

**A CASE STUDY ON THE GROWING MOVEMENT TOWARDS PATIENT- AND
FAMILY-CENTERED CARE IN HOSPITALS AND THE EFFECT IT HAS ON THE
QUALITY OF CARE**

by

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ABSTRACT

Current healthcare quality improvement measures were examined with the growing movement towards implementing patient-and family-centered care (PFCC) in hospitals and the effects the movement has on quality of care. The transitions of three hospitals into healthcare organizations that implement PFCC throughout their settings were analyzed to determine the effect PFCC has on a hospital's quality of care. The analysis shows that the implementation of PFCC initiatives throughout a hospital can significantly improve quality of care and is instrumental in reforming the healthcare system while enabling hospitals to profit and meet mandated regulations. The need for quality improvement in the delivery of care has been recognized as an issue of public health significance and an increasing number of organizations are taking measures to advance improvements.

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1.0 INTRODUCTION

The quality of healthcare delivery in the United States (U.S.) has declined as a result of a poorly organized provider-centered system in which care is provided at the convenience of the provider with limited personal connection with the patient. Providers often order unnecessary diagnostic tests, hospitalizations, prescriptions, or referrals instead of engaging with patients to better understand their conditions. No consideration to the perspective of patients or their family is given in a provider-centered healthcare system. The practice of provider-centered care has resulted in increased healthcare costs and less desired health outcomes.

Patient- and family-centered care (PFCC) recognizes the vital role families play in the health and well being of the patient and centers delivery of care more towards the needs and preferences of both the patient and their family. Through the PFCC approach, patients and families are actively engaged not only in their own care, but also in the planning, delivery, and evaluation of healthcare services and programs. PFCC is based on forming mutually beneficial partnerships among patients, families, and healthcare providers.

The intention of this paper is to examine the PFCC movement and demonstrate how implementing a PFCC program can be instrumental in reforming the healthcare system while enabling hospitals to profit and meet mandated regulations.

1.1 PROBLEM

The need for improved patient care has created an increased focus on improving the quality of care while reducing the costs of healthcare throughout hospitals in the U.S. In 2001, the Institute of Medicine (IOM) published *Crossing the Quality Chasm*, a report examining the quality of the healthcare system, and proposed a strategy to improve fundamental weaknesses. In this report, the IOM established six aims of improvement intended to ensure that care is safe, effective, patient-centered, timely, efficient, and equitable in an effort to improve the system (IOM, 2001). Acknowledging the need for improvement in the U.S., the Patient Protection and Affordable Care Act (ACA) of 2010, a healthcare reform law, includes standards that align with the IOM's six aims of improvement. The law is designed to provide affordable, quality healthcare for U. S. citizens, expand the role of public assistance programs, and improve the value, quality, and efficiency of the healthcare system while reducing wasteful spending and increase accountability through transparency as well as encourage innovations in the healthcare workforce (Democratic Policy and Communications Center, 2012).

Despite current improvement efforts and the fact that the U.S. leads the world in medical innovations and has some of the best doctors, its healthcare system continues to rank last among most industrialized nations. Annual international health policy studies, conducted by the Commonwealth Fund, a private organization dedicated to improving healthcare practice and policy through independent research, to compare performance measures of healthcare systems in several countries, continuously rank the U.S. last, being outperformed by every country in quality measures. The results of these studies indicate the need for significant improvement in delivering patient-centered care and effective care, in order to meet IOM's aims for improvement (Davis et al., 2014).

Furthermore, a high level of dissatisfaction with the overall patient experience was evidenced among U.S. patients participating in surveys conducted by the American Hospital Association (AHA), indicating their desire to be more involved in their treatment and decisions that affect their health and wellbeing. Patients surveyed, expressed concern that providers were not emotionally supportive and did not share enough information to help them understand and manage their care (American Hospital Association et al., 2004).

Periodic changes in the healthcare environment as well as the growing number of complex regulations and industry-wide reforms present true challenges for hospitals striving to profit and grow while providing quality care. ACA mandates, discussed in the following section, are difficult and often costly for providers to execute due to the complex details and implementation time limits involved.

1.1.1 ACA Mandated Programs

In an effort to reform the U.S. healthcare system, the ACA of 2010 mandates programs influencing policies relating to the patient and family engagement, patient experience, and quality measures concepts of PFCC. Three key mandated incentive programs are described here.

The Inpatient Quality Reporting (IQR) program is a pay-for-reporting program selected by the Center for Medicare and Medicaid Services (CMS) requiring hospitals to report specific data. The Hospital IQR Program measure set includes chart-abstracted measures related to heart attack, heart failure, pneumonia, and surgical care improvement measures; claims-based measures associated with mortality and readmissions; healthcare-associated infections measures; a surgical complications measure; a patient experience of care survey-based measure;

immunization measures; and structural measures that assess the capacity a hospital has to improve quality of care (CMS, 2013).

Reimbursements are based on the hospitals submission of the report in accordance to proper guidelines, not on performance measures. Hospitals that fail to report the required data are penalized with a two percent reduction from their annual Medicare payment. The collected data is published for public viewing on the Hospital Compare Website in order to provide information for consumers interested in making informed decisions about healthcare options (AHA, 2014). The IQR program is intended to encourage hospitals to provide quality inpatient care as well as to provide information to patients.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is used as a measure of patient experience of care in the IQR program (Health Services Advisory Group, 2014). Developed and tested in 2002 by CMS and the Agency for Healthcare Research and Quality (AHRQ), it is the first publicly reported national standardized survey designed to measure how patients evaluate their care experiences, create incentives for hospitals to improve their quality of care, as well as to increase the transparency of the quality of hospital care to enhance accountability.

To assure that the survey is useful, credible, and practicable, CMS published Federal Register Notices inviting the public to comment on HCAHPS and responded to over a thousand comments. AHRQ tested the survey through rigorous scientific processes, which entailed a public call to submit measures, a literature review, cognitive interviews and testing, consumer focus groups, input from stakeholders, a pilot study in three states, small field tests, as well as reliability and validity testing. In May 2005 the survey received the endorsement of the National Quality Forum (NQF), a national non-profit membership organization representing the consensus

of many healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research organizations dedicated to protecting patients and promoting healthcare quality through measurement and public reporting. The HCAHPS survey was finally implemented by CMS in 2006 and in March 2008 results began to be publicly reported; survey results continue to be reported in four-quarter increments (CMS, 2014b; Health Services Advisory Group, 2014; HCAHPS on-line, n.d.).

The HCAHPS survey is 32 questions in length. Twenty of these questions pertain to aspects of a patient's hospital experience: communication with doctors and nurses, including discussions regarding medicines; approachability of hospital staff; management of pain; information regarding discharge; hospital cleanliness; as well as the quietness of the environment and care transition. Four of the questions are screener questions, directing patients to relevant questions and five are demographic questions for analytical purposes and to adjust for case mix across hospitals. The additional two questions are for the sole purpose of supporting the use of congressionally mandated reports (**Table 1**). HCAHPS surveys are administered in four accepted manners: mail, telephone, telephone call follow-up to mail, and Active Interactive Voice Response (IVR). Hospitals may include additional questions in addition to the HCAHPS questions as long as the additional questions are clearly differentiated from the HCAHPS questions and response categories (HCAHPS on-line, n.d.).

Table 1. Examples of Questions From the HCAHPS Survey

Hospital Experience Questions	
<i>Communication with doctors and nurses</i>	
During this hospital stay, how often did doctors explain things in a way you could understand?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> Always
<i>Approachability of hospital staff</i>	
How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> Always
<i>Management of pain</i>	
During this hospital stay, how often was your pain well controlled?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> Always
Screenener Questions	
During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?	<input type="checkbox"/> Yes <input type="checkbox"/> No → If No, Go to Question 12
During this hospital stay, did you need medicine for pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No → If No, Go to Question 15
Demographic Questions	
What is your race? Please choose one or more.	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native
Are you of Spanish, Hispanic or Latino origin or descent?	<input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino
Question to Support the Use of Congressionally Mandated Reports	
Would you recommend this hospital to your friends and family?	<input type="checkbox"/> Definitely no <input type="checkbox"/> Probably no <input type="checkbox"/> Probably yes <input type="checkbox"/> Definitely yes

HCAHPS surveys are distributed to a random sample of Medicare and non-Medicare patients who are eighteen years of age or older and have spent a minimum of one night in the hospital within 48 hours to six weeks after they are discharged. Patients excluded from the HCAHPS survey include patients who do not wish to be contacted; prisoners; diagnosed

psychiatric patients; patients with a foreign home address; patients who are discharged to a hospice, nursing home, or skilled nursing facility; and patients omitted due to state regulations. Hospitals must survey patients throughout each month of the year and are required to report a minimum of 300 HCAHPS surveys over four calendar quarters unless they have an insufficient number of eligible HCAHPS discharges (Health Services Advisory Group, 2014).

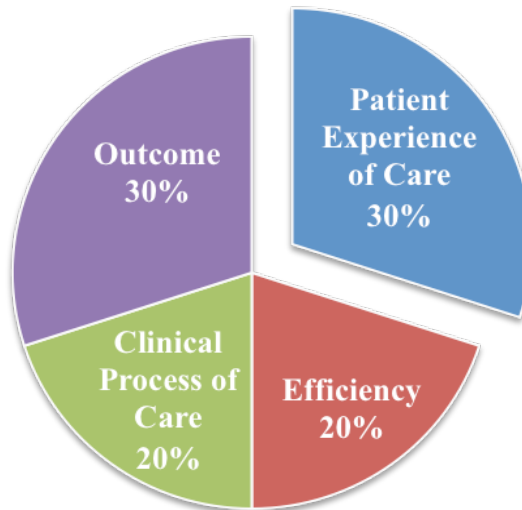
HCAHPS scores are publicly reported as part of the IQR program on the Hospital Compare Website along with hospital reports on quality measures of clinical processes, structure, efficiency, care costs, and outcome such as mortality and readmission (IFMC, 2011). Public reporting of this data provides consumers with comparable patient satisfaction data to help them make more informed decisions when choosing a hospital. In addition, it gives hospitals the incentive to identify and make quality improvements to the care they provide; therefore, public reporting can facilitate improvements in the quality of healthcare (Elliott et al., 2010). HCAHPS scores are utilized to determine Medicare compensations in the ACA mandated pay-for-performance reimbursement program.

The Hospital Value-based Purchasing (HVBP) program is a pay-for-performance reimbursement program designed by the U.S. Department of Health and Human Services (HHS) to adjust Medicare reimbursements on the basis of quality measurements. With emphasis on improving the quality of the U.S. healthcare system, Section 3001 of the ACA mandated this pay-for-performance program that redistributes Medicare payments to reward hospitals for improving the quality of care they deliver. The better a hospital performs or improves during a fiscal year, the higher their value-based incentive payment for the fiscal year would be. In other words, hospitals with higher performance rates in terms of quality receive a greater proportion of the payment than lower performing hospitals. In the past, the U.S. healthcare system operated

strictly under a fee-for-service model in which inpatient prospective payment system (IPPS) hospital payments were based merely on the volume of services they provided. The implementation of the HVBP program is intended to improve the quality of healthcare in the U.S.; as of October 2012, Medicare payments to participating hospitals are based on the quality of care delivered, instead of the quantity of services provided (Department of Health and Human Services, 2012).

Under the HVBP program, payments are awarded to eligible hospitals based on the scores a hospital receives for performance as well as for improvement. The HVBP establishes a baseline as well as a performance period for hospitals and calculates two scores for each hospital. Achievement scores are determined by how well a hospital performed certain quality measures compared to other hospitals. Improvement scores are determined by how much the performance of a measure improved during a baseline period. According to the ACA, the list of measures being used in Medicare reporting and payment shall be updated annually. For fiscal year (FY) 2015, hospitals will receive two scores on each of the 26 measures selected. There are also four domains that reflect hospital quality that will be used to calculate the total performance score (TPS) to adjust payments in FY 2015 (**Figure 1**). The Total Performance Score (TPS) is comprised of the Clinical Process of Care domain score (weighted as 20% of the TPS), the Patient Experience of Care domain score (weighted as 30% of the TPS), the Outcome domain score (weighted as 30% of the TPS), and the Efficiency domain score (weighted as 20% of the TPS). Currently, there are twelve clinical process measures for the Clinical Process of Care domain. The Patient Experience of Care domain contains eight important aspects of hospital quality and is based on the HCAHPS survey. The Outcome domain encompasses a set of healthcare activities that affect the well being of a patient, such as survival, functional ability, and quality of life. The

Medicare spending per beneficiary measure evaluates the cost of care for the Efficiency domain (Department of Health and Human Services, 2012; CMS, 2014a).



This figure illustrates what percentage of a hospital's TPS each of the four domains accounts for.

Figure 1. Total Performance Score (TPS) Domain Weights.

To meet eligibility requirements, hospitals must report on at least ten cases for a minimum of four Clinical Process of Care domain measures, at least two of the five measures of the Outcome domain, at least 25 episodes of care for the Medicare spending per beneficiary measure, as well as a minimum of 100 HCAHPS surveys for the Patient Experience of Care domain during performance periods. IPPS hospitals that fail to participate in the IQR program, that are cited for issues that place patients' health and safety in danger, or that have an inadequate number of cases, measures, or surveys required by the HVBP program in more than two domains during the specified performance period are excluded from the program (CMS, 2014a).

To generate funds for the HVBP incentive payments, a percentage is withheld from the Diagnosis-Related Group (DRG) payments that participating hospitals receive for services

performed. The applicable percentage withheld began at 1.0% for 2013 with incremental increases of 0.25% each FY until it reaches 2.0% in 2017, where it will remain for each consequent year. Hospitals are given the incentive to earn back the withheld funds by performing quality services and continuing to improve to ensure they are receiving a net positive incentive payment rather than a loss (Klein et al., 2012). The HVBP program is intended as an incentive for hospitals to provide quality care as well as to promote better clinical outcomes for hospital patients and improve their experience of care during hospital stays.

Efforts by healthcare organizations like IOM along with mandates through the ACA have generated some improvement in the quality of healthcare provided; however, much more needs to be done. Many experts agree that the U.S. healthcare system needs to be restructured on many levels in order to truly make improvements (Conway et al., 2006). In order to meet the requirements of federal mandates and improve care quality, hospitals are looking for innovative approaches to deliver quality care. One such innovative approach that is gaining attention by many hospitals is PFCC. While PFCC has begun to be implemented in several hospitals, the effectiveness of increasing quality care by improving the patient experience is as of yet undecided.

2.0 PATIENT- AND FAMILY-CENTERED CARE (PFCC)

PFCC is an approach to the delivery of care that establishes a partnership between the patient, their family, and healthcare providers. The approach is based on the belief that patients and families are important members of the healthcare team and that their needs and preferences should be respected. The aim of PFCC is to generate a philosophy of quality that emphasizes “care, compassion, respect, and concern” in the healthcare field by providing the education and support needed to empower patients and families to make informed decisions and participate in their own care to obtain desired outcomes (Ellis, 2015).

The philosophy of PFCC encompasses all policies, programs, facility design, and staff day-to-day interactions involved in the delivery of quality healthcare. The approach promotes the health and well being of a patient by providing the essential emotional, social, and developmental support needed to restore their dignity and sense of control over their health. With the PFCC approach, patients and families are considered essential allies and treated as true partners, not clinical objects or visitors. This approach to healthcare has been credited with delivering better health outcomes and greater patient and family satisfaction by providing competent care in a respectful, compassionate, and culturally safe collaborative fashion. The delivery of PFCC is sensitive to the needs, values, cultural backgrounds and beliefs, and preferences of patients and their family members (Ellis, 2015).

2.1 PFCC HISTORY

Originally referred to as family-centered care (FCC), PFCC was first initiated in a number of children's hospitals to increase the role the family played in the care of hospitalized children. While PFCC did not emerge as a valued concept in the healthcare environment until the late 20th century, its origins can be traced back to earlier in the century.

The environment of early children's hospitals was often emotionally traumatizing to ill children. Children were commonly admitted without a parent present and visits from parents were prohibited or limited to one weekly half hour visit. It was not uncommon during this time period for ill children to be hospitalized for extended times without seeing their parents, as treatment often lasted months, sometimes years, for children with tuberculosis and other long-term diseases. The hospital environment was industrialized, as a chief concern of the hospital staff was to prevent the outbreak of infectious diseases that could damage the reputation of the hospital. Therefore, maintaining order and cleanliness to prevent the spread of disease took precedence over the emotional needs of the child. Fortunately, by the 1940s, it was determined that parental visits had no effect on the rate of infection in a hospital. As theorists became more concerned about the psychological effects prolonged separation from parents had on hospitalized children, a number of influential studies were conducted and the behavioral approach used to care for children in hospitals began to change.

The distress and emotional trauma many suffered after being separated from loved ones during World War II caused an increased interest in the psychological effect that separation had on both adults and children. The number of European children that suffered after being evacuated prompted psychologists to consider the parallels between the phenomenon of child-parent separation caused by evacuation and the separation that took place when children were

admitted to hospitals (Jolley and Shields, 2009). In 1945, Renée Spitz, one of the first child psychiatrists to conduct child observations began using the term “hospitalism” to describe the weakening condition of children hospitalized for a lengthy period without the benefit of a home environment and parents. British psychiatrist, John Bowlby and social worker, James Robertson were both instrumental in the evolution of the PFCC movement due to their collaboration on research regarding separation of mother and child. After years of studying the effects separation has on children, Bowlby created his attachment theory, which indicates that the bonds children form with caregivers early in life tremendously impact their ability to form healthy adult relationships; this is a premise from which the foundation for PFCC was formed. Robertson applied the theory to practice by closely observing the effects separation from parents had on hospitalized children. He documented his observations on film and campaigned for the welfare of children in hospitals by distributing his series of documentaries to healthcare organizations around the world. The work of Bowlby and Robertson prompted the British government to form a parliamentary committee to investigate the emotional health of children treated in hospitals. The Platt Report, developed by the committee in 1959, outlined a number of recommendations for the non-medical care of hospitalized children highlighting that mothers be admitted with the child and accommodations be provided for the mother. Consequently, the report set the groundwork for the PFCC programs of today (Young, 1992; Shields, 2011).

The manner in which care was delivered gradually began to change as different models of nursing care emerged. The “parent participation” model, evolved as healthcare providers started to accept that parental visitations were essential to the recovery of the hospitalized child and did not contribute to the spread of infection. Accordingly, the first model of care introduced in the U.S. in the 1960s was “care-by-parent,” which allowed parents to stay in special hospital

accommodations with the child and help administer care. This model of care allows parents to retain responsibility for the child while he or she was under the care of the medical staff. The care-by-parent model is believed to reduce the emotional stress hospitalization has on both the child and parent, improve communication between medical staff and parent, decrease the number of cross infection incidences, and shorten the length of hospital stays. Few care-by-parent units were actually built, however, because most hospitals could not budget for the expense of building care-by-parent units as well as the time and cost involved in the training and supervision of parents administering care (Sainsbury et al., 1986). In the late 1980s, the “partnership-in-care” model that concentrated on establishing a working partnership between nurses and the hospitalized child and his parents was introduced. Nurses acknowledged that parents best understood the needs of their children and should therefore have control over the decision-making as well as the administration of care. This model called for nurses to educate and support the parent in providing appropriate care and to provide the necessary treatment in the absence of the parents. Communication and cooperation were essential elements of this model. Each of these models led to the evolution of FCC, which was implemented in many children’s hospitals by the 1980s (Jolley and Shields, 2009; Shields, 2011).

While the initial concept of PFCC concentrated mainly on pediatric care, it has grown to encompass the care of hospitalized children of all ages and has expanded into adult and geriatric care. The concept has evolved from an effort to increase the role that families play in the treatment of hospitalized children to improving the healthcare experience of all patients through promoting mutually beneficial partnerships among healthcare providers, patients, and families. PFCC has continued to evolve and has become an essential element of healthcare through the

work of organizations like the Picker Institute and the Institute for Patient- and Family-Centered Care (IPFCC).

2.1.1 The Picker Institute

The Picker Institute was an independent, nonprofit organization credited with having coined the phrase “patient-centered care.” The institute was dedicated to the development and promotion of a patient-centered approach to improving healthcare focused on the perspective of the patient (Conway, 2006). Working in partnership with educational institutions and other organizations committed to promoting the patient-centered care movement, the mission of the institute was to promote a broader comprehension of the changes necessary to assure a more patient-centered approach to healthcare that centered on the concerns of patients and other healthcare consumers. From its establishment in 1986 until the close of operations in 2013, the institute was recognized as a forerunner in the extensive research of the patient and family experience within the healthcare industry (Picker Institute, 2013; “Picker Institute ceases operations,” 2013).

During its years of operations, the Picker Institute established itself as a leader in the advancement of PFCC. The Picker Institute introduced the concept of using patient survey tools to assess the perspective patients have on the healthcare experience. The institute developed standardized patient-experience surveys and databases used by healthcare providers as valid instruments for improving the delivery of care. The patient perspective has become a standard measurement of performance for healthcare organizations around the world (Frampton, 2008).

Through a collaboration of various focus groups, which included recently discharged patients and members of their families, medical and non-medical hospital staff members, along

with researchers from Harvard Medical School, and a review of relevant literature, the Picker Institute identified eight dimensions of patient-centered care.

1. *Respect the values, preferences and expressed needs of the individual patient.* Patients should be treated with respect and understand that healthcare providers recognize them as an individual whose medical condition is important to them. Caregivers should treat all patients with dignity, respect, and sensitivity to the cultural values of the individual. Patients should be kept informed and involved in decision-making in regard to their medical condition.
2. *Coordination and integration of care.* Care should be properly coordinated to avoid the powerless and vulnerable feelings patients often feel in the face of illness.
3. *Communication, information, and education.* Communication is essential to alleviate the fears patients facing treatment for illnesses often experience. To relieve these fears, information must be provided regarding the clinical status, progress and prognosis of the illness, along with the details of the treatment and procedures to be performed. Providers should also educate the patient to make informed healthcare decisions, care for him or herself, and maintain good health.
4. *Physical comfort.* The level of physical comfort has a definite impact on patients' experience and recovery; therefore, providers should provide adequate pain management, assistance with daily activities and living needs, and provide a safe comfortable environment.
5. *Emotional support and alleviation of fear and anxiety.* To alleviate potentially debilitating fears and anxieties often associated with illnesses affects, caregivers should take the necessary measures to relieve the anxieties a patient often has regarding their

physical condition, the necessary treatment, and the probable prognosis of treating the disease. Emotional support should also be provided to address concerns the patient may have regarding the physical and financial impact the illness may have on themselves and their family.

6. *Involvement of family and friends.* Providers should recognize the individuals who the patient relies on for social and emotional support by acknowledging their role in decision-making and involve them as advocates for the successful recovery of the patient. Accommodations, training, and support should be provided for caregivers.
7. *Transition and continuity.* To ensure transition and continuity after being discharged, staff members should provide the patient with easy to understand yet detailed information regarding medications, physical limitations, dietary needs, and all information relevant to their recovery. All required ongoing treatment or services necessary after discharge should be planned and coordinated with the patient and caregivers. Providers should also continue to provide information regarding access to clinical, social, physical, and financial support.
8. *Access to care.* Healthcare in general should be easily available to all patients. Patients need to know they can access care when it is needed. Appointments in conveniently located facilities should be available when needed and easy to schedule. Specialists or specialty services should also be easily accessible and providers should offer assistance or provide clear instructions on when and how to get referrals. In addition, transportation should be made available to patients in need.

These dimensions have remained the established protocol for the delivery of PFCC in healthcare organizations around the world.

Before ceasing operations in 2013, the Picker Institute made arrangements to pass major programs on to leading healthcare organizations that have endorsed their commitment to advance excellence in patient-centered care by focusing on the measurement of the patient experience. The Picker Institute website is now hosted by the Institute of Patient-and Family-Centered Care (IPFCC) (Picker Institute, 2013).

2.1.2 The Institute of Patient- and Family-Centered Care (IPFCC)

The IPFCC is a non-profit organization established in 1992 to promote PFCC by encouraging collaboration between healthcare providers and patients with their families. PFCC aims to support and encourage patients and families to be fully engaged in their health and with their healthcare team. To advance the understanding and practice of PFCC, the institute conducts baseline assessments for interested healthcare organizations and provides staff development and professional training programs, as well as assistance with product and action plan development, and offers guidance to apply PFCC principles to policies, programs, facility design, staff practices, and professional education. The institute also has a number of publications, videos, and self-assessment tools available to help professionals recognize their existing strengths, identify opportunities for improvement, and develop action plans (Institute for Family-Centered Care, n.d.).

Healthcare organizations around the world continue to recognize the four core concepts identified and defined by the IPFCC.

1. *Respect and dignity.* Healthcare providers will listen to patient and family perspectives and incorporate the knowledge, values, beliefs, and cultural backgrounds of the patient into the planning and delivery of care.

2. *Information Sharing.* Healthcare professionals will communicate complete, accurate, and unbiased information to patient and families in a useful, encouraging, and timely manner.
3. *Participation.* Healthcare professionals will encourage and support patients and families to participate in the delivery of care and make necessary decisions in a manner that is comfortable to them.
4. *Collaboration.* Healthcare providers will collaborate with patients and families on an institution-wide basis regarding the delivery of care and include them in discussions concerning policy and program development, implementation, evaluation, as well as healthcare facility design and professional education (Institute for Family-Centered Care, n.d.).

2.2 PFCC AND QUALITY OF CARE

The IOM has defined quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The IOM’s report, *Crossing the Quality Chasm*, identified patient-centered care as one of six aims of improvement needed to improve the current healthcare system and defined it as “care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions” (IOM, 2001). The report established ten general principles to meet the improvement aims, which correspond with the approaches of PFCC (Conway et al., 2006).

1. *Care is based on continuous healing relationships.* Healthcare should be accessible to all patients and delivered in a manner that responds to their needs, i.e., in-person visits, by telephone, through the Internet.
2. *Care is customized according to patient needs and values.* The healthcare system should be designed to respond to the individual needs of the patient, giving consideration to their personal values and preferences.
3. *The patient is the source of control.* Patients should be provided with the necessary information and encouraged to make informed decisions regarding their healthcare. The healthcare system should promote participation in collective decision-making.
4. *Knowledge is shared and information flows freely.* There should be effective, communication and unrestricted information sharing between healthcare providers and patients.
5. *Decision-making is evidence-based.* Care should be based on the best scientific evidence without inappropriate variation in practice.
6. *Safety is a system property.* Healthcare should be delivered in a manner that prevents harm to the patient, reduces risk, and mitigates errors.
7. *Transparency is necessary.* Patients and their family should have access to information that will allow them to make informed decisions regarding healthcare providers and alternative treatments, i.e., patient satisfaction, provider credentials, performance measures.
8. *Needs are anticipated.* Patient needs should be anticipated by the healthcare system.
9. *Waste is continuously decreased.* Patient time and resources should not be wasted by the healthcare system.

10. *Cooperation among clinicians is a priority.* The healthcare system should promote active collaboration and communication between clinicians and professionals to ensure the appropriate information is exchanged and care is properly coordinated and integrated throughout the system (IOM, 2001).

To improve the quality of the healthcare delivered, providers should incorporate strategies that are respectful of the values and preferences of the patient and family while encouraging and supporting them to engage in the delivery of care.

2.2.1 PFCC Strategies for Quality Improvement

Studies indicate that outcomes improve through collaboration and communication and when patients and families are empowered to make informed decisions and participate in their own care. With the desire to improve and transform the patient care experience and deliver quality healthcare, many healthcare organizations are implementing PFCC initiatives using strategies such as information-gathering and performance improvement tools. In addition, the establishment of a guiding council to act as a governing body to investigate the urgency for transforming care and to take action to do so is an essential PFCC strategy being used to improve the quality of healthcare organizations. Made up of healthcare administrators, staff, and community members, along with past and present patients and members of their family, the council should meet on a regular basis to initiate efforts to encourage patients and family members to participate, form necessary committees, and conduct training sessions to help staff and families learn to work collaboratively.

Information-gathering tools like patient and family shadowing, care experience flow mapping, storytelling, and patient and family surveys are used to gather information about the

way patients actually experience care and provide true insight into areas of operations that need improvement. Patient and family shadowing calls for directly observing the steps in the care process and gives a true perception of what the patient experiences. Flow mapping involves recording or mapping the flow of care for patients and families and helps providers better understand the patient's reactions to what happens at each step. Another way to understand what patients and families experience is patient and family storytelling. Storytelling allows patients and families to explain what they are experiencing, and why they feel the way they do about the care received. The stories are either written down or captured on audio or video recorders. Furthermore, patient and family surveys are one of the best ways to find out how patients and families really feel about their care. Information gathering tools help promote communication among patients and family members and engage them in their own care (DiGioia et al., 2012).

Performance improvement tools, which include hospital-based methods such as rounds, bedside nurse shift reports, patient and family initiated rapid response teams, and discharge phone calls, are used to engage patients and families in the safety and quality of their care. PFCC rounds are scheduled daily sessions during which the care team checks in on the patient and communicates with the patient and family members. Rounds are designed to directly involve the patient, their family, and healthcare team members in discussions concerning the patient's medical condition, care, treatment, and discharge plans. Patients can talk with the doctor and ask questions to learn more about their health issues in order to make informed decisions regarding care. Discharge plans are also discussed as well as a care plan for when the patient is home. Bedside nurse shift reporting is a process intended to get the patient more involved in their treatment. Shift-to-shift reports are generated at the patient's bedside to provide opportunities for patients to participate in the dialogue about the plan of care, concerns that have arisen, and

progress made. The reports facilitate the smooth transition of nursing staff and reduce anxiety of the patient and family members by letting them know who their next caregiver is and providing reassurance that incoming staff understand their plan of care. Patient and family initiated rapid response teams encourage patients and their family to be actively involved by providing information upon admission and a mechanism for alerting the care team about a noticeable change in the patient's condition. Program brochures are available in public areas and signs are posted in patient rooms. In the event of an emergency the patient or family member call a dedicated line, that is manned 24/7, and a rapid response team is immediately dispatched to the patient's bedside. A number of hospitals in the U.S. have implemented this as an important safety initiative. Additionally, discharge phone calls are designed to alleviate the overwhelming feelings often associated with returning home after being discharged as they strive to schedule medication, doctors' appointments, rehabilitation exercises, and other changes into their daily routines. A discharge phone call can effectively bridge the gap between hospital and home (Saskatchewan Ministry of Health, 2011).

PFCC strategies are designed to coincide with the philosophy and core concepts of PFCC and are intended to make patients and their families members of the healthcare team and involve them in the delivery of care by empowering them to manage their condition, actively participate in treatment, and collaborate with their providers. Emphasis is placed on the patient and their family to feel in control of their health by forming more positive beliefs about their conditions and improving their quality of life.

As an increasing number of hospitals have begun implementing PFCC initiatives throughout their organizational culture over the years, the impact of these initiatives on the

hospitals' quality of care should be analyzed to identify the appropriateness of a nationwide patient-centered health reform.

2.2.2 Georgia Regents (GR) Health

Georgia Regents (GR) Health, formerly named MCGHealth with the consolidation of MCG Medical Center and MCG Children's Medical Center, in Augusta, Georgia has implemented PFCC initiatives and activities throughout its facilities. Initial PFCC initiatives were carried out in the Children's Hospital of Georgia before evolving into the GRHealth Medical Center. The decision to implement PFCC was prompted by the results of a delivery model assessment performed in 1993 that identified that the care delivered was centered on the needs of the provider, but gave no consideration to the needs of their patients or family members. With the understanding of the importance of patient and family involvement, GRHealth made the commitment to implement PFCC in the development of its new children's hospital. Training sessions were held with administrators, clinical and non-clinical members of staff, along with patients and families to help staff and families learn to work collaboratively. A Family-Centered Services Committee, which included patient and family members, was formed to investigate ways to implement PFCC concepts and strategies into the design and construction of the Children's Hospital of Georgia. A children's advisory council made of pediatric patients, both current and past, was formed in 1996 to provide their perspectives and offer valuable suggestions to shape hospital policies designed to meet the needs and concerns of the patients.

In 1997, GRHealth expanded its commitment to PFCC to include the adult services offered at GRHealth Medical Center. With a focus on the needs and values of all patients and their families, a strategic plan called for the formation of various patient and family advisory

councils throughout the hospital to ensure that all aspects of care are representative of patient and family perspectives. Families are looked at as healthcare partners that are members of the healthcare team, rather than as just visitors. PFCC initiatives in adult services include patients and family involvement in the development and redesigning of patient care services, which include the Multiple Sclerosis Center, the Neurosciences Center, the Behavioral Health and Family Medicine Clinic, as well as a mammography suite. Patients and families have also become involved in developing patient safety measures and designing a campaign to encourage patients and families to become active and informed members of the healthcare team. A Patient and Family Faculty Program was developed to educate staff and students on the concepts of PFCC and collaborate with patients and families by sharing their stories during education and training sessions. Through participation on various customer service committees, patients and families are also involved in efforts to improve customer service and monitor patient satisfaction (“Leading the Nation,” n.d.; Institute for Patient- and Family-Centered Care, n.d.; “Partnering With Patients,” n.d.).

Serving as a model for PFCC, the unit design and philosophy of GRHealth Neurosciences Center of Excellence were developed through collaborative efforts to be accommodating to patients and families. Family members have access 24/7 to the patient’s room and a bed is made available to them if they choose to stay the night. Patients and families are encouraged to engage in bedside rounds. Ten of the rooms on the unit are designed in a way that minimizes room transfers during a patient’s stay at the hospital as they are universally equipped to function as intensive care unit (ICU), step down unit (SDU), and general medical-surgical unit rooms. A room has been designated in the unit to be used by patients, families and healthcare professionals to access the Internet and gather informative materials. In addition, quiet areas are available

throughout the unit to provide a private place for family members to meditate or discuss confidential information with providers.

The execution of PFCC throughout GRHealth facilities has resulted in substantial improvements in the financial, care quality and safety, satisfaction, and market share measures of the system (Institute for Patient- and Family-Centered Care, n.d.). When asked in an interview to reflect on the impact implementing PFCC has had on the quality of care provided at GRHealth Medical Center, the former senior vice president of PFCC indicated that the hospital has noted considerable improvement since involving patients and families in 1993 (“Partnering With Patients,” n.d.). The Hospital Compare website indicates that the HCAHP scores for GRHealth are at or very close to the U.S. national averages and risk-adjusted readmissions and mortality rates are consistent with the U.S. national rate (Hospital Compare, n.d.).

The Children’s Hospital of Georgia has become one of the top ranked children’s hospitals in the nation as a result of the PFCC initiatives and activities implemented. The hospital consistently ranks in the top ten percent of the Press Ganey national database for children’s hospitals since it opened its doors in 1998 (“Partnering With Patients,” n.d.; Institute for Patient- and Family-Centered Care, n.d.). In 2009, the University HealthSystem Consortium (UHC) ranked the hospital number one in the country for overall patient quality and safety in pediatric care. The hospital also ranked at the top in seven of fourteen Agency for Healthcare Research and Quality (AHRQ) composite measures, which measure quality based on many indicators. The chairman of pediatrics and medical director at the hospital associated these achievements with its commitment to center around children and their families. Incorporating patient and family perspectives into all aspects of care has enabled the hospital to deliver a higher degree of quality care than the average hospital (“The Children’s Medical Center,” 2009).

The quality of care throughout GRHealth Medical Center has also been positively impacted after integrating PFCC into its organizational culture. This impact can be identified when analyzing specific units within the hospital, such as the Breast Health Suite and the Neurosciences Center of Excellence. Patient satisfaction scores for the Breast Health Suite increased significantly, moving from the 40th percentile in 2003 to the 90th percentile after involving breast health patients and families in the unit planning process according to the Press Ganey national database for testing and treatment services in 2006. In addition, the Neurosciences Center of Excellence quality improvement data has skyrocketed since the unit opened. Based on three years of patient satisfaction scores, the center has increased from the 10th percentile in 2003 to the 95th percentile in 2006. Furthermore, the quality improvement data shows that length of stay for neurosurgery patients has decreased by 50%, medical errors have been reduced by 62%, discharge rate has increased by 15.5%, staff vacancy rate has decreased from 7.5% to 0%, and faculty and staff have improved their skills and are more committed to continually making improvements while possessing and preserving the new culture (“Partnering With Patients,” n.d.; Institute for Patient- and Family-Centered Care, n.d.).

2.2.3 Bronson Methodist Hospital (BMH)

Bronson Methodist Hospital (BMH), a tertiary care hospital located in Kalamazoo, Michigan, has also implemented PFCC throughout its organizational culture as it strives for excellence in healthcare quality. BMH focuses on partnering with patients and their families and respecting their preferences while including their values and perspectives in all methods of performance. As “listening and learning” from patients and their families is built into the BMH culture, the hospital bases many of its organizational changes on the feedback gathered through

bedside rounds, patient and community surveys, telephone follow-ups after discharge, and focus groups.

The hospital won the Malcolm Baldrige National Quality Award in 2005 and has continued to strengthen its efforts to implement PFCC initiatives throughout its environment (McCarthy, 2007). To ensure that the entire organization continues to promote and sustain the PFCC culture, the hospital distributes a one-page “Plan for Excellence” document to all of its employees that emphasizes PFCC in its requirements for excellence and outlines expectations that “every staff member has every day, with every interaction, with every customer” (Shaller, 2007). In 2006, BMH established a patient and family advisory council, a key resource to engage patients and their families in the hospital’s planning process by providing their input and ensuring PFCC is carried out in all aspects of the hospital (Howland, 2014). The Patient and Family Advisory Council (PFAC) is made up of volunteers from the community as well as staff and administrators from various departments of the hospital. The council meets monthly to share perspectives and evaluate current policies, processes, and designs to initiate change when necessary. The council has recognized expected behaviors of providers in a PFCC organization, which has led the hospital to identify unit-specific expectations for staff behavior based on the four core concepts of PFCC (McCarthy, 2007).

BMH educates staff daily on ways to tailor care to meet the needs of patients and their families. A number of methods utilized by the staff to provide opportunities for family members to participate in the patient’s care include goal setting, whiteboards, overnight accommodations, bedside rounds, and information kiosks. To tailor care around individual needs the hospital staff assists the patient in developing health goals that will help expedite their discharge. The goals are displayed on whiteboards hung in the hospital room so family members can see and encourage

the patient to work to achieve their goals. Accommodations are available for family members wishing to stay overnight with the patient or during a procedure and family members are encouraged to participate in bedside rounds so they may review the status, goals, and progress of the patient (McCarthy, 2007). In addition, BMH provides kiosks for patients and their families to access maps, service directories, and other healthcare related information. Furthermore, to enhance information sharing and fulfill the IOM's rule to make healthcare accessible to all patients and deliver it in a manner that responds to their needs, BMH offers a means for providers to provide care through the Internet to patients while they are out of the hospital (Shaller, 2007).

BMH has successfully achieved its goal to become a leader in healthcare quality by focusing on and implementing PFCC activities throughout the hospital. HealthGrades, a leading source for quality ratings and other information about healthcare providers, gave BMH a 5-star rating and labeled it as a "best practice" organization (Baldrige National Quality Program, 2007). The hospital has witnessed the turnover rate for nurses in its organization decrease from 21.3 percent in 2000 to 7.3 percent in 2006 as employee satisfaction has increased with patient and family involvement. In addition, compared to the national nurse vacancy rate average of 10.6, BMH was able to drop way below this average to 5.5 percent in 2006. With higher nursing staff retention, it is believed that over a five-year period, the hospital has saved \$3 billion (McCarthy, 2007). Furthermore, when considering quality measured at BMH through patient satisfaction, various patient satisfaction surveys have indicated, in the past and the present, that the hospital is a leader in providing quality care. From 2000 to 2003, BMH was consecutively presented the Highest Overall Patient Satisfaction Award from Arbor Associates (Bronson Healthcare, 2015). In 2007, BMH performed at the 98th percentile for inpatient loyalty and ranked in the top five

percent in the Gallup Organization's patient satisfaction survey database (McCarthy, 2007). In addition, with current HCAHPs scores above the national average in all eleven quality topics except one, it is obvious that BMH has the ability to continuously provide high quality care to its patients. While the hospital falls short of the national average by 1% for the topic that discusses the quietness of the patient's room at night, its scores in the other ten measures are exceptional. Its commitment to share information with patients is illustrated as 65% of patients who responded to the survey reported that they were explained about each medicine by the hospital staff before they were given any and 89% stated that they received information describing what they need to do at home during their recovery. As communication is essential in a PFCC organization, the effort of BHM to enhance communication with providers is evident as 81% of patients reported that their nurses always effectively communicated with them. In addition, patient preference for the hospital is presented as 82% of respondents rated the hospital either a 9 or a 10 on a scale from 0 to 10, with 10 being the highest possible score, and 86% indicated that they would definitely recommend the hospital (Hospital Compare, n.d.).

3.0 CONCLUSION

The need to improve the quality of care provided by healthcare organizations continues to be evident throughout the U.S. healthcare system. Despite the implementation of numerous nation-wide quality improvement initiatives over the past two centuries to enhance the quality of care delivered, indications exist that suggest additional measures are needed. The PFCC approach, designed to improve quality and safety performance by advocating the engagement of patients and family in the healthcare experience while incorporating accountability measures through transparency and encouraging innovations in the workforce, has presented itself as the most common motivator of change. Restructuring the system to incorporate PFCC models throughout every healthcare organization has the potential to improve the quality of the entire system without increasing healthcare costs.

It is the opinion of this author that the cases analyzed in this paper may be indicative of the capability PFCC has to help healthcare organizations achieve quality improvement goals and become leaders in today's healthcare system. However, the reliability of these analyses may be questioned due to limited generalizability since no method of scientific inquiry was used to directly link the recognized improvements in quality to the PFCC model. Therefore, the author recommends initiating qualitative research to determine the direct impact specific elements of PFCC have on improvements in quality of care. By continuing to incorporate PFCC concepts into healthcare delivery models in conjunction with qualitative research, leaders committed to

the engagement of patients and families in all aspects of their healthcare have the potential to advance patient-centered reforms to significantly improve quality of care and transform the current healthcare system.

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