All In: Exceptional Patient and Family Experience

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Objectives

- Identify the relationship between patient/family experience and healthcare outcomes
- Utilize the critical aspects of strategic alignment; team engagement – physicians, nurses, all team members, and patient advisors; individual accountabilities; and infrastructure that creates the best outcomes and the best environment to work
- Develop action plans to share with colleagues
All In! Exceptional Patient and Family Experience: Setting the Context-Transforming Health Care

Kris White

Session Agenda

- Why Are We Here?
- Consumer Perspectives
- Strategic Significance and Alignment of This Work
- How Do We Get there?
Session Objectives

At the end of this section, participants will be able to:
- Articulate the context for patient experience – why it is vital to organizational health and how it fits in healthcare transformation
- Describe the relationship between patient experience and the domains of patient safety, quality of care, staff engagement, and financial vitality

Why are you Here?

Individually – words or phrases:
- What brings you to this session?
- What are your bright spots in your work with Patient and Family Experience?
- Where are you stuck?

At your table – share briefly then:
- Summarize the top 2 themes in each
Why Are We Here?

- Is there anything else we would truly rather be doing?
- At the end of the day, everything every one of us does somehow impacts a patient/family.
- The patient/family is at the center of all we do.

*START with “WHY”*

Activity: Force Field Analysis

Driving forces ↔ Restraining forces
Disclaimer

- Exceptional experiences are not about being “nice.” It is a skill.
- Not an educational program
- They result when:
  - Mission, vision, values align.
  - Leadership team commits
  - Processes and behaviors are reliable
  - Infrastructure, development, expectations, and core processes are complimentary.

It is about…

- Intentionally designing a culture of excellence.
- Creating a culture that oozes a sense of care, compassion, respect, partnership and concern.
- Being clear about our goals and intentions.
  - The goal is not “happy people.”
  - The goal IS about partnership.
- Developing the skills and processes to thrive
Some “Why’s”

- Age of consumerism
- Every patient and family leaves with opinion of “care” provided.
- Opinions form reputation
- Reputation drives business
- Systems thinking
- Focus on true impact and outcomes
- Focus on highest and best use of all resources

Healthcare Reform

- Is real
- VBP is here
- CAHPS marches on
  - HCAHPS
  - CGCAHPS
  - Hospice quality reporting
  - Cancer Care CAHPS
  - HH-CAHPS
  - Pediatric CAHPS
  - More on the horizon
**Expected outcomes**

- Experience and loyalty trifecta!
- Improved quality and safety
- Improved community perception and reputation
- Increased market share/volume
- Financial Health
  - Effective and efficient care
  - Decreased dissatisfaction and associated costs
  - Decreased claims/losses

**Bottom line:**
best and most efficient care

**Evidence – Connecting the Dots:**
Patient Experience, Quality, Safety, Engagement, and Financial Vitality

“Prepared, engaged patients are a fundamental precursor to high-quality, lower costs, and better health care”

*IOM meeting summary 2013*
*Partnering with Patients to Drive Shared Decisions, Better Value, and Care Improvement*
Focus

- Lets focus on things that matter!
  - To patients and families
  - To our colleagues
  - To the communities we serve

Consumer perspectives
Consumer Expectations

Consumer Perceptions of Healthcare
What do consumers want?
- To be listened to - truly listened to
- To trust
- To be partners in their health
- Access to their information and control over who has access
- Information and choices that can be easily understood…quickly
- Care tailored for the individual, within their context
- Confidence in the “team”
- Involvement of their “family” as desired
- Respect and compassion

Bottom Line:
Best, affordable and safest care

(BTW- assume best and safest)
Doing To, For or With

- Thou shalt…(TO)
- Great customer service …(FOR)
- What’s your biggest concern and worry…?(WITH)
- What matters to you? (WITH)

Example: Shared decision making

Question:
What Percentage of Patients who…

- want an equal say in care decisions?
- prefer to leave decisions to their care provider?
Shared Decision Making: Perspective

Answer: Depends on **what** and **how**

- Initially
- If clear information about treatment options is provided

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Consumer Perceptions of Healthcare

Reprinted Courtesy of Blue Shield of California Foundation.
Clues Tell the Story

**WORK**

**WHAT**

**Functional:** Does it function/work reliably and consistently

**Look**

**Mechanic:** The tangibles, first impressions

**How**

**Humanic:** People, behavior and appearance

**Feel**

**RATIONAL**

**EMOTIONAL**

Adapted from Carbone/Haeckel, 1994, revised by Berry/Seltman, 2008

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Clues tell the story

“Didn’t anybody tell you? Fridays are casual day in the O.R.”
Clues Tell the Story

Everyone leaves with an opinion of their experience

work look feel

Proposition:

Make sense of everything, and align all efforts as seen through the eyes of our patients and families.
It \textit{is} possible!

Patient and Family experience + safety + engaged team + quality + financial vitality

\textit{What are your examples?}

\textbf{Whose “Job” Is It?}

- All in!
- Connect each person to their “why”
The Perfect Model

- A perfect model to create an exceptional patient and family experience. We must...
  - Create it
  - Own it
  - Do it

How Do We Get There?

- Aligned and integrated with all priorities
  - Patient and Family Experience
  - Financial health
  - Quality & Safety
  - Fully engaged workforce
  - Strong partnerships with our medical staff
  - Growth
- Part of the DNA of organization versus a program or initiative
“Hope is not a plan!”

Culture eats Strategy …for Lunch!!
How Do We Get There?

Combination of:
- Organization wide strategies and tactics
- Local ownership and accountabilities to drive change

Organization Wide Tactics

- What are your examples?
  - “Promises”
  - Family Presence
  - Post Discharge Calls
  - Access to schedules and clinicians in offices/clinics
  - Others?
Local Ownership and Accountability

- What are your examples?
- Coaching
- Environmental opportunities
- Effective team behaviors
- Handoffs

Leadership is absolutely Critical

- This cannot be overstated
- Vision- with clarity
- Courage
- Role modeling
- Being “present”
- Coaching and accountability
- “connecting the dots”
A firm foundation

“The study of stunted, immature and unhealthy specimens can yield only a neurotic psychology and neurotic philosophy.”

– Abraham Maslow

Never accept the “suckers choice”!
Maslow’s Hierarchy of Needs

- Basic needs: food, water, warmth, rest
- Safety needs: security, safety
- Belongingness & Love needs: intimate relationships, friends
- Esteem needs: prestige, appreciation & accomplishment
- Self-actualization: personal growth & fulfillment

Maslow Meets Patient Experience

- Consistency
- Reliability
- Easy
- Efficient
- Respectful
- Compassion
- Effort
- Problem Solving
- Creativity
- Complete
- Continual Learning
- Clinical Integration
- Access
- Coordination
- Patient-centered
- Facilities designed for patient
- Safety in general
- Ensuring clinical quality & patient safety
5 emerging trends and a thought…

1. No longer optional: Engagement of patients and families
2. Integration and coordination of care: “all in” from the p/f perspective
3. Must get “smart” with consumer facing technologies and build enabling information technology platforms
4. Must stop doing things that don’t matter
5. Must never forget that healthcare is…and will always be… a human event

Focus on Value to Patients- so that…

…purposeful, wholistic and targeted transformation can occur which is critical, and absolutely essential to thrive in the future

Don’t listen to hear, listen to understand
“I attribute my success to this – I never gave or took an excuse.”

– Florence Nightingale
Improving the patient experience of care (including quality and satisfaction);

Improving the health of populations; and

Reducing the per capita cost of health care.

Framework for Public and Patient Engagement
<table>
<thead>
<tr>
<th>Techniques</th>
<th>When it’s Useful</th>
</tr>
</thead>
</table>
| Asking and Listening| - Conversations  
                    - Soliciting preferences, wishes  
                    - Focus groups  
                    - Surveys  
                    - Panels  
                    - Town meetings  
                    - When the purpose is to listen  
                    - When there is no commitment to do anything  
                    - When an initiative is being shaped |
| Informing           | - Fact sheets  
                    - Websites  
                    - Media campaigns  
                    - Resource centers  
                    - Patient Portals  
                    - In a crisis  
                    - When the issue is simple  
                    - When a decision has already been made  
                    - When there is no opportunity to influence the outcome  
                    - When factual information is needed to describe a program/policy/process |
| Participating       | - Priority setting  
                    - Ranking  
                    - Voting  
                    - When there is a capacity for the public to shape initiatives/programs/policies  
                    - When the public has accepted the challenge of developing solutions  
                    - When there is agreement to implement solutions/improvements |

The Framework

- Environment
- Organization
- Microsystem
- Personal Experience

The Conversation Project

IHI – PCFF one of 4 areas of strategic focus

- Seminars and Collaboratives
- Patient/Family Network
Don’t do more. Do better.

Culture of Safety Enhanced

Engaging patients at the bedside enhances all safety protocols.

Engaging families extends safety to the home.

Engaging Patient/Family Advisors in planning saves time and precious resources.
Patient Experience

Moving from “What is the matter?” to “What matters most to you?”

Where Are You in Action and Attitude?

- Doing To
- Doing For
- Doing With
Working Definition of Patient/Family Advisor

- A patient & family advisor works in a variety of healthcare settings sharing their personal stories to represent all patients & families in bringing authenticity, empowerment, respect and inspiration to the design and delivery of healthcare systems. Patient & Family Advisors' roles include educator, speaker, advocate, collaborator and leader, ensuring the focus of healthcare is on the patient & the family.

What Is The Role of a Patient/Family Advisor?

- Patient Activist
- Community Advocate
- Patient/Family Advisor
- Partner in Care
- Engaged Patient
- Speaker
- Leader
- Organizer
### Formal Roles

- Support
- Policy
- Provide Assistance
- Executive Team
- Advisor
- Family Leader
- Customer Service
- Trainer
- Develop training for staff
- Voice of Patient & Family

- Represent Patient
- Hospital Volunteer on Unit
- Chair PFAC
- Train residents
- Recruit
- Sit on Committees
- Partner
- Market patient stories
- Activate patient
- Teaching peers

- Member of Patient Voices network
- Speaking
- Consumer Advisory Board
- Education staff on DME
- Access to Board
- Facilitate community groups
- Being assertive
- Share stories
- Teleconferences – share info

### Informal Roles

- Bring urgency
- Compassion
- Cookies
- Dignity
- Non-threatening
- Listening
- Affirmation of patient experience
- Confirmation
- Comfort

- Sense of humor
- Hospitality
- Hope
- Balance & level headedness
- Empathy
- Humanity
- Framework for discussion
- Understanding
- Expertise

- Respect for all views
- Perspective
- Empower
- Caring
- Change
- Inform
- Engage
- Organize
- Truth teller
Who is Ready?

- A patient or family member in your setting with current experience
- Reached a state of healing – wants to make the world better for others
- Has a community outside health care that “holds” them; family, office, social, spiritual
- Ask a busy person.

Developing Health Care Team Members

- Remember – it is not just Patient/Family Partners who need development to work with healthcare team members!
- Most healthcare team members are not skilled in working in true partnerships with patients/families. We are used to being “in charge.”
- Specify listening behaviors to use in activities with Partners to assure their talents are being used effectively.
Transformative Learning

- Not spontaneous (requires work and discipline)
  - Creates new meaning to life, events, facts, interactions with others
  - Results in change in perception; knowing which requires different action or structure
- What is the learning that creates a new habit of mind?
  - Change perspectives and paradigms
  - Challenge and validate assumptions
  - Critical self-reflection
  - Include and integrate experiences

Based on the work W. Edwards Deming

Transformational Learning: 1st Reflection

- Think of a time in your life (situation or incident) where you were vulnerable.
  - Where were you?
  - Who was involved?
  - What happened?
  - What made you feel vulnerable?
  - Make note of your feelings

- What advice did you or would you have liked to give those who influenced your experience?

Developed by Jane Taylor and Pat Rutherford
Transformational Learning: 2nd Reflection

- Think of a time in your life when someone provided you genuinely “helpful” help.
  - What was your experience?
  - What did you feel?
  - Describe the characteristics of “helpful” helping

- Think of a time when someone provided you some “not-so helpful” help.
  - What was your experience?
  - What did you feel?
  - Describe the characteristics of “not-so helpful” helping

Developed by Jane Taylor and Pat Rutherford

All In: Patient and Family Experience
Team Engagement: Joy and Meaning in Work
Barbara Balik, RN, EdD

IHI Forum
December 8, 2013
Best Job

Think of the best job you’ve ever had

- What image comes to your mind?
- What 2 words describe how you feel about it?
- How would you describe your boss? Your co-workers?
- Share with someone near you

So What?

- Why does team member engagement matter to patient and family experience?
- Why does team member engagement add to safety, quality, and financial vitality
Engagement

- Relationships that –
  - Encourages the heart through respect and dignity
  - Connects us with each other and with our purpose – to contribute to something larger than ourselves
  - Enables us to act in service to our mission
  - Nurtures a culture of healing and of excellence

Link to Outcomes

- Do I know what is expected of me at work?
- Do I have the materials & equipment I need to do my work right?
- Do I have the opportunity to do what I do best every day?
- In the last seven days, have I received recognition or praise for good work?
- Does my supervisor seem to care about me as a person?
- Is there someone at work who encourages my development?

Gallup Organization
Can we answer “Yes”? 

Can each person in the workforce answer yes to these questions each day?

- Am I treated with dignity and respect by everyone?
- Do I have what I need so I can make a contribution that gives meaning to my life?
- Am I recognized and thanked for what I do?


What We Know

- Internal (intrinsic) motivation is the key
  - We do something because we want to do it
- External (extrinsic) motivation (carrots & sticks)
  - Squelch internal motivation
  - Rarely work
  - Can risk decreased performance, limited creativity, and diminished positive behavior
  - Compliance → decreased results
- Creating environments that nourishes internal motivation enables great results
Motivation

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less common in organizations despite 25+ years of research</td>
<td>Common approach in most organizations</td>
</tr>
<tr>
<td>We do something because we want to</td>
<td>If – Then</td>
</tr>
<tr>
<td>We know what needs to be done and choose to do it - commitment</td>
<td>Compliance</td>
</tr>
<tr>
<td>Individuals take needed action whether a supervisor is present or not</td>
<td>Carrot – Stick</td>
</tr>
<tr>
<td></td>
<td>Heavily relies on managers making sure people are compliant</td>
</tr>
<tr>
<td>More likely to be highly connected to their work and more energized</td>
<td>More signs of burnout</td>
</tr>
</tbody>
</table>

Culture of Respect

- A substantial barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect
- Range of disrespectful conduct
  - Disruptive behavior
  - Humiliating, demeaning treatment of nurses, residents, and students
  - Passive-aggressive behavior
  - Passive disrespect
  - Dismissive treatment of patients
  - Systemic disrespect – waiting; wasteful systems for everyone

**Burnout**

<table>
<thead>
<tr>
<th>Burnout</th>
<th>Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhaustion/Fatigue – individual dimension</td>
<td>Personal resilience</td>
</tr>
<tr>
<td></td>
<td>Workload</td>
</tr>
<tr>
<td></td>
<td>Fairness</td>
</tr>
<tr>
<td></td>
<td>Meaningful and valued work</td>
</tr>
<tr>
<td>Cynicism and detachment – interpersonal</td>
<td>Control</td>
</tr>
<tr>
<td>dimension</td>
<td>Community- positive</td>
</tr>
<tr>
<td></td>
<td>connection with others</td>
</tr>
<tr>
<td>Sense of ineffectiveness or lack of</td>
<td>Recognition &amp; reward</td>
</tr>
<tr>
<td>accomplishment – self-evaluation dimension</td>
<td></td>
</tr>
</tbody>
</table>

*Maslach, C., Schaufeli, W., & Leiter, M. Job Burnout. Annu. Rev. Psychol 2001, 52:397-422*

**Motivation**

- Study of transformational healthcare leaders
- Four of the nine characteristics – engaging hearts and minds:
  - Genuinely care about and trust others
  - Engage everyone
  - Part of the team, part of the solution
  - Enable others to grow

Motivation

Four factors that contribute to intrinsic motivation:

- **Purposeful and meaningful work**
  - To be part of something larger than ourselves; to make a contribution

- **Competence or mastery**
  - To grow in our skills

- **Choices** in how we direct our lives; self-directed or acting by choice in teams

- **Progress** towards a desired outcome

When these factors are present, great results occur.

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Institute for Healthcare Improvement

Journey Mapping

*All In*

IHI Forum
December 2013
Patient and Caregiver Journey Mapping

The purpose is to:

- *Learn through the patient’s and caregiver’s eyes.* Understand the journey from the patient, family, and caregivers’ view, not from assumptions of how we think care happens.

- *Be curious.* Role model how to learn how to improve experiences; approach the observation with curiosity and respect (not judgment) of those providing care and service; we may not like what we see but that is the real experience of those providing and receiving care.

- *Design in partnership.* Design effective operational and emotional processes in partnerships with patients and caregivers.

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Observation Guide

- Simple actions
  - Go see, listen, and learn
  - Ask to understand
  - Respect people
  - Keep excellent patient care and experience as the purpose
Steps

1. Identify the process you want to improve - ask patients
2. You can do segments of the process or the whole process – as long as you keep the whole journey in mind
3. Engage a team of those involved in the process and Advisors (2-3) who have used the process

Steps Part 2

4. Observe the entire process – see observation guide
   • What is the goal of this step?
   • Who is involved?
   • What operationally needs to occur for the process to work?
   • Who is involved at each step and what do they do?
   • How do they know they’ve done the work defect free?
   • How do transitions occur – from who to who?
   • Where there are gaps or actions are unclear or unspecified?
Steps Part 3

5. Capture the Emotions of experiencing the process
   - Ask Advisors, ‘what was going through your mind right now?’; what did it feel like to be here?; ‘how would you describe this step to others?’
   - Ask Caregivers the same questions – may signal areas where they are distracted from patient
   - Listen for strong emotional words that signal Touchpoints for patients/family members

6. Draw the map:
   - The steps in the process; time for each step; waits and delays; people or roles involved
   - Sticky notes describing the emotional map – the words used by Advisors to describe that step; words used by Caregivers

Steps Part 4

7. Design Ideal State
   - Using the team (that includes Advisors and PI support) design the ideal state
   - What would it look like if the map – both process and emotional – were ideal?
   - It is an opportunity to improve experience, safety, clinical outcomes, and reduce waste

8. Small tests of Ideal State
   - Rapid tests of Ideal State as prototype
   - Identify new process and outcome measures
   - Keep testing and improving – spread to everyone involved
**Team exercise**

- 5 min – Share personal patient experiences. Choose one to use for a case study
- 2 min – Choose your roles as 1) operational recorders or 2) emotional observers. Operational will record in longhand, emotional will record in pictures
- Walk through the experience from the patient perspective. This would include non-clinical events such as travel to the appointment, having to arrange school pick up because the appt. runs over, etc.
- Record the activities and emotions of both staff and clinicians, patient and family.

**Group Discussion**

- How do emotions of patient and staff compare?
- What is the relationship between the process or operation and the emotions? Are they the same for staff and patients?
- How did you feel in your different role?
- What might you change as a result?
Grow People

- "If you want 1 year of prosperity, grow grain. If you want 10 years of prosperity, grow trees. If you want 100 years of prosperity, grow people."
- Chinese proverb

In Closing

- So what is your burning platform?
- What can you leave here and do next week?
Resources

Resources


Resources

- Spear, S., Schmidhofer, M. Ambiguity & Workarounds as Contributors to Medical Error. Annals of Internal Medicine, April, 19, 2005, Vol. 142, No. 8, 627-630.
Selected Evidence

- Across countries, engaged patients reported fewer medical errors, higher care ratings, and more positive views of the health system as a whole

- In a review of 55 published studies representing a wide range of health care settings and study designs, the authors found consistent evidence of a positive association between patient experiences and clinical and safety outcomes, providing support for the inclusion of patient experience as a central component of health care quality.

Selected Evidence

- A qualitative study sought to provide insight into patients’ and care providers’ views and experiences related to the hospital discharge process, using data from interviews and a questionnaire survey of care providers, patients, and family members from a hospital and surrounding community in the Netherlands. On the basis of their analysis, the authors identify deficiencies in communication and coordination of care as primary barriers to safe and effective discharge transitions, suggesting that efforts to improve the safety and quality of the discharge process should focus on these concerns
Selected Evidence

Systemic literature reviews illustrate the link among experience, clinical quality, and overall efficiency of care. For example, in a national study of hospitals by Isaac et al. (2010), examining the relationship between patient experiences and other measures of hospital quality and safety, researchers found consistent relationships between patient experiences and technical quality as measured by the measures used in the Hospital Quality Alliance (HQA) program, and complication rates as measured by the AHRQ Surgical Patient Safety Indicators.


Selected Evidence

“... both theory and the available evidence suggest that such measures are robust, distinctive indicators of health care quality. Therefore, debate should center not on whether patients can provide meaningful quality measures but on how to improve patient experiences by focusing on activities (such as care coordination and patient engagement) found to be associated with both satisfaction and outcomes, evaluate the effects of new care-delivery models on patients’ experiences and outcomes, develop robust measurement approaches that provide timely and actionable information to facilitate organizational change, and improve data-collection methods and procedures to provide fair and accurate assessments of individual providers.” p. 20

Selected Evidence

- Engaged patients have fewer adverse events – most hospitalized patients participated in some aspects of their care. Participation was strongly associated with favorable judgments about hospital quality and reduced the risk of experiencing an adverse event.
- Notable factors that may affect satisfaction of patients include ability to have all of their questions answered, incomplete discussion of medication side effects, and failure of physicians to listen and form personal connections with them.
  - Blanden AR, Rohr RE. Cognitive interview techniques reveal specific behaviors and issues that could affect patient satisfaction relative to hospitalists. Journal of Hospital Medicine. 2009; E1-6 (9).

Selected Evidence

- The potential for engaging patients in patient safety is considerable but further research is needed to examine the influences on patient involvement, the limits and the possible dangers. Patients can act as safety buffers during their care but the responsibility for their safety must remain with the health care professional.
Selected Evidence

Likes & Quality: A study that found that Facebook “likes” were indeed an indicator of hospital quality and patient satisfaction. Researchers compared the 30-day mortality rates and hospital patron recommendations to the number of “likes” on the hospitals’ Facebook pages from 40 hospitals near New York, NY. They found that Facebook “likes” were positively associated with patient recommendations and that a one percentage point decrease in the 30-day mortality rate corresponded with almost 93 more Facebook “likes.”


Selected Evidence

First do no harm. Researchers find, “…you can improve care while reducing costs by making sure that everything you do is centered on what the patients want… specific goals are… tailor a treatment plan to ensure we provide the specific care he/she wants.”

Selected Evidence

“To gain deeper insights into what experiences patients were using when responding to the overall satisfaction questions, we found that hospitals that score high on questions such as ‘skill of nurses (physician),’ ‘how well the nurses (physician) kept you informed,’ ‘amount of attention paid to your special or personal needs,’ ‘how well your pain was controlled,’ ‘the degree to which the hospital staff addressed your emotional needs,’ ‘physician’s concern for your questions and worries,’ ‘time physician spent with you,’ and ‘staff efforts to include you in decisions about your treatment’ also tended to score high on patient overall satisfaction. In contrast, there was no association with scoring high on questions concerned with the room, meals, tests (e.g., ‘time spent waiting’), discharge (e.g., ‘speed of discharge process’) and the patient overall satisfaction score. Moreover, patient satisfaction with nursing care was the most important determinant of patient overall satisfaction, thus highlighting an important area for further quality improvement efforts and underscoring the role of the entire health care team in the in-hospital treatment of patients with AMI.” p. 193.


Selected Evidence

Patient Experience correlated with other key outcomes:
Health outcomes – patient adherence, process of care measures, clinical outcomes; Business outcomes – patient loyalty, malpractice risk reduction, employee engagement, financial performance

Selected Evidence

Simply sitting instead of standing at a patient’s bedside can have a significant impact on patient satisfaction, patient compliance, and provider–patient rapport, all of which are known factors in decreased litigation, decreased lengths of stay, decreased costs, and improved clinical outcomes. Practice implications: Any healthcare provider may have a positive effect on doctor–patient interaction by sitting as opposed to standing during a hospital follow-up visit.


Selected Evidence

- Financial benefits: Reduced length of stay, lower cost per case, decreased adverse events, higher employee retention rates, reduced operating costs, decreased malpractice claims, increased market share

Selected Evidence

- We found positive associations of Family Centered Care with improvements in efficient use of services, health status, satisfaction, access to care, communication, systems of care, family functioning, and family impact/cost.

Selected Evidence

- Research suggests that patients can contribute significantly to health-care improvements, in particular through their assessment of non-clinical aspects of care, their assessment of the care environment and their observations and experience with the care process.
Selected Evidence

Patient and Family Centered Care: Academic Centers Six Core Elements of Sustainable Change:
- 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.

Shaller D, Darby C. High performing patient and family centered academic medical centers. 2009 Picker Institute.

Selected Evidence

Rand-based Cost Containment Strategies
- Adopt comprehensive payment reform
- Adopt and use health information technology
- Implement evidence-based coverage informed by comparative effectiveness information
- Develop health resource planning
- Support system redesign
- Implement health plan design innovation to promote use of high-value care
- Enact malpractice reform and peer review protections
- Implement administrative simplification
- Engage consumers
- Encourage healthy behaviors
- Further promote transparency