Profiles of High-Performing Patient- and Family-Centered Academic Medical Centers

Medical College of Georgia Health
Augusta, Georgia

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About the Profiles

This profile is one in a series of six case study reports funded by The Picker Institute that document examples of how academic medical centers can achieve high levels of patient- and family-centered care (PFCC). 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.

The six centers were selected for study on the basis of several criteria, including a mix of geographic location, safety and non-safety net hospitals, expert opinion on high-performing centers, actual performance on available metrics such as H-CAHPS scores, and varied approaches to achieving patient- and family-centered care documented in previous studies. Data were collected primarily through site visits to each center that 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.

The profiles resulting from these case studies are each organized according to a common set of topics that emerged as cross-cutting themes common to successful implementation of patient- and family-centered care in these organizations. Each individual profile is designed to provide real-world, operational examples of how these core elements of patient- and family-centered care are brought to life in practice. Samples of available documents and tools related to these core elements are provided as attachments. A separate summary analysis of key factors contributing to patient- and family-centered care across all six centers also will be compiled and made available as part of this project.

List of Academic Medical Centers Profiled

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

The Medical College of Georgia Health (MCGHealth) is an academic medical center that provides a full range of health care to patients in Georgia, South Carolina and the rest of the southeast region of the United States. Facilities include a 478-bed adult hospital and a 154-bed children’s hospital. MCGHealth is also a safety net hospital and a Level 1 Trauma Center for the region. The Ambulatory Care Center includes over 80 practice sites covering all major specialties and subspecialties, as well as over 90 satellite clinics.

MCGHealth started its journey in patient- and family- centered care (PFCC) in 1993 when patients and family members were consulted to get their views about the design of a new children’s hospital. Those planning the project may have been somewhat skeptical about the input they would garner. But, what started as a modest effort to get “customer” input has led to what today is a full partnership with patients and families. MCGHealth and its principal PFCC champion, Pat Sodomka, have received broad recognition for their work. One of the most notable is the "Hand in Hand" segment in the award- winning Public Broadcasting System documentary, “Remaking American Medicine: Health Care for the 21st Century”, produced in 2006.

From its early beginnings and throughout the next 15 years, MCGHealth has demonstrated some of the same characteristics common to other successful PFCC initiatives. Key among them is to find opportunities and turn them into success. For example, in 1998 leaders seized an opportunity to spread PFCC more thoroughly in the adult hospital. At the time, MCGHealth was being transitioned from a state-run facility under the Board of Regents to an independent non-profit corporation. Don Snell, the newly-recruited CEO of MCGHealth, had a period of several months before taking over control of the system to develop a strategic plan. The plan included full incorporation of PFCC throughout the newly constituted organization.

Systematic effort was undertaken to institutionalize PFCC throughout the clinical system. Staff worked to develop new policies and infrastructure including human resource policies and programs, facilities, and a dedicated role to support PFCC. The spread of PFCC continued through the outpatient facilities and then to the Ambulatory Care Center.

In 2004, the establishment of the Center for Patient- and Family-Centered Care signaled the institutionalization of PFCC principles throughout the organization. MCGHealth enumerated these principles which are reinforced in training for all health care providers in the Medical Center:

- People are treated with **respect and dignity**.
- Health care providers communicate and share complete and unbiased **information** with patients and families in ways that are affirming and useful.
• Individuals and families build on their strengths through **participation** in experiences that enhance control and independence.

• **Collaboration** among patients, families and providers occurs in policy and program development and professional education, as well as in the delivery of care.

A key element in the MCGHealth strategy is the development and nurturing of its network of Patient and Family Advisory Councils. The number of advisors has grown from the 20 or so who helped with MCGHealth Children’s Medical Center planning in 1993 until the current number of 250 advisors, over three-quarters of whom are active participants. In addition, the councils are present in almost every unit or department of the enterprise and serve a diversity of functions. They have been articulated into three tiers. These are the four Institutional Councils, six Program Level Councils and numerous Hospital and Academic Committees.

MCGHealth 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. The organization has used patient experience data extensively to assess overall performance as well as to evaluate specific initiatives. It also has focused on demonstrating the business case for PFCC. Data are regularly reported to the Board of Directors and other senior leaders on the positive influence of PFCC on such metrics as costs, length of stay and staff ratios.

MCGHealth is likely to continue to be a focal example that other medical centers point to as a demonstration of what can be accomplished through dedicated leadership, strategic planning, and thoughtful hard work aimed at building real partnerships with patients and families. Its challenge ahead is to keep new ideas flowing and the energy level high as the organization continues to work on spreading PFCC into its ambulatory care programs and beyond.
Background on MCGHealth

MCGHealth comprises MCG Health, Inc., clinical services provided by the faculty employees of the Medical College of Georgia (the Health Sciences University) and the Physician Practice Group. Within this overall structure MCG Health, Inc. is a not-for-profit corporation that manages the MCGHealth clinical operations. It includes the MCGHealth Medical Center, MCGHealth Children’s Medical Center, the MCGHealth Sports Medicine, MCGHealth Ambulatory Care Center, Georgia Radiation Therapy Center and related clinical facilities and services.

MCGHealth is an academic medical center that provides a full range of health care to patients in Georgia, South Carolina and other parts of the southeast region of the United States.

Its vision is “to achieve excellence in compassionate patient care, life-long learning, dedicated public service and leading edge research.” MCGHealth functions with two medical staffs, one for the MCGHealth Medical Center and one for the MCGHealth Children’s Medical Center. While drawing on the faculty of the Medical College of Georgia, both centers also operate with non-faculty medical staff.

Facilities include a 478-bed adult hospital and a 154-bed children’s hospital. MCGHealth is also a safety net hospital and a Level 1 Trauma Center for the region. The MCGHealth Ambulatory Care Center includes over 80 practice sites covering all major specialties and subspecialties, as well as over 90 satellite clinics.

In 2007 MCGHealth employed 3,272 staff and 597 physicians. There were nearly 73,789 emergency room visits, 14,754 adult admissions and 4,595 pediatric admissions. The ambulatory center has approximately 365,000 patient visits annually. Net patient service revenue was over $340,000,000 and MCGHealth provided $7,300,000 in charity care.

The Medical College of Georgia’s Health Sciences University includes schools of Allied Health Sciences, Dentistry, Graduate Studies, Medicine and Nursing. It is the sole academic institution in Georgia that is dedicated exclusively to the health sciences and has an enrollment of 2,913 on its main Augusta campus.

MCG Health Inc. is establishing a series of Centers of Excellence. These centers are designed to provide comprehensive programs of care to patients and families in one organizational unit. Two exist today. The MCGHealth Neuroscience Center is a comprehensive program for treating adults and children for stroke, epilepsy, movement disorders and brain tumors. The MCGHealth Children’s Medical Center serves the special health care needs of children.
MCGHealth serves the community in a variety of ways including holding health fairs, encouraging staff to participate in charity events, and training youth in various sports skills through the MCGHealth Sports Medicine Center. In one particular program, MCGHealth is the lead agency for the East Central Georgia SAFE KIDS Coalition, a national child safety advocacy program. Within the local community SAFEKIDS focuses on car seat safety, fire prevention, emergency first aid and injury prevention.

**Evolution of PFCC at MCGHealth**

MCGHealth is recognized as a pioneer in the design and implementation of patient- and family-centered care and remains a leader in the field. The work of MCGHealth was highlighted in the “Hand in Hand” segment of the 2006 Public Broadcasting System documentary, “Remaking American Medicine: Health Care for the 21st Century”. [See video at: http://www.mcg.edu/centers/cpfcc/video/ram.html] If it is possible in a field as new as PFCC, MCGHealth represents the establishment. Through long and concerted effort, MCGHealth has become an institutional touchstone exemplifying many of the central features and processes of PFCC. [See Web page on MCGHealth Patient- and Family-Centered Care at: http://www.mcghalnThe_d.org/Patient_Visitor_Info/patient-family_center-care/index.html]

Like most other programs, it started by acting on an opportunity created by the planning for a new MCGHealth Children’s Medical Center in 1993. MCGHealth sought the active participation from parents of children who had been in the children’s units of the existing hospital and from children, both former and current, in the planning process. This step, it turned out, was just the first in a long journey which changed the culture at MCGHealth, not just in the children’s medical center, but in turn in the adult medical center, and which is now spreading to ambulatory care and to the MCG education and research components, as well. Once on the journey MCGHealth never turned back. [See Appendix B for a PFCC journey timeline in the AMC.]

Staff involved in the children’s hospital planning learned to view health care from the perspective of the parents and children, some for the first time. While they were focusing on designing the structure and new processes, the staff began to see a new way of viewing the role of patients and families. For example, previously family members were seen as visitors. Through hearing the families’ stories and viewpoints the staff came to appreciate that parents were experts about their children and a necessary partner on the team providing care. If family members were seen only as visitors, the staff would be missing out on help from an important partner. When MCGHealth Children’s Medical Center was opened in 1998, open access for family members was instituted. As well, the physical design and architecture of the building reflected the new culture. For example, there were single rooms for patients with space and beds for family members to stay overnight in the room. Nurses’ stations were open with chairs for family members.
Another major change was implemented in the children’s hospital when family members were encouraged to participate in in-room rounding. The process kept family members updated and gave them a chance to ask questions.

In 1998, PFCC had developed a full head of steam following the opening of the MCGHealth Children’s Medical Center, but had not yet spread consistently to the adult facility. However, at this time there was a major change in the clinical system at MCGHealth. The hospital was being transitioned from a state-run facility under the Board of Regents to a separate, nonprofit 501-c-3 corporation. Don Snell, the CEO of MCGHealth, recalled that during the transition period he was afforded the opportunity to take the time to carefully plan for the new operation. He picked up on the momentum from the children’s hospital experience and together with senior leadership developed a strategic plan for the full incorporation of PFCC throughout the newly constituted organization.

Systematic effort was undertaken to institutionalize PFCC throughout the clinical system. Staff worked to develop new policies and infrastructure including new human resource policies and programs, facilities, and establishment of a dedicated role to support PFCC. During this time the Patient and Family Advisory Councils grew from the 20 or so advisors who helped with the MCGHealth Children’s Medical Center planning to two councils and 40 advisors. More regarding the human resource policies and Advisory Councils is described in later sections.

Introduction of PFCC in the following programs illustrates how PFCC was taking hold.

**MCGHealth Breast Health Center**

The MCGHealth Breast Health Center provided the first opportunity for introducing PFCC into the adult hospital. Staff worked closely with a breast cancer survivor to get the patient’s perspective on the process. It led the staff to re-conceptualize mammography from a “diagnostic test” to “a woman doing something good for herself”. It drew the focus away from the technology of mammography and to the overall experience for the woman. Improvements were made in the physical setting to make it more like a home with a quiet, welcoming and comforting tenor than a hospital examination room. Staff focused more on the person living the experience and less on the mechanics of the test. The changed perspective was brought to the design and implementation of every aspect of breast care in the center and served as a critical learning experience in bringing about necessary culture change throughout the adult hospital.
MCGHealth Neurosciences Center of Excellence

In late 2002, the leadership of the MCGHealth Neurosciences Center of Excellence began to develop a PFCC agenda. The first initiative was launched in the multiple sclerosis (MS) clinic. Leadership of the clinic met with a group of patients to hear their ideas about how to make the clinic embody principles of PFCC. Patients had very different ideas than those of leadership. Patients expressed fundamental needs, such as getting help to make them more independent, having their calls to the clinic returned promptly, and getting the support they needed. Leadership responded to these concerns with action. Their steps included moving the clinic to the Rehabilitation Services location to improve the care received by the patients with MS. As with the Breast Health Center, staff understood better how to partner most effectively with patients and they worked to apply the learning to other parts of the Center. The patient advisors who had helped with the changes in the MS clinic were enlisted to assist in the design of a new neurological intensive care unit. With the advice from these patients, the design and processes of the unit facilitated communication and collaboration among health care providers, patients and families. Patient advisors were also invited to interview unit staff and faculty prior to the opening of the unit. These innovations resulted in improvements in the Center’s patient satisfaction scores, RN vacancy rate, neurosurgery length of stay, discharges from the service line, high morale among staff and physicians and reduction in medication errors.

In 2004 the establishment of the Center for Patient- and Family-Centered Care signaled the institutionalization of PFCC principles throughout the inpatient facilities and into the health sciences university. MCG enumerated these principles which are reinforced in training for all health care providers in the MCGHealth Medical Center:

- People are treated with respect and dignity.
- Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.
- Individuals and families build on their strengths through participation in experiences that enhance control and independence.
- Collaboration among patients, families and providers occurs in policy and program development and professional education, as well as in the delivery of care.

In concert with these principles, a set of standards to be adhered to by clinical staff also had evolved:

- Involve patients and families in all aspects of the planning, delivery and evaluation of health care services.
• Recognize families as important members of the health care team. Encourage and support families in care planning and decision-making.
• Support patients in involving their families in the health care experiences in ways that they choose. Be flexible.
• Welcome family members at all times regardless of rounds, change of shift or events on the unit.
• Encourage and support family members to be present during procedures and treatments, if this is the preference of the patient.
• Provide information, in ways that patients and families would find helpful, empowering and supportive in nurturing, care-giving and decision-making.
• Provide easy and accessible opportunities for patients and families to ask questions of doctors and nurses.
• Provide care that respects patients’ values, preferences and expressed needs.
• Coordinate and integrate the care for the patient -- coordinate services (i.e. tests, consultations or procedures).
• Provide timely, tailored and expert care in managing the physical comfort of the patient.
• Provide emotional support in relieving fear and anxiety that accompanies an injury or illness -- such as fear of pain, disability or disfigurement, loneliness, financial impact or the effect of illness on the family.

[See the Web site for the Center for Patient- and Family-Centered Care at: http://www.mcg.edu/centers/cpfcc/index.html]

**MCGHealth Ambulatory Care Center**

With the near full saturation of PFCC on the inpatient side of MCGHealth, the leadership of ambulatory care took up the charge to bring PFCC to the large MCGHealth Ambulatory Care Center. Under the direction of Richard Bias, senior vice president of ambulatory and network services, the leadership set out to become the provider of choice in the greater Augusta area and knew that providing PFCC was important to achieving that goal. To learn more about PFCC, twelve leaders attended an Institute for Family Centered Care Conference in 2006.

An initial step was to conduct an assessment of the staff’s understanding of and attitudes toward PFCC. They found that there were misunderstandings and negative attitudes regarding PFCC.

In January 2007 MCGHealth’s ambulatory care managers and directors participated in a learning laboratory to find out more about PFCC from the Children’s Medical Center, Breast Health Center and Neurosciences Center of Excellence. Learning laboratory participants were impressed by the stories patient and family advisors shared about their role in the design of the PFCC program on the inpatient side and how much their
perceptions of the care they received influenced their choice to continue coming to MCGHealth for their care. This note of loyalty really hit home for a leadership wanting its center to become the provider of choice. They also learned of the success of PFCC in the inpatient settings for improving patient and staff satisfaction, patient outcomes and shortening length of stay.

Soon thereafter, senior leaders attended the University HealthSystem Consortium (UHC) Ambulatory Care Council meeting and learned of many ongoing efforts to conduct PFCC in ambulatory care settings. Armed with new information and assured they were headed in the right direction they 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. Ambulatory Care holds weekly meetings at which two different sites present their action plans and progress, a practice that helped keep PFCC front and center in the minds of managers and staff.

The Patient and Family Advisory Council has become a mainstay for ambulatory care as it has been for inpatient care. After family medicine formed its council many other departments followed suit. Advisory Councils are involved in initiatives to improve scheduling and billing, and helped with the design of the new cancer treatment center, currently under construction.

Leadership acknowledges that even though they have made great progress, total adoption of PFCC across sites is not uniform and each site has its own “personality”. They are committed to continue their journey and say, “we are learning as we go, and it is a privilege”.

**Medical Education**

PFCC has reached the point that it is central to virtually every department and service throughout MCGHealth. This is also true of the MCG Allied Health Sciences, Dentistry, Graduate Studies, Medicine and Nursing divisions of the Medical College. Families and patients are actively involved in the education of students by being invited as family faculty, into the classroom or to speak at campus forums. Family members teach in the schools providing firsthand accounts of the preferred practice of PFCC. They also participate in special programs to provide students real life experience with patients who are living with special health care needs. These are described in a later section of the profile, Involvement of Patients and Families.

The School of Allied Health Sciences has adopted PFCC as one of two strategic initiatives. A school wide retreat has been held with ongoing collaboration with family faculty. The School of Allied Health Sciences assessed what they were doing in their program and acted to include reinforcement of the principles of PFCC in their
curriculum. The Nursing School redesigned its curriculum to incorporate PFCC as a preferred approach to care. The Nursing School took the lead in making the MCG campus smoke-free.

An annual Patient- and Family-Centered Care Conference brings together faculty and MCG Health, Inc. staff for professional development about PFCC and offers an opportunity to learn about national and international PFCC initiatives.

**Research**

A new Educational Discovery Institute at MCG is conducting research to identify ways in which education for medical and health sciences can be made more effective. The Institute will look at ways to overcome the barriers to providing patient-centric care in the educational process. It will focus on evaluating innovations and providing evidence for those that are successful.

MCG’s Department of Psychiatry and Health Behavior is piloting a project to assess how mental health care is taught in an academic medical center. Project GREAT (Georgia Recovery-Based Educational Approach to Treatment) uses a peer specialist to teach psychiatric trainees (including medical students, interns and residents) a new approach to care for persons with mental illness. This new approach to “recovery-oriented” care focuses on involving the patient in decision-making about their treatment while in recovery. The peer specialist uses wellness skills, learned through living in recovery, to teach others the concepts and skills. The project has shown some success with delivering the message at MCG and has shown the feasibility of hiring a peer specialist at a medical college.

Although new, the Improving Patient Rounds (IPR) project, funded in 2008 by the Picker Institute, has enabled MCG to expand the role of patient advisors in PFCC research, not as subjects but as team members. Trained patient advisor observers round with the Red Medicine team on a general medicine unit in the adult care hospital to observe the care team and patient/family interaction and then provide feedback to the attending physician and doctors-in-training. This research will help illuminate patients’, their families’, nurses’, students’ and faculty members’ perceptions of engaging patients and families in academic bedside rounds.

**The Role of Leadership**

PFCC is so well established at MCGHealth that the commitment to it from leadership, in word and deed, is present throughout many aspects of the organization. It is difficult to single out all of the leaders of the Patient- and Family-Centered Care charge because
there is such visible support among so many, but three leaders certainly deserve credit for its growth and sustainability at MCG Health, Inc. and the Medical College of Georgia.

The most visible champion is Pat Sodomka, Senior Vice President of Patient- and Family-Centered Care at MCG Health, Inc., and Director of the Center for Patient- and Family-Centered Care at the Health Sciences University. The Center and Pat’s position were created in 2004, formalizing the role she plays in developing and spreading PFCC throughout both the clinical and university branches of the academic medical center organization. Pat is a central figure and very well known outside of MCG and MCGHealth in the growing national and international community of PFCC practitioners. She sits on external committees that are studying or promoting PFCC in various aspects of health care. For example, she currently serves on a committee for the Accreditation Council for Graduate Medical Education that is developing standards for medical school curricula in PFCC.

Pat is a member of the senior leadership team for the health system and reports to the President and Chief Executive Officer. Among her duties, she promotes the development and implementation of PFCC in the adult hospital, children’s hospital, Ambulatory Care Center, and affiliated MCG and Physician Group entities. As Center Director and a faculty member, she also works collaboratively with MCG schools of allied health, dentistry, nursing and medicine on the development and integration of PFCC in the student curricula. She is also responsible for facility planning and design. [See Appendix C for her job description]

Don Snell, President and CEO of MCG Health, Inc., is also a strong proponent of PFCC. As the chief executive he plays an important role in making the business case for PFCC. He has demonstrated the importance of PFCC for maintaining efficient staffing ratios, reducing length of stay and reducing costs. In its market, MCGHealth is the lowest cost provider. His responsibility includes reporting these results and the role of PFCC in achieving key metrics to the Board. He emphasized that the Board members understand and appreciate the importance of PFCC to providing quality care and remaining competitive. [See Appendix D for a trend chart of organizational performance goals from 2000 through 2008.]

Richard Bias, Senior Vice President, Ambulatory and Network Services, has played an active role in the spread of PFCC throughout the ambulatory care services. He embraced PFCC as a key element in making ambulatory care services competitive in the marketplace. He closely monitors the various practices’ progress on their PFCC action plans and ensures that staff have the resources they need.
Focus on the Workforce

MCGHealth has operationalized PFCC in the workforce through its selection process, orientation, staff and leadership development, performance appraisal, incentive programs and employee relations programs and training.

Before the Human Resources staff incorporated PFCC into its functions they received training on a model developed in-house on how to reinforce staff behavior.

PFCC standards were established for all 600+ job titles in the system. Managers and staff were educated on the new standards. Position descriptions for staff indirectly involved in patient care as well as those directly involved include competencies on and compliance with PFCC practices. Those not directly involved in patient care also are expected to adhere to MCGHealth’s standards of PFCC. Those directly involved with patient care have one or more additional specific competencies for PFCC that they must demonstrate. Thus these position descriptions form the basis for the type of staff who are recruited and hired as well as a template evaluating and rewarding performance. A clear sign of the seriousness of commitment to PFCC in hiring is one in which patient and family advisory council members may play an active role in interviewing candidates for jobs at MCGHealth. Bernard Roberson, Director of Family Services Development, shared that the advisory council members were his toughest interviewers when he applied for his position at MCGHealth.

The orientation of new staff and house staff includes a session which covers PFCC principles, standards, and practices and the role of Patient and Family Advisors. During the presentation house staff are told that the bottom line for PFCC is that “the patient’s experience of care is as important as the technical quality in obtaining best outcomes.” The new employee’s Orientation Manual has a section on PFCC that reinforces its importance in daily practices.

As noted earlier, when Ambulatory Services began its launch of PFCC it held a series of retreats to train staff in PFCC practices. The same orientation is now provided to all new Ambulatory Care Center staff. In both the inpatient and outpatient facilities staff are asked to sign a pledge to practice the standards of PFCC.

The Patient- and Family-Centered Care Employee Conference, comprised of two half-day sessions, is designed to promote PFCC and reinforce how its core concepts can be applied within any area of the health system. Although it is called an employee conference, faculty, patient advisors and their families attend. Staff are invited to display posters and through an application process are selected to make presentations.

Including PFCC core competencies in staff performance evaluations is not just a concept; it carries the possibility of substantial financial rewards as well. About $3 million is
available for annual staff bonuses with PFCC performance measures constituting a significant determinant. Non-monetary recognition and acknowledgement helps reinforce PFCC standards of care through “Healthcare Heroes”, an in-house newsletter published periodically to highlight the praise staff have received from patients and families.

Human Resource personnel indicated that managers are key to making PFCC work with the staff. A series of motivational and educational sessions known as “Silos to Systems” aid in this effort by using team building exercises and tools for implementing PFCC. For staff members who are struggling to embrace the PFCC behavioral standards, managers may provide supportive improvement programs. But, there are times when certain staff appear unable to conform to the expected behavior and therefore must be asked to “get off the bus”.

**Involvement of Patients and Families**

Another engine that drives PFCC at MCGHealth is the network of Patient and Family Advisory Councils. In 1993, when MCGHealth Children’s Medical Center was being planned, a group of about 20 advisors participated in the planning of the Children’s Medical Center. Staff were unsure how that would work but the advisors’ involvement was such a success that the seeds were planted for the expansion of Advisory Councils to other settings and departments within MCGHealth. By 2004, when the Center for Patient- and Family-Centered Care was established, there were eight councils with 130 advisors. As noted above, the number of advisors has grown to a current level of 250.

The growth has not been only in the number of councils and advisors, but in the expanding scope of their functions as well. Patient and family advisors are involved in all major units of the inpatient and outpatient facilities, as well as the medical school. There are three levels of councils. The first are the four Institutional Councils which service the full scope of the components of MCGHealth. These councils are:

- Children’s Medical Center Family Advisory Council
- The MCG Health Partners
- Children’s Advisory Council
- Physician Practice Group Advisory Council

In addition, six program level councils serve specific units within MCGHealth. These are:

- MS Clinic Council
- Behavioral Health
- Cancer Center
- Family Medicine
• Perinatal
• Cystic Fibrosis

These various councils have also spawned numerous committees to work on special projects within the health care facilities and the medical school. On the health care side the committees have tackled a variety of challenges including a patient safety campaign, facilities services, medication reconciliation, tobacco cessation, a Speak-Up Campaign, equipment and safety, quality and safety, patient-centered medical records, and wayfinding. On the academic side advisors have been involved in curricula development, and teaching students about patient care drawn from their firsthand experience as patients or as family members.

The following examples of the work of the advisory groups capture the nature of their activities.

**Speak Up Campaign**

A Patient Advisory Council was instrumental in designing the Speak Up campaign to help make patients and families aware that they are partners in their care and to encourage them to ask questions of their doctors or to raise concerns if they believe something is not right. The goal is to provide better quality and safer care. Posters and display cards were created to announce and explain the campaign, and details on the campaign are included in the Patient Handbook, along with information on “Questions to Ask My Doctor.”

**Facilities Services**

Advisors have worked with the facilities service department very closely in developing new safety and security measures, providing input into food and nutrition planning, interviewing candidates for leadership positions in the department, advising on environmental quality, and construction. For example, advisors are an integral part of all construction projects. They are active members of the committee that selects architects for new building or renovation projects; in this role they provide input into interior design and conduct site visits of in-progress construction.

**Kids ART**

The Kids ART Advisory Council members are children and teenagers who give input into a variety of topics such as menu planning, or items for inclusion in a game room, and advice on how to modify the behavior of medical staff when interacting with kids (e.g., have staff ask them questions, not just their parents). These engaged youth actively help with various hospital fundraisers within hospital and out in the community.
Life (Learning in Family Environments)

Learning in Family Environments 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.

Family Medicine Center

The Family Medicine Center (FMC) was the first center to appoint a Patient and Family Advisory Committee in the Ambulatory Care Center. Candidates were nominated by staff and physicians. The FMC Patient- and Family-Centered Care Advisory Committee met in October 2006. Examples of the Committee’s recommendations implemented to date include:

- Change the greeting on the call line
- Work with front desk staff to improve customer service image
- Place hand sanitizers in the waiting room for patients
- Create a medication reconciliation program

Family Faculty

What better way for students to learn about the patient and their family member’s perspective about their health care than to get the most knowledgeable experts on the topic, patients and family members, to teach it? 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.

At MCGHealth the belief is that more is gained from having Advisory Councils that have an ongoing relationship with the organization than from ad hoc data collected from focus groups. Their rationale is that the Advisors have a greater knowledge and a history to draw upon to make recommendations than do focus group participants.
Experienced advisory council members also develop a sense of what is possible and come to know what challenges the organization faces. They also learn from the outcomes of their involvement, hone their skills for their significant roles, and become a valuable resource for MCG, MCGHealth and its students as well as for other patients and their families.

One concern is that the advisors may become too much an “insider” to give the “outsider’s” perspective. The main goal after all is to have an independent assessment from a knowledgeable observer. However, MCGHealth staff indicated that they have not seen any hesitation on the part of advisors to speak their mind and give constructive criticism. In their words, the advisors “tell the good, the bad and the ugly”. Ongoing efforts continually bring new advisors aboard to try to get new ideas and fresh opinions and to gain broader representation of patient consumer base.

**Patient and Family Communication and Education**

The Family Resource Library located in the CMC contains over 1,500 books and resources related to children’s health and self-help topics and leisure reading. Internet access is also provided for patients and families. The library provides a number of programs including:

- Tea Time – Provides time for families to share their stories and learn about resources available to them.
- Parent to Parent- A Georgia representative of this program is available to provide support to families.
- Reach Out and Learn – Provides information on community resources and special hospital services which are available.
- Project Link – Offers a program that helps empower parents to advocate for their child with special health care needs.

**Performance Measurement and Monitoring**

MCGHealth 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.

An example in the most recent fiscal year, 2008, was a program to try to raise 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 75th percentile (score of 89.3) and no units would be below the 60th percentile. At the end of the first quarter of FY 2008 the overall score was 87.4. There were a small number of units at the 99th
percentile and just a minority above the threshold 60th percentile. The majority (103 units) were below the threshold which were characterized as “You don’t want to be here”, with 21 units below the 10th percentile (“You really don’t want to be here”).

With support from senior leadership all staff were trained on service recovery emphasizing the importance of communication and follow-up with patients. Staff received training to acknowledge, and apologize for mistakes and offer to make amends as appropriate to recover trust. These service recoveries were seen as opportunities for performance improvement. Particular focus was placed on responding to concerns and complaints, responding to the call light and maintaining cleanliness. Staff then reported back quarterly to senior leadership on progress. While this quality improvement initiative focused on those below the desired threshold, those units above threshold were strongly encouraged not to backslide.

[See Appendix E for a summary chart of increases in Press Ganey scores from FY 2004 through FY 2009. Appendix F shows comparative HCAHPS scores for March 2009.]

Barbara Brumbaugh of the MCG School of Graduate Studies and Pat Sodomka studied two Intensive Care Units (ICU) at MCGHealth, one in which PFCC was fully integrated and one in which it was not. The study utilized cost and length of stay measures from the University HealthSystem Consortium (UHC), patient safety indicators from the Agency for Healthcare Research and Quality (AHRQ), and patient satisfaction measures from the MCGHealth Press Ganey survey. In the fully integrated PFCC unit, costs were lower, length of stay was shorter, patients experienced fewer safety issues (measured by fewer complications) and patient satisfaction was higher. These findings confirmed the results of earlier studies that PFCC positively affects other important dimensions of performance.

The use of data by the Senior Leadership to build the business case has already been mentioned. The Board of Directors is regularly presented the business case for PFCC. Also specific projects, such as the Neurosciences Center of Excellence’s PFCC initiative, demonstrated the positive impact of PFCC on patient satisfaction, cost and other outcomes.

MCG also conducts a Patient- and Family- Centered Care Culture Survey which is administered to faculty, staff, students, and residents in MCG, MCGHealth staff and PPG staff and physicians. The survey seeks to assess the attitudes of staff, faculty, students and residents relative to the culture of PFCC at MCGHealth. It includes measures of the respondent’s own personal philosophy of PFCC, professional and educational experiences relative to PFCC, perceptions of faculty, leadership and staff attitudes and behaviors in regards to PFCC, perception of the communications of standards of care and perception of the general practice of care.
The culture survey is available for use by other organizations with permission of MCGHealth which holds the copyright. [See Appendix G for a comparison of survey results in 2005 to 2008.]

The Built Environment

As in other areas patients and families have played a key role in the design of new facilities and renovation building projects since the inception of PFCC at MCGHealth. They truly partner in the process, giving input during the design phases, helping to select architects and construction contractors, and testing unit layouts, furniture and other amenities before also signing off on final plans. They played an active role in the design of the Children’s Medical Center, Breast Health Center, Neurosciences unit, Ambulatory Surgery Services, Senior Center, Outpatient Cardiology facility and the Gamma Knife and PET/CT facility. MCGHealth learned long ago that getting patient and family input before construction saves time and costs. Hospital staff and facilities planners think about the technical, regulatory and operational aspects of a facility. Patients and families think about the subjective aspects of a welcoming and healing environment.

Challenges and Future Directions

MCGHealth has developed the leadership and infrastructure needed not only to sustain PFCC throughout the organization, but to take on new initiatives. Its inclusion of PFCC principles in the education and research arms of the organization provides the capacity to design and evaluate innovative strategies that could bring needed new energy and approaches to PFCC. The trick is to put the infrastructure to work to maintain momentum and to keep growing.

MCGHealth has been a model for others to study and possibly follow. Hopefully, MCGHealth will continue to share what it learns about PFCC with the rest of the growing PFCC community, and will likewise draw what it needs from what the larger PFCC community is learning. Even for the well-established, PFCC is an ongoing journey.
Appendix A:
List of Advisory Panel Members

- Paul Cleary, PhD, Dean of Public Health, Department of Epidemiology and Public Health, Yale School of Medicine
- Christine Crofton, PhD, CAHPS Project Officer, Agency for Healthcare Research and Quality
- Susan Edgman-Levitan, PA, Executive Director, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital
- Donna Farley, PhD, Senior Health Policy Analyst, RAND
- Sir Donald Irvine, CBE, MD, FRCGP, FRCP, Chair, Picker Institute Europe (Member, Picker Institute Board and Project Oversight Committee)
- Beverley Johnson, President and CEO, Institute for Family-Centered Care
- Patricia Sodomka, Senior VP, Patient/Family Centered Care, Medical College of Georgia and MCG Health, Inc.
- Kathy Vermoch, Project Manager, Operations Improvement, University HealthSystem Consortium
- Gail Warden, President Emeritus, Henry Ford Health System (Member, Picker Institute Board and Project Oversight Committee)
MCG Health, Inc.
Senior Vice President for Patient- and Family-Centered Care

1. Scope of Responsibilities
The Senior Vice President for Patient- and Family-Centered Care is responsible for providing overall leadership and direction in the development and implementation of patient and family centered principles and concepts in the delivery of patient care. The Senior Vice President for Patient- and Family-Centered Care is also responsible for the cost effective management and operational excellence of Facilities Services and Family Services Development. The Senior Vice President for Patient- and Family-Centered Care serves as a member of the senior leadership team for the health system and reports to the President and Chief Executive Officer of MCG Health, Inc.

2. Principal Accountabilities

- Promotes the development and implementation of Patient- and Family-Centered Care in the adult hospital, children’s hospital and Ambulatory Care and throughout affiliated Medical College of Georgia and Physicians Practice Group entities.

- Works collaboratively with the Medical College of Georgia schools of allied health, dentistry, nursing, and medicine in the development and integration of patient and family centered care concepts, principles, and techniques in student curricula.

- Responsible for facility planning and design for the health system.

- Works collaboratively with members of MCG Health, Inc.’s medical and senior leadership to incorporate patient and family centered care in clinical pathways and care delivery models.

- Develops partnerships and affiliations with various providers and organizations to optimize and promote family- and patient-centered care.

- Provides cost effective leadership for Facilities Services and Family Services Development.

- Develops appropriate labor, operating, and capital budgets for assigned budget units.
Monitors and insures the achievement of financial and organizational goals for assigned areas of responsibility.

Provides leadership in JCAHO preparation and regulatory compliance for the health system.

Responsible for patient safety, and family services.

Responsible for facility operations.

Develops and establishes operational reports regarding assigned budget unit performance and appraises the President/CEO on a regular basis concerning the financial operation of assigned budget units.

Develops short and long term operational and financial goals consistent with corporate organizational performance goals.

Staffs and supports Board of Directors committee’s as assigned.

Develops recommendations for revenue and business growth and enhancement.

Develops appropriate operating policies and procedures.

Provides leadership in development of MCG Health, Inc.’s capital budget.

Maintains professional growth and development.

Performs related duties as assigned by the President/CEO of the health system.

3. **Position Qualifications**
   Master’s Degree in Health Care Administration or Business Administration. Substantial experience at the senior leadership level in a large health care system or hospital.
## Organizational Performance Goals

### Year End Results

<table>
<thead>
<tr>
<th>Measurement Category</th>
<th>Index</th>
<th>Year Ending June 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Success</td>
<td>Total Margin</td>
<td>0%</td>
</tr>
<tr>
<td>Profitable Business Growth</td>
<td>Volume Units</td>
<td>619,834</td>
</tr>
<tr>
<td>Cost</td>
<td>Solucient Expense Per Adjusted Admission</td>
<td>$10,228</td>
</tr>
<tr>
<td>Cash Flow</td>
<td>Net Days in Accounts Receivable</td>
<td>196</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>UHC Total Mortality (Observed vs Expected)</td>
<td>1.29</td>
</tr>
<tr>
<td>Customer Satisfaction</td>
<td>Press-Ganey Overall Satisfaction Score</td>
<td>N/A</td>
</tr>
<tr>
<td>Cash Position</td>
<td>Days Cash on Hand</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Results: Patient Satisfaction

Average of Monthly Overall Facility Rating, All Surveys

December 2008

89.8

Three month avg
Average Score
The Beginning
Target (75th%)
## HCAHPS - Discharges from July 2007 to June 2008

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Hospital</th>
<th>National</th>
<th>2009 COTH Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do patients rate the hospital overall?</td>
<td>Score</td>
<td>Average</td>
<td>25th PCTL</td>
</tr>
<tr>
<td>Patients who gave a rating of 9 or 10 (high)</td>
<td>64%</td>
<td>64%</td>
<td>58%</td>
</tr>
<tr>
<td>Patients who gave a rating of 7 or 8 (medium)</td>
<td>24%</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>Patients who gave a rating of 6 or lower (low)</td>
<td>12%</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>How often did doctors communicate well with patients?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors always communicated well</td>
<td>77%</td>
<td>80%</td>
<td>76%</td>
</tr>
<tr>
<td>Doctors usually communicated well</td>
<td>17%</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>Doctors sometimes or never communicated well</td>
<td>6%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>How often did nurses communicate well with patients?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses always communicated well</td>
<td>69%</td>
<td>74%</td>
<td>70%</td>
</tr>
<tr>
<td>Nurses usually communicated well</td>
<td>23%</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Nurses sometimes or never communicated well</td>
<td>8%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>How often did patients receive help quickly from hospital staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients always received help as soon as they wanted</td>
<td>53%</td>
<td>62%</td>
<td>55%</td>
</tr>
<tr>
<td>Patients usually received help as soon as they wanted</td>
<td>26%</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>Patients sometimes or never received help as soon as they wanted</td>
<td>21%</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>How often did staff explain about medicines before giving them to patients?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff always explained</td>
<td>57%</td>
<td>59%</td>
<td>54%</td>
</tr>
<tr>
<td>Staff usually explained</td>
<td>17%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>Staff sometimes or never explained</td>
<td>26%</td>
<td>23%</td>
<td>19%</td>
</tr>
<tr>
<td>How often was patients' pain well controlled?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain was always well controlled</td>
<td>63%</td>
<td>68%</td>
<td>64%</td>
</tr>
<tr>
<td>Pain was usually well controlled</td>
<td>28%</td>
<td>24%</td>
<td>22%</td>
</tr>
<tr>
<td>Pain was sometimes or never well controlled</td>
<td>9%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>How often was the area around patients' rooms kept quiet at night?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always quiet at night</td>
<td>59%</td>
<td>56%</td>
<td>48%</td>
</tr>
<tr>
<td>Usually quiet at night</td>
<td>31%</td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>Sometimes or never quiet at night</td>
<td>10%</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>How often were the patients' rooms and bathrooms kept clean?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room was always clean</td>
<td>62%</td>
<td>69%</td>
<td>63%</td>
</tr>
<tr>
<td>Room was usually clean</td>
<td>26%</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Room was sometimes or never clean</td>
<td>12%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Were patients given information about what to do during their recovery at home?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, staff did give patients this information</td>
<td>76%</td>
<td>80%</td>
<td>77%</td>
</tr>
<tr>
<td>No, staff did not give patients this information</td>
<td>24%</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Would patients recommend the hospital to friends and family?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES, patients would definitely recommend the hospital</td>
<td>69%</td>
<td>68%</td>
<td>60%</td>
</tr>
<tr>
<td>YES, patients would probably recommend the hospital</td>
<td>23%</td>
<td>26%</td>
<td>21%</td>
</tr>
<tr>
<td>NO, patients would not recommend the hospital (they probably would or definitely would not recommend it)</td>
<td>4%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Notes:
- *The number of cases is too small (< 100) for purposes of reliably predicting performance.*
- Source: AAMC Analysis of HHS Hospital Compare Database - March 2009

### Response Rate
- 21%
### MCG Faculty, Resident, and Staff Perceptions Re: PFCC

<table>
<thead>
<tr>
<th>Percent Strongly Agree</th>
<th>2005</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCG Health System has defined how patient care will be provided relative to the experience of care.</td>
<td>18.7%</td>
<td>26.0%</td>
</tr>
<tr>
<td>The concepts of the philosophy of care are shared with patients and families in the patient and family handbook</td>
<td>24.3%</td>
<td>29.3%</td>
</tr>
<tr>
<td>The concepts of the philosophy of care are shared with patients and families in the MCG Health System Web site.</td>
<td>22.3%</td>
<td>29.5%</td>
</tr>
<tr>
<td>In-service programs support staff in acquiring patient- and family-centered care knowledge, skills, and attitudes.</td>
<td>14.55</td>
<td>25.8%</td>
</tr>
<tr>
<td>Position descriptions define expectations for behaviors consistent with patient- and family-centered concepts.</td>
<td>17.0%</td>
<td>22.4%</td>
</tr>
</tbody>
</table>