pickerinstitute.org](http://www.pickerinstitute.org).

## Site Selection and Case Study Methods

The six centers included in this case study project were selected on the basis of several criteria, including:

- a mix of geographic location,
- both safety and non-safety net hospitals,
- expert opinion on high-performing centers provided by members of the project advisory panel,
- performance on available metrics such as HCAHPS scores, and
- varied approaches to achieving patient and family-centered care documented in previous studies.

The identification and recruitment of centers was greatly facilitated by previous groundwork laid through the Patient and Family-Centered Care Benchmarking Project sponsored by the University HealthSystem Consortium (UHC) in 2007. In this project, twenty-six UHC member organizations completed a PFCC survey and self-assessment, and were invited to submit reports on innovative strategies they had implemented to improve PFCC. Five of the six centers included in the Picker case study project had participated in the UHC benchmarking project.

### Centers Included in the Case Study Project

- Harborview Medical Center in Seattle, Washington
- Medical College of Georgia Health (MCGHealth) in Augusta, Georgia
- State University of New York (SUNY) Upstate in Syracuse, New York
- University of Colorado Hospital in Aurora, Colorado
- University of Pittsburgh Medical Center in Pittsburgh, Pennsylvania
- Vanderbilt Medical Center in Nashville, Tennessee

The summary findings presented in this report are derived from the individual case studies conducted primarily through site visits to each of the participating organizations. The site visits, lasting between one to two days, included a tour of facilities and detailed interviews with senior leadership, board members, medical department chiefs, key staff responsible for patient and family-centered programs and initiatives, front line staff, and patient and family advisory council members. Extensive documentation was gathered before, during, and after the site visits to supplement the information and perspectives obtained through interviews.

## A Journey to Change the Culture

A very clear consensus emerged across the six centers that in order to achieve sustainable patient and family-centered care it is necessary to change the culture of the organization. While each of the centers had specific initiatives or programs that were successful and contributed to the spread of PFCC in their organizations, it was only at the point where they had begun to fundamentally change the culture that they felt such growth could be sustained.

The process of transforming the culture in each organization was uniformly described as a journey. However, each center differed with respect to the events that triggered the beginning of the journey, the processes used for developing and spreading PFCC, whether initiatives originated from senior leadership and were communicated down through the organization or emerged from the grassroots, and the degree to which PFCC was formalized in the organization. The journey started at different places in each organization, never followed a straight line, sometimes slowed or stopped and then started and moved at a different pace at different times for each center. Moreover, as the organizations moved along their journey, changes took place that affected how PFCC was perceived and practiced. For example, new leadership was hired in one center, an addition to the hospital was planned in another, and the governance of one organization was completely converted from a state-run entity to a non-profit structure with a new board of directors and chain of accountability. Over time, the acceptance and implementation of PFCC in each of these six centers progressed and became more thoroughly integrated into the organization.

### Getting Started on the PFCC Culture Change Journey

*Getting started or continuing the momentum for PFCC often means seizing an opportunity that presents itself. Such opportunities may take many forms. One example is presented here to illustrate: the decision to construct a new hospital at MCGHealth.*

#### Building a New Children's Center at MCGHealth

Planning and constructing a new building can present a reason to focus on PFCC and make it part of the planning process. In an existing facility, the established pattern of operations and physical layout may present barriers to the introduction and spread of PFCC. For example, cramped space in an existing facility may hamper efforts to permit family members to stay overnight in a patient's room. Or it may be that such a physical barrier could be addressed, but is used instead by staff as an excuse for not having family members present.

Whether in a new building or an existing one, most commonly PFCC starts in the children's hospital or the children's unit of the main hospital. According to Terrell Smith, Director of Patient/Family Centered Care at Vanderbilt, the concepts of PFCC are "just so intuitive" in the children's hospital. As a result, planning a new children's hospital offers a particularly attractive opportunity to introduce or reinforce PFCC concepts.

When MCGHealth started construction of its new Children's Medical Center in 1993, it sought the active participation of parents of children who had been in the children's units of the existing hospital. Including patients and families in the planning process significantly improved the design of the new facilities from the perspective of the patient and family. But it also helped center staff to begin viewing patients and families in a different light. For example, previously family members were seen as visitors to be accommodated. After partnering with them in planning the new hospital, staff realized they were valuable partners in the care of patients. This recognition was just the first step in a long journey of changing the culture at MCGHealth, not just in the Children's Medical Center, but gradually within the adult medical center and ambulatory care center as well.

## Six Core Elements of a Sustainable Change Strategy

While each center's culture change journey follows different paths, there are several core elements in common across these organizations that appear to have contributed to their success along the way.

Each organization is characterized by strong, visionary leadership committed to achieving the goals of patient and family-centered care. These leaders rely on a dynamic, dedicated champion responsible for driving necessary changes at the operational level. Key to the change strategy is developing true partnerships with patients and families in the various phases of the PFCC journey and incorporating PFCC principles into the human resource policies and practices that determine the way staff are recruited, trained, and rewarded. Effective communication at every level of the organization is required to spread and reinforce PFCC principles and procedures. Finally, continuous measurement and monitoring is needed to assess progress and identify new opportunities for improving performance.

The importance of these six elements to achieving patient-centered care has been documented in other studies.<sup>1</sup> The following sections describe each of these core elements in further detail with examples drawn from the six organizations.

### 1. Visionary Leadership

In each of the six centers, senior leadership at the level of the CEO and board of directors was instrumental in establishing the vision for PFCC, communicating the importance of PFCC through both word and deed, and holding staff accountable for performance. However, the differing ways in which senior leadership have carried out these essential functions demonstrate that strategies need to fit the culture and circumstances of each organization.

- At Vanderbilt, senior executives decided in 2004 to launch a five-year journey called “Elevate” with the aim of infusing a shared vision or “credo” for the organization grounded in very clearly defined behaviors. The credo and behaviors, which incorporate key elements of PFCC, now permeate the organization from the top executives to the front line care providers. The Vanderbilt example illustrates a “top-down” approach in which leadership adopts a systematic, organization-wide strategy to set a vision, communicate its importance, and provide the necessary institutional support to sustain it.
- In an approach similar to Vanderbilt, implementation of PFCC at SUNY Upstate received a substantial boost when the new University President began an organization-wide strategic planning initiative, Engaging Excellence. PFCC has become one of the central elements of the initiatives, giving it prominence throughout the University.
- In contrast, the culture at Harborview has supported more of a “bottom-up” strategy in which senior leaders have attempted to infuse the organization with PFCC principles. The CEO, COO and other senior leaders at Harborview had all risen up through the ranks of the organization, from nurse managers to their senior positions. When they reached the top, it was not necessary to convince them of the importance of PFCC, since they had practiced and espoused it at each organization level on their way up. As a result, PFCC now permeates the culture at Harborview. Having home grown leaders who are committed to PFCC also sends the message to staff that these senior leaders clearly benefitted in their careers from their practice of PFCC.
- The leadership at UPMC has successfully combined both a grassroots and top down approach. The culture of innovation and entrepreneurial activity has provided a fertile environment for the development and spread of PFCC at multiple levels throughout the system. At the grass roots level, the evolution of PFCC has been guided by the passionate commitment of Anthony M. (Tony) DiGioia III, MD, a practicing orthopedic surgeon. According to Dr. DiGioia, although top leaders must be involved and supportive, the real work of change is by its nature

1 Shaller, D. “Patient-Centered Care: What Does It Take?” The Picker Institute and Commonwealth Fund. October 2007.

disruptive and at times rebellious; for change to occur, staff at the grass roots level must be given the latitude to innovate and empowered to make change happen. At the same time, at the system level, senior leaders support multiple approaches and help to identify new opportunities for introducing PFCC in other processes and levels of the organization.

## Spreading PFCC throughout the Organization

*Just as leadership strategies differ across organizations, so do strategies for spreading PFCC. While some organizations such as MCGHealth and the University of Colorado Hospital rely heavily on the creation of Patient and Family Advisory Councils as a mechanism for diffusing PFCC, others have adopted other innovative approaches.*

### Using the IHI Learning Collaborative Model at Harborview

At Harborview, leaders who were trained in the Institute for Healthcare Improvement's collaborative model decided to adapt the IHI model on an organizational level as a mechanism for promoting PFCC concepts throughout the facility. Beginning in 2006, over 150 staff and managers from every department and level of the hospital who have contact with patients and families were recruited as part of an intra-organizational collaborative involving fourteen teams, participating in three learning sessions at six-month intervals. Each team received training in PFCC concepts as well as change management, and then selected a specific PFCC-related project relevant to their own units. This unique cross-departmental collaborative approach to spreading PFCC has met with considerable success, as measured by progress on specific initiatives as well as a growing awareness and support for PFCC among all staff involved.

### Exporting the PFCC Methodology at UPMC

A methodology for implementing PFCC that was successfully piloted in the Orthopaedics Program at Magee-Womens Hospital of UPMC is now being "exported" to other units and hospitals in the UPMC system. Senior leadership strategically select units and hospitals that appear especially ready for or in need of PFCC adoption. Examples of such "beta" sites are the Trauma Unit and the Day of Surgery Department at UPMC Presbyterian Hospital. Both units have implemented the PFCC methods with dramatic results in improving the patient and family experience, as measured through surveys, and increasing organizational efficiencies, such as reducing hospital length of stay or wait times in the operating room. The Innovation Center established at Magee-Womens now serves as the "epicenter" of PFCC and the incubator of new tools and strategies for supporting the spread of PFCC projects throughout the UPMC system.

## 2. A Dedicated Champion

Although senior leadership commitment is essential, the successful day-to-day implementation of PFCC requires the dedicated focus of an individual champion at the operational level. Each of the six sites has at least one such champion, who serves as the "point person" for translating the vision for PFCC articulated by senior leaders into practical operating programs and procedures. By background and training, these individual champions are often former nurses with long institutional memories and the necessary connections with both administrative and clinical staffs to get things done. They uniformly possess a passion for PFCC and are by nature excellent organizers and team leaders. They also all have ready access to senior corporate officials, which both legitimizes their role and helps speed approval and support for implementing specific projects. Those with nursing backgrounds also have an important advantage in communicating the benefits of PFCC to frontline nurses and nurse managers, since they have the credibility of having "been there, done that", and have a clear understanding of how the message will be perceived.

*It is not possible to recognize each individual responsible for guiding and promoting implementation of PFCC in these centers, since so many dedicated people are involved and integral to the work. The following individuals from three centers are highlighted to illustrate the range of roles that can be played by these champions.*

**Leola Rodgers** is the central linchpin for PFCC at SUNY Upstate. As the Associate Administrator of the Golisano Children's Hospital and Pediatric Business Services, she is able to spend about three-quarters of her time on PFCC activities. She leverages her role by getting others involved, since turning to other staff not only augments her efforts but helps to integrate PFCC across the organization. According to Leola, the strength of PFCC at SUNY Upstate is that it is not a separate "program", detached from the rest of the hospital operations. Everyone owns it. While many others are involved, Leola Rodgers is the one that looks at new programs and asks, "How can PFCC become a part of that?"

In contrast to Leola Rodgers, **Pat Sodomka** at MCGHealth devotes 100% of her time to PFCC. She is the Senior Vice President for Patient- and Family-Centered Care and serves as the Executive Director of the Center for Patient- and Family-Centered Care. She serves as a member of the senior leadership team for the health system and reports to the President and Chief Executive Officer. PFCC at MCGHealth

is heavily institutionalized and Pat is the established representative and "go-to" person. She is well known outside of MCGHealth in the growing national and international community of PFCC practitioners and sits on several external committees that are studying or promoting PFCC.

At Harborview Medical Center, **Tracy Gooding** is the day-to-day manager of PFCC activities and carries the title of Director, Patient Relations and Volunteer Services. She has been with the organization for 15 years. Tracy partnered with **Becky Pierce**, Assistant Administrator for Patient Care Services, to initiate the collaborative model for rolling out PFCC at Harborview. They believe this partnership between Patient Relations and Nursing has been crucial to the success of the program. Becky, who has been at Harborview for 18 years, is also the chair of the Patient and Family Advisory Council and the executive sponsor of the Patient/Family Centered Care improvement initiative process. Together, these two individuals have helped guide the implementation of PFCC as they rose up through the organization.

### ***3. Partnerships with Patients and Families***

At the very heart of patient and family-centered care is the concept of partnering with patients and families. As observed in these six academic medical centers, such partnerships play out at multiple levels: 1) at the point of care delivery, where patients and families participate as active members of the care team in providing information and sharing in decision-making related to treatment strategies; 2) at the level of planning and policy development, where the perspectives and voices of patients and families are vital to implementing PFCC; and 3) in the process of medical education, where patients and families can provide valuable input in the training of medical students and residents.

#### ***Partnering in the Care Process***

Each of the organizations in this case study project has made significant strides toward building the care process around the needs of patients and families. Some of these strides began with what appear to be small steps, but which once taken have led to other, more dramatic changes. For example, all six centers have adopted "open access" policies in most departments and units, in which family and friends are encouraged to visit according to their own schedules and availability, not those of the professional staff. At Harborview Medical Center, replacing "visiting hours" in the ICU with an open access policy led to a series of related changes, such as involving families in rounds in the Trauma/Surgery ICU. This change was initially resisted by the surgeons and nurses but now is widely accepted as an efficient strategy for improving communication and understanding among patients and families. Families also are now invited to participate in bedside change of shift reports. These initiatives have led to fewer interruptions for staff and have increased patient and family satisfaction. They also represent an impressive culture change

from a traditional academic medical center emphasis on physician and staff control to one of openness and inclusion, promoting a more positive environment for workers as well as patients and families.

Another example of successful process redesign to improve care for patients and caregivers alike is the “Condition H” program at the University of Pittsburgh Medical Center. Condition H (where the “H” stands for “help”) is a rapid response program that enables the patient or a family member to call for immediate assistance when they notice a clinically significant condition or event that is not being addressed by the care team. The program was inspired by the case of a woman in an east coast hospital that lost her 18-month old daughter as the result of breakdowns in hospital communication. It was designed as a means of empowering patients and families to focus medical attention quickly on potential problems. Traditionally, condition codes are designed to be activated by health care professionals. Condition H broadens the concept by including patients and visitors as part of the care team by alerting caregivers to clinical changes.

Numerous other examples could be cited of how these academic medical centers have made real changes in care processes to involve patients and families as partners. In almost all cases, these design changes have met with some initial resistance by professional staff, but in virtually every instance the resistance has faded as experience is gained and the benefits to all parties become clear and compelling. Indeed, in some cases, even the most skeptical physicians who at first opposed such changes have over time become the most vocal and tireless advocates for PFCC initiatives.

### *Partnering in Planning and Policy Development*

In order to continuously identify new opportunities for building patients and families into the care process, these organizations have adopted several approaches for obtaining input in an ongoing and systematic way. In addition to regular focus groups and patient and family surveys, all six centers have created Patient and Family Advisory Councils as a means to bring patient and family perspectives into care delivery planning and improvement initiatives.

The organization and scope of these councils vary by center. For example, at SUNY and Harborview there is a single Patient and Family Advisory Council that meets periodically to help with the design of programs. At MCGHealth, the councils have grown considerably in number and scope. From the initial council of about 20 advisors that helped plan the Children’s Medical Center in 1993, the number has grown to 250 advisors, over three-quarters of whom are active participants. In addition, the councils are present in almost every unit or department of the system and serve a diversity of functions.

Across the six organizations, Patient and Family Advisory Councils have been involved in planning and assisting with implementation of a wide range of activities, including:

- Design of new buildings and units, including selection of architects;
- Input on the configuration of health care delivery space, especially patient rooms and waiting areas, including selection of furniture and other design features;
- Development of policies related to human resource practices, family visitation, and family involvement in rounding and change of shift reporting;
- Design and preparation of patient and family educational materials; and
- Interviewing and selecting new staff, including in some cases senior leadership for the organization.

At SUNY Upstate, the Family Advisory Council helped design the new East Tower so that it will address the physical constraints faced in the current space. With the help of the Council the plan for the new space includes all single rooms, space for family members to stay overnight, new amenities for patients and families including wireless In-

ternet access and refrigerators, improved signage and a large auditorium where children can attend special events such as circus and musical performances. The physical design staff used an architect accustomed to getting family and patient input into the design and have followed principles promoted by the Center for Health Care Design, an organization devoted to evidence-based health care facility design.

Medical center staff responsible for working with advisors have gained useful experience in identifying and recruiting council members who will not just relate to their own experience but also be able address broader issues that all patients and family members face. They also look for people who are good communicators and adept at delivering constructive criticism. A widely shared perspective is that patient and family advisors with an ongoing relationship with the organization have far more to contribute than ad hoc data obtained from focus groups. Such advisors have a greater knowledge and a history to draw upon to make recommendations than focus group participants. They have a sense of what is possible and what challenges the organization faces. They also can learn from the outcomes of their involvement and hone their skills in providing constructive advice and criticism.

### ***Partnering in Medical Education***

Another important area in which patients and families can provide valuable input is in the planning and delivery of the teaching mission of academic medical centers. For example, at the Vanderbilt Children's Hospital, families play an important role in the medical education process by teaching classes and providing an orientation for students regarding the role of families in care. Medical students have reported that this inclusion of families in the curriculum has had a big impact on them. In another program, medical students have the opportunity to stay for a period of time in the homes of family members, in order to assimilate the experience of patients and family members dealing with an extended illness or episode of care.

A related initiative known as FACT (Families As Classroom Teachers) brings families with chronically ill or disabled children to the medical, nursing and special education classroom. This program provides first hand opportunities for instructors and students to learn about the daily challenges these families face. A directory of families who are willing to participate in this program is distributed to faculty each fall. Faculty then plan appropriate parent-as-teacher sessions for their particular courses. Parents receive a modest compensation for their service.

At MCGHealth there are two programs for students that involve participation by patients and families. Learning in Family Environments (LIFE) was introduced into the curriculum to afford students an opportunity to experience the life of families with children who have chronic or special health care needs. Prior to participating in the program families receive an orientation making sure they understand the program's goals and their roles. Next, a student and a family are paired. The student spends time with the family in their home and in school meetings, doctor appointments, therapy sessions and after school activities. The intent is for students to gain an understanding of how the child's condition affects his or her daily life and that of the entire family. This time with the family and child is coupled with in-class sessions on patient and family-centered care and theories of child development and health. The course enables students to gain a sense of what a child's life is like after they leave the hospital and permits students to broaden their perspective on the care provided to patients during hospitalization.

MCGHealth also involves patients and family members as faculty. Patients and family members are approached by nursing staff to gauge their interest as potential advisors. Interested parties are interviewed, carefully selected and then trained for their family faculty role. Instructors in all five schools that comprise the health sciences university have access to a Family Faculty Directory. Since inception patients and families have shared their stories and insights with medical, allied health and nursing students.

## Teaching Residents through PFCC Role Modeling on Rounds

Dr. Richard Miller, attending surgeon and head of the Trauma Unit at Vanderbilt Medical Center, provides an impressive illustration of both the patient care and medical education value of involving families in bedside rounding and shift change handoffs in the ICU.

Each morning, beginning at 8:00 a.m., up to two family members are invited to be present with a patient at the time of the rounding. Medical students follow a standard protocol for each patient: each resident reports on the last 24 hours of care, nurses report on the last 12 hours, and reports are given by other staff related to respiratory, pharmacy, nutrition, and case management. The chief resident then outlines the plan for the next 24 hours. All orders are recorded by a medical student in real time in the electronic medical

record using a mobile terminal stand at the bedside. Family members are involved in a discussion at the end of the round. Dr. Miller estimates that the family conversation adds about 5 minutes to the round but results in huge benefits in terms of ongoing communication, information, understanding, and reassurance to both families and patients.

All issues are discussed, including discharge planning and insurance coverage, not just clinical issues and prognosis. It is a win-win strategy for everyone, including the medical students who are able to observe and learn from the role modeling of Dr. Miller interacting with the family and patient.

### *4. Focus on the Workforce*

In addition to the visible commitment from senior leadership and the strong, motivating influence of individual champions, each of these centers has made extensive use of their human resources infrastructure to help further embed PFCC values and principles in the workforce. Mindful of the relationship shown in previous studies between staff satisfaction and a positive patient and family experience, these organizations are all committed to cultivating an environment that values and respects its employees on an equal basis with patients and families.

While all six organizations recognize the importance of hiring, training, evaluating, compensating, and supporting a workforce committed to patient and family-centered care, some centers have more formalized policies and procedures than others. For example, MCGHealth follows a highly structured process of orienting all new staff that includes a session on PFCC principles, standards, and practices and the role of Patient and Family Advisors. New employees also receive an orientation manual with a section on PFCC. Specific standards for achieving PFCC in job performance are included in the position descriptions for staff both directly and indirectly involved in patient care. These position descriptions form the basis for the type of staff who are recruited and hired as well as a template for evaluating and rewarding performance. Of the \$40 million available each year for staff bonuses, a significant portion is allocated on the basis of performance against PFCC competencies.

Similar policies and procedures are followed at Harborview, Vanderbilt, SUNY Upstate, University of Colorado, and UPMC. Such formal human resource practices focusing on PFCC help to communicate and reinforce its importance. However, success in getting staff to practice PFCC comes in large measure from senior leadership and managers sustaining an environment in which PFCC behavior becomes the norm. This commitment leads to staff members who not only practice PFCC, but act as role models for other staff to emulate.

## FOCUS Training and Evaluation at Vanderbilt Children's Hospital

At the Vanderbilt Children's Hospital, through a process of defining core values, leaders developed a framework for continuous learning given the acronym, FOCUS, which stands for: Family-centered care, One team, Continuous improvement, Unique environment for children, and Service excellence.

Using this framework, the leaders began to restructure hospital policies and processes in a way that would reflect these new values. One of the most significant areas chosen was human resources. Staff recruitment and hiring policies were modified to incorporate FOCUS values. Prospective employees are told about FOCUS and are then asked how they

have used such values in previous places of employment. All new employees sign a statement indicating their commitment to FOCUS values. FOCUS has been integrated into the hospital's orientation program. The program, in which parents participate as trainers, presents guidance on how to translate FOCUS values into specific behaviors. The performance-appraisal system has also been revised: now each employee is asked to describe an example of how he or she has applied a FOCUS value during the previous year.

Even with the careful attention to PFCC in recruiting, hiring, training, evaluation and compensation, not everyone is able to embrace the principles or the behavior norms. Programs to help employees better understand and accept the principles have been helpful in this regard. One example is the Center for Patient and Professional Advocacy at Vanderbilt, a program offering assistance to physicians and staff that are working through specific job performance issues. Other organizations rely more on the management and modeling techniques of unit managers who demonstrate daily examples of how PFCC can be practiced. However, all centers noted that in some cases, employees could not be guided or trained to fit into the PFCC culture and therefore were encouraged or directed to find their way to another job.

### ***5. Effective Communication***

Clear and pervasive communication within and across every level of the organization is critical to the growth and sustainability of PFCC. The following are highlights of some of the practices observed in the six centers.

#### ***Board and Senior Management***

The Engaging Excellence strategic planning initiative at SUNY Upstate and the Elevate initiative at Vanderbilt are both examples of comprehensive efforts to gather input from multiple levels and then communicate a clear and consistent message about the strategic vision and priorities of the organization. The ability to communicate strategic goals systematically throughout all levels of the organization is vital to PFCC implementation. At Harborview, board members view PFCC as being at the heart of the medical center's mission, and actively support it through participation in management meetings as well as in rounding at the hospital. Each center uses regular meetings and periodic retreats to reinforce commitment to PFCC practices and to plan programs for incorporating PFCC into overall operations.

#### ***Medical Chiefs and Frontline Staff***

Regular meetings and special events such as off-site planning retreats and attendance at conferences are strategies used by all six centers to communicate PFCC principles and methods to managers and frontline staff. For example, in the process of spreading PFCC from the inpatient to ambulatory care settings at MCGHealth, senior leaders instituted a series of 4-hour off-site PFCC retreats for staff. After the retreats, staff returned to their practice sites and developed PFCC action plans tailored to their site. These plans are updated monthly and the ambulatory care center

holds weekly meetings at which two different sites present their action plans and progress, a practice that helps to keep PFCC front and center in the minds of managers and staff.

The use of mottos or taglines is another strategy found among these organizations to continually reinforce the focus on patient and families. At Harborview, the leadership has promoted the concept of “every patient, every time” as a motto for employees. At UPMC, the unifying vision is found in the phrase, “the right care, at the right time, the right way, every time”. At Vanderbilt, the Elevate “Credo” is printed on the reverse side of each employee’s name badge:

*“We provide excellence in healthcare, research, and education.  
We treat others as we wish to be treated.  
We continuously evaluate and improve our performance.”*

MCGHealth, the University of Colorado, and SUNY Update also reinforce their PFCC principles through posters and employee newsletters and other regular communications devices.

## Communication is a Key Element of the PFCC Methodology at UPMC

At UPMC, frequent communication is a core element of the PFCC methodology promoted by Dr. DiGioia. The PFCC methodology involves a series of steps, beginning with the selection of a care experience and the creation of a PFCC care experience guiding council including a clinical leader as well as a senior administrative leader.

The next step consists of a systematic assessment of current processes to identify gaps in the patient and family experience and opportunities for improvement. The data gathering and analysis steps employ several innovative tools, including a patient/family shadowing and mentor process that maps the entire patient experience from beginning to end. The shadowing results are combined with time studies, patient and staff surveys, focus group input, and other data to prioritize problems.

A project working group is then assembled according to the patient and family flow map. Working group members include representatives from any service area or person that comes in contact with a patient or family member. This group becomes the “creative problem solving engine” that derives its shared vision by collectively writing a story of the ideal patient and family experience through the eyes of the patient. The working group meets weekly as a whole and more often in subgroups to target problems, test solutions, evaluate results, revise solutions as needed, and test again.

The PFCC methodology is critical to establishing a continuous cycle of learning and innovation aimed at redesigning processes to improve the patient and family experience.

## Patients and Families

Patients and families clearly represent one of the most important audiences for communication in the implementation of PFCC. All six centers use a variety of approaches and programs to communicate with patients and families, incorporating print, electronic, and personal modes of communication. Some of the most common methods include:

- **Patient portals:** Several centers have established Web-based portals that allow patients to send and receive secure electronic messages with their doctor, make appointments, view and pay bills online, view personal health information online, see lab test results and receive health information tailored to patient needs and preferences via e-mail. Vanderbilt's "My Health at Vanderbilt" and the University of Colorado's "My Doctors Office" and "My HealthConnection" are state-of-the-art examples of information technology applications for engaging patients in their health care through online communications.
- **Web sites:** Each center has invested substantial resources in creating a branded Web site to provide information for patients and families about the facility, how to navigate the campus, affiliated providers, specialized centers, and specific health conditions. Vanderbilt has just launched a new site devoted specifically to its Patient and Family-Centered Care programs. MCGHealth maintains a similar site.
- **Patient and family resource centers:** Several of the centers maintain resource centers that provide walk-in support for accessing patient education materials, as well as services such as classes on specific health topics, support groups, hospital discharge preparation, and movies and video games.
- **Interpreter services and liaison programs:** Many of these centers serve culturally diverse patient populations that require interpreter services as well as in-person, one-on-one support in navigating the complex health care delivery environment. Several centers have created special programs to respond to the need of trauma and cancer patients, through a variety of communication, education and outreach initiatives.

### CEO E-mail Program at the University of Colorado

An innovative approach to patient communication and feedback was instituted by the Dennis Brimhall, former CEO of the University of Colorado Hospital, in 2000. The hospital's e-mail service enables patients to send feedback about their experience directly to the facility's top administrator, and receive immediate, personalized responses in return. Following their first clinic visit, patients receive an initial standardized e-mail and are asked to respond to three questions and provide feedback about their experience. The hospital's CEO

replies to all comments, negative or positive, who can also forward the e-mail to the appropriate clinic staff and faculty. According to Mr. Brimhall, the system enabled him to spend a mere 20 to 30 minutes a day responding to patient concerns and praise via e-mail. Many patients comment that their next visit was better and they felt that it was so because the CEO intervened on their behalf. As patient feedback is compiled, the results are published on the hospital's Web site for all to see, including current and prospective patients.

## 6. Performance Measurement and Monitoring

The final element of a successful PFCC change strategy running across these organizations is the capacity to systematically measure and monitor performance through a “balanced scorecard” of metrics. All of the centers included measures to assess overall performance at the facility level, performance within specific units or departments of the organization, and performance of a specific initiative. In general these measures included patient experience and/or satisfaction surveys, staff culture surveys, clinical measures, and organizational and financial performance metrics. These measures are analyzed and tracked using both internal and external benchmarks (when available), as well as over time to monitor changes in performance.

As shown in the table below, not all of these centers are top performers on the facility-level performance metrics publicly reported in March 2009 on the Centers for Medicare and Medicaid (CMS) Hospital Compare web site. With regard to HCAHPS scores, only Vanderbilt Medical Center consistently scores above the national average. Vanderbilt, UPMC, and Harborview also score high on the composite measure of clinical quality compiled by the Commonwealth Fund on its [whynotthebest.org](http://www.whynotthebest.org) site.

### Hospital Compare Performance Scores (March 2009)

Performance Metric	National Average	Harborview	MCG Health	SUNY Upstate	Vanderbilt	Colorado	UPMC Magee Womens
<b>HCAHPS Dimension</b>	<b>Percent Most Favorable Response</b>						
Nurse Communication	74	63	69	69	77	70	69
Doctor Communication	80	71	77	73	82	73	78
Staff Responsiveness	62	45	53	52	68	54	55
Pain Management	68	59	63	66	72	66	61
Medication Communication	59	55	57	56	64	60	55
Cleanliness	69	57	62	56	58	61	59
Quiet	56	38	59	33	61	66	45
Discharge Information	80	78	76	85	84	78	77
Rating (9-10)	64	52	64	55	75	69	64
Willingness to Recommend	68	63	69	66	82	74	71
Average HCAHPS Score	68	58	65	61	72	67	63
Overall Quality Score	90.83	92.06	84.99	90.31	94.70	89.71	95.92

Source: [www.whynotthebest.org](http://www.whynotthebest.org)

(red indicates below, green indicates above the national average)

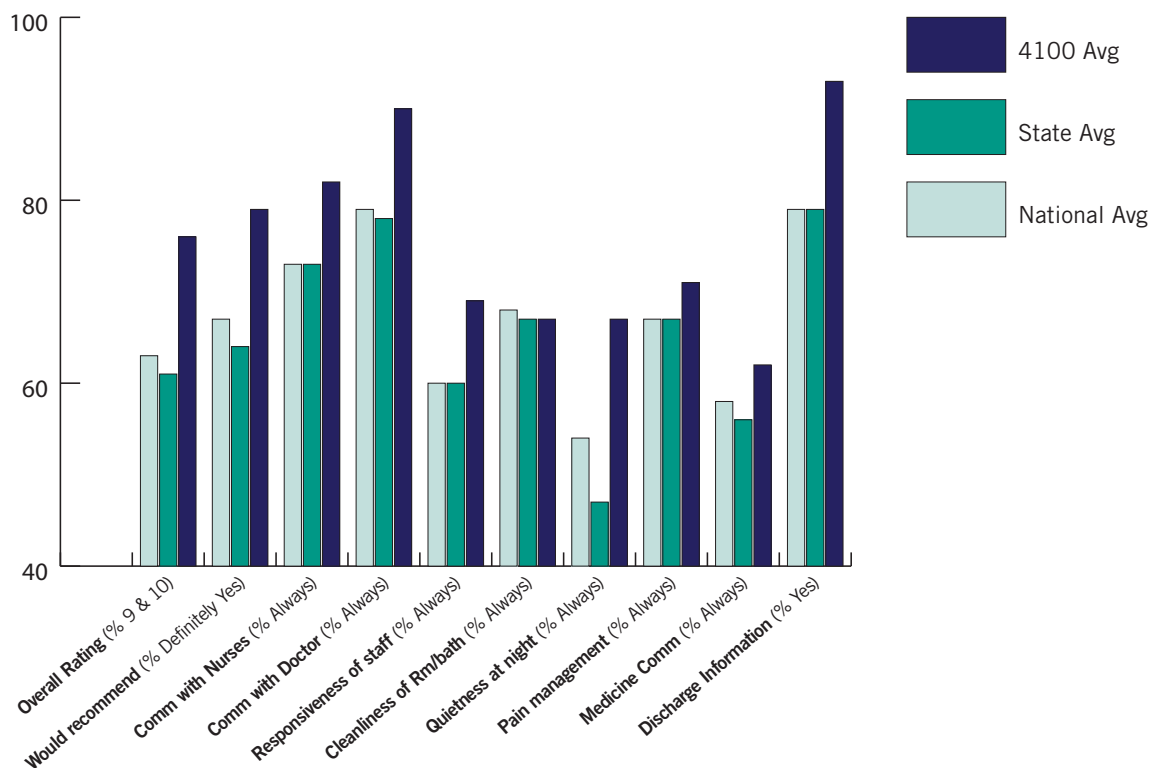
Although not all top performers, each of these centers has been aggressively implementing programs aimed at improving their scores, and most are succeeding impressively in the specific departments or units they have targeted.

For example, the HCAHPS scores for the Magee Womens Hospital at UPMC are not exceptional when viewed at the facility level, but a different picture emerges by looking at the department level scores where specific PFCC initiatives have been underway. As shown in the table on the following page, the HCAHPS scores for the Orthopaedic Unit that was the test site for the PFCC methodology developed Dr. DiGioia rank in the upper percentiles for most dimensions. In addition to high patient experience scores, this unit also performs in the top percentile using other metrics, such as infection rates and pain measures.

MCGHealth also has made extensive use of measures to monitor their PFCC performance. As they track performance they have identified areas for improvement, taken action to improve on the measures and then continue to track performance to evaluate the impact of their interventions. For example, an initiative was launched in 2008 with the aim of raising all patient care units at least up to a threshold level on patient satisfaction scores as measured by the Press Ganey Survey. The initiative, called “Getting Everyone into Range”, sought to raise all scores so that MCGHealth as a whole would be at the 75<sup>th</sup> percentile (score of 89.3) and no units would be below the 60<sup>th</sup> percentile. With support from senior leadership they trained everyone on service recovery emphasizing the importance of communication and follow up with patients.

### HCAHPS Scores for Orthopaedic Program (Unit 4100) at Magee-Womens Hospital (10/1/06 – 9/30/07)

	4100 Avg	State Avg	National Avg	Nat'l % Rank
Overall Rating (% 9 & 10)	76	61	63	97
Would recommend (% Definitely Yes)	79	64	67	91
Comm with Nurses (% Always)	82	73	73	98
Comm with Doctor (% Always)	90	78	79	99
Responsiveness of staff (% Always)	69	60	60	92
Cleanliness of Rm/bath (% Always)	67	67	68	44
Quietness at night (% Always)	67	47	54	94
Pain management (% Always)	71	67	67	68
Medicine Comm (% Always)	62	56	58	80
Discharge Information (% Yes)	93	79	79	99



SUNY Upstate also uses a combination of HCAHPS and the Press Ganey Survey to monitor performance. They have tracked performance on the measures since 2005. Results on the Press Ganey items show a generally upward trend.

Harborview has used patient survey data to evaluate particular initiatives or to track patient feedback through the Press Ganey Surveys. According to board members and senior leaders, the public reporting of HCAHPS has made a difference in bringing more focus to patient and family centered care. For each of Harborview's 2008 patient and family centered care initiatives, a measure of baseline performance and a goal for improvement were set. One initiative for 2008 was to improve communication through an initiative to educate and support staff and providers in developing interactive skills to encourage patients and families to be their own advocates. They are using HCAHPS scores to track performance on communication with doctors, nurses and about medications, and are monitoring progress with the aim of increasing these scores by 2-3 percentage points.

## Conclusions

The six case studies of high-performing patient and family-centered academic medical centers reviewed in this summary report provide examples of how core elements of a successful change strategy can be implemented in different ways as part of an overall culture change journey. While each organization has followed its own path, the six core elements of sustainable change are common across the centers. Previous case studies have documented similar factors contributing to achieving excellence in patient and family-centered care. The intended contribution of this project has been to provide specific operating examples of how these elements can be achieved in the context of the complex organizational structures characteristic of academic medical centers.

The apparent inconsistency between these centers' high-performing reputations and actual facility-level HCAHPS scores is a troubling phenomenon that requires further exploration. An internal University Health System Consortium (UHC) analysis comparing HCAHPS scores of UHC members to non-members suggests that overall, academic medical centers tend to have somewhat lower scores than general community hospitals (which are heavily weighted in the HCAHPS national comparisons). Also, as noted earlier, HCAHPS scores at the facility level do not reflect variations, either high or low, within the organization at the department or unit level. Several of the academic medical centers studied indicated that they have not yet been able to spread patient and family-centered care throughout the organization. Therefore, it is likely that there will be individual units or departments that are lowering the overall facility score. The extent to which this is so will only become clear when data on patient experience are collected regularly at least at the unit level, and ideally at the level of individual clinicians. Finally, it is important to look at performance over time, since organizations with some of the lower scores appear to be making significant improvements that are not captured in these cross-sectional comparisons; the HCAHPS scores of these highly regarded centers will likely increase over time as they address specific HCAHPS domains more fully.

Although each center profiled in this study has made a significant organizational commitment to patient and family-centered care, it should be noted that professional and staff resistance to PFCC concepts remains an important obstacle in academic medicine. Acceptance of PFCC in children's centers has been relatively easy and straightforward, since parents are naturally involved in the care and treatment of their children. Implementing these concepts in adult care academic medical centers is more difficult, because of traditional attitudes that PFCC is for pediatrics, will take too much time, will interfere with patient care, and is not as important as clinical outcomes or more technical measures of health care quality. The strategies for overcoming these professional biases profiled in these case studies, such as linking PFCC to the business case or making the connection to the Institute of Medicine's six aims for the health care system, offer valuable guidance to leaders and champions in other organizations. However, more work needs to be done in academic medicine to instill the importance of the patient and family experience as an intrinsically valuable aspect of health care delivery in its own right, as well as an intrinsic element of professionalism for physicians, nurses and other health care practitioners. A promising step forward in this regard is the movement underway to build PFCC principles and values into the medical education curriculum and to see these regularly and enthusiastically demonstrated in everyday practice by clinical teachers.

Each organization profiled as part of this project has clearly achieved success in many areas related to patient and family-centered care, but the leaders and staff of these centers will be the first to note that much work remains. A common refrain is that the journey to change the culture is never quite over. Indeed, for most of these centers, achieving top level performance on HCAHPS and other relevant measures of the patient and family experience remains a challenging goal as compared to regional and national benchmarks. How much further work is yet to be done, then, if the standard of performance is raised from "best in class" to nothing short of 100 percent on the available metrics? Setting a new standard of excellence at 100 percent declares that providing excellence in patient-centered care is something that should happen for all patients all the time. The six centers in this study demonstrate that, while much has been accomplished, a great deal remains to be done by way of further culture change to ensure that every patient and family experiences optimal care. Indeed, the public may come to expect no less.

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The late Charles Darby, an independent consultant based in Baltimore, Maryland, assisted organizations with the implementation and use of the CAHPS® suite of patient experience surveys. Mr. Darby was a former project officer at the Agency for HealthCare Research and Quality responsible for the direction of the CAHPS project.