



Patient and Family Centered Care Methodology and Practice FAQs

Questions and Answers Included in this FAQ:

- The PFCC Methodology and Practice
- Touchpoints
- Shadowing
- Patient and Family Involvement
- How PFCC is Different than other Approaches
- Staff Engagement
- Resistance
- Working Group Attendance
- Time Commitments
- Sustaining a Project
- Incorporating Improvements on a Unit
- How Success is Measured
- Metrics
- Budget

See Reverse Side



The PFCC Methodology and Practice

How do you start?

The first step is to decide which Care Experience you are ready to transform for patients and families. Our care can always be improved, so choose one area on which to focus your transformation efforts. However broadly or narrowly you define the Care Experience, decides where it actually begins.

To start “grass root” efforts, how do you recommend approaching people to join your group?

Letters are usually sent out to all the Touchpoints that were recognized when evaluating the current state. The letters are to come from the top of the organization. These letters then ask those Touchpoints to join in the PFCC efforts and become part of the Working Group. This is good for “grass root” efforts because everything comes from one valid and recognizable source.

What is the composition and size of a Guiding Council?

The Guiding Council should include three types of PFCC champions, each with the seal of approval from the top of the organization to lead change. An Administrative Champion, such as a Vice President, Chief Operation Officer, or Chief Executive Officer, whose involvement will put the hospital's stamp of approval on your use of the PFCC Methodology and Practice. A Clinical Champion, who will inspire colleagues to make and sustain needed changes. In the case of non-clinical departments, such as human resources, housekeeping, food services, or valet parking, the person in this role is called the Champion. A Facilitator, who will guide you in using the PFCC Methodology and Practice. The Guiding Council should also include a Scribe through whom all PFCC communication flows. The Scribe is the administrative assistant of the Guiding Council and is responsible for arranging meeting, sending updates, ensuring the prompt and complete flow of information to all involved in the PFCC process, and maintaining lists of active, completed and future projects.

Who receives invitations in the organization and who decides who to invite?

Guiding Council members pick Care Givers from each Touchpoint, or each department with which patients and families come into contact, to serve on the Working Group. Working Group members include physicians, nurses, aides, those who work in the OR, therapists, social service providers, dieticians, parking attendants, those who work in information technology, pharmacists, and others as needed.

When you have completed Step 3 - mapping the flow of care to clarify Touchpoints, and using the other tools described to help you view the Care Experience through the patients and families eyes-your Guiding Council will be ready to invite members to serve on a Working Group to transform care. Staff invitations to serve on the Working Group should come “from the top.”

How might PFCC work on a smaller scale (i.e.: a four doctor outpatient practice)?

No matter how small a group, PFCC can still be successful. The methodology and steps are the same, but there might be minor variations. The most important thing to remember is to include anyone that comes in contact with the patients and family.

How is PFCC working to bridge the gap between the Care Givers who “touch” the patient and the administrators who buy into the PFCC Working Groups, culture and concepts?

PFCC is about breaking down the silos that exist between groups, in this case, Care Givers and administrators. Because all these people have an impact in the patient and family experience, they are brought together to all work with one another to help improve the Care Experience.

How do you pick a first project when starting out?

Identify potential projects by comparing the current state to the ideal patient and family experience and prioritizing by patients and families. Care Experience Flow Mapping, Patient and Family Shadowing, and other tools described in Step 3 reveal the current state of patient care at every Touchpoint. What do you see when you overlay, on top of the current state, the ideal patient and family Care Experience as revealed not only by patients and families through their stories and their responses to surveys, but by your own stories of the ideal Care Experience as outlined in Step 5? You will see the gaps between what is and what should be from patients’ and families’ points of view. Make a list of each of these gaps to help you identify potential care transformation projects.

How do you prioritize the process for selecting top projects out of a list (simple vote)?

Working Group members should use feedback from patients and families to list and prioritize Working Group Projects. Prioritize your projects according to frequency with which patients cite particular aspects of their care as problems at various Touchpoints. Also, to help prioritize your projects, begin by focusing improvements involving easy-to-do, low-tech, low-cost solutions.

Where do you begin for a facility not yet fully engaged in PFCC?

A facility that has little knowledge of PFCC but still wishes to change the way that care is delivered can become engaged in PFCC. The steps of the PFCC Methodology and Practice are still the same. The first step is to decide which Care Experience you are ready to transform for patients and families. However broadly or narrowly you define the Care Experience, decides where it actually begins.

Do PFCC facilitators educate on the process?

Facilitators are there to help ensure that the methodology is being followed properly. The facilitator helps with ensuring that silos are coming down as well as providing the Working Group with project ideas, or suggestions that others Working Groups have completed.

What is the group process in the Working Group to look like?

The Working Group is comprised of members from each of the Project Teams. At the Working Group meeting each week, a member or members of the Project Teams are to briefly present an update on the work that is being done as well as any obstacles.

How do you implement Step #3 (evaluate the current state through the eyes of the patient and family) for groups whose experience tends to be more invisible to us in health care, for example the limited-English proficient folks?

A good way to evaluate the current state, even for a situation such as this, is through shadowing. Through shadowing and observing the patient and family one can gain a better understanding of the difficulties that the patient and family might face, and areas for

improvement. From shadowing you can gather times, interactions with others, as well as patient and family reactions.

Does the working group ever end?

The Working Group never ends. However, Project Teams are fluid. They can be disbanded when projects are completed and reformed when the Working Group decides to make future projects active ones. The PFCC Methodology and Practice relies on the continual gathering of information and making the needed changes in response, including changes in Project Teams.

Touchpoints

Touchpoints are often identified through the shadowing process. If you have a 3rd party liaison follow a patient and/or family member through their episode of care in a clinical setting to make observations, every interaction that patient or family has with an individual or entity is considered a Touchpoint. For example, the parking valet, registration clerk, gift shop attendee and automated pay station, can all be considered Touchpoints in a Care Experience.

Shadowing

“Shadowing” the patient and family throughout the care process highlights the details of the care process itself and will help you understand the Care Experience from the patient’s and family’s point of view at every Touchpoint, as they go through it. Define where the Care Experience you want to observe begins and ends, and follow patients and families along this defined pathway throughout the care process. Note where they go and for how long, observe their experiences, and record their reactions. For example, you may choose to start from the time the patient and family arrives to park their car until the time they drive away after discharge. Shadowing can also be applicable to inpatient and long term care patients.

Patient and Family Shadowing will allow you to:

1. Observe the steps in the care process as they happen, including how long each step takes.
2. Record and understand the patient’s and family’s reactions to what happens at each step.
3. Map the flow of care.

Patient and Family Shadowing will help you see both what is good, and what is not so good, about their care. Did a nurse explain a procedure clearly and completely, easing a patient’s anxiety? Or did a patient wait too long for care or information in one department? If patients and families are satisfied with their care, of course you want to know about it. But if they are dissatisfied or anxious about any aspect of their care, knowing about it quickly becomes a matter of urgency—because you and your colleagues will want do something about it, and fast!

***Note:** Patient privacy is very important. The patients are aware ahead of time that they will be followed throughout their entire experience, and in turn, some of their personal information will undoubtedly be revealed to the PFS liaison. However, the patient’s name and any personal information are never to be included in any of the finalized shadowing reports or presentations.

There are limited restrictions on who can help to shadow. A great resource may lie within summer interns and graduate or medical students. Such observers have fresh eyes and have no preconceptions or biases. Plus, using interns or students can be inexpensive or free.

The best way for someone to learn the act of shadowing is to actually get out there and do it; to essentially “shadow a shadower”. Also, a Patient and Family Shadowing Training Guide is currently being developed to further the learning process.

In order to avoid intimidating or influencing staff when their particular workspace or patients are being shadowed it is important to be sure that they are notified and educated ahead of time. Once they understand that the sole purpose of PFCC is to improve the patient and family experience, any feelings of vulnerability should diminish.

Patient and Family Involvement

Viewing care through the eyes of the patients and families is key in the PFCC Methodology and Practice, therefore patient and family involvement is very important. There is no rule of thumb on when to bring patients and families into the 6 steps and each Guiding Council or Working Group should make this decision based on when they feel it would be appropriate. If not brought in earlier patients and families will come into play for the Step 3 – Evaluating the Current State. In this step, patients and families are shadowed, surveyed, and tell their stories. Patients and families can also be brought in as a member of the Working Group, a Project Team, or as part of a Patient and Family Advisory Council.

When determining who is best suited to recruit patients and families keep in mind the level of involvement you are requesting from the patient and/or family. Recruitment can be done at all levels, Working Group member, project lead, champion, front line staff, shadower, etc. If patients or families have been on a unit for awhile, or are a return patient, choose someone you feel will open up about their experience. If this isn't an option in your area don't be afraid to approach new patients because you never know who is willing or eager to share feedback.

How PFCC is Different than other Approaches

The key to PFCC is to approach the Care Experience from the perspective of the patient and family. This is how it may differ most significantly from other approaches like LEAN, CGI, TPS, etc. However, it is important to note that PFCC works collaboratively with any and all other approaches to quality, process, or performance improvement. It does not compete with these approaches; rather it works best as the framework or umbrella under which any other improvement effort can be utilized. The PFCC Methodology and Practice is considered a “low tech” approach to transformation and does not require advanced training or certification to implement (no belts required).

Staff Engagement

PFCC definitely demonstrates improved Care Giver satisfaction. This occurs through involvement, engagement, and ultimately ownership. There is no real pyramid within a PFCC Working Group or Project Team. All members have equal say and for many members it may be the first time they have actually been asked for their input or advice on how to improve a situation which directly affects them. In fact, being closest to the work in question makes them the best resource. Over time, as the Care Experience improves for the patient and family, it eases the burden of responsibility for the Care Giver as well so their work experience improves as does their satisfaction on the job. Also, by eliminating the non value-added work and keying in on core responsibilities, Care Givers can get back to the real reason they chose the work they did – patient care.

Resistance

While most areas are more than ready for the changes that PFCC can bring, from time to time and in some areas, resistance to starting the PFCC Methodology and Practice is encountered. In general people tend to think PFCC is just the next “flavor of the month” or just like any other change effort. It is important not to deal with that kind of resistance head on by telling everyone how wrong they are about those kinds of perceptions. Just ask them for 2 hours of their time per week and begin the shadowing process to determine the current state of care as soon as possible. By shadowing patients and families early on, the Working Group members get a completely new perspective of the Care Experience... that of the patient and family. This process inevitably opens their eyes in a new and different way which then creates a sense of urgency on their part to change and improve that experience. Their interest in the process builds as they begin to feel a part of the larger team and realize that their suggestions are the only thing between the current Care Experience and the ideal Care Experience. There is no department or organization where PFCC cannot work. There is only different levels of resistance that would need to be overcome in new and engaging ways.

Some physicians can tend to bring additional challenges in terms of PFCC buy-in. Approach this subject in the same manner you approach PFCC in general...by taking as many roads into the situation as possible. One of those roads will lead to the open door...eventually!

Working Group Attendance

Surprisingly, the Working Group members usually realize immediate results as the Methodology and Practice encourages starting with the low hanging fruit, easy to implement ideas, and momentum grows from there. Once a few projects are under their belts, they are eager to see what else they can accomplish to benefit the patient. In many cases, improvements that benefit patients and families are beneficial to staff as well.

Time Commitments

Time commitment is a common concern when you are beginning any initiative and that holds true for PFCC too. However, the difference is that the PFCC Methodology and Practice makes

efficient use of the Care Givers time by giving them the tools they need to improve the Care Experience.

The total time commitment is approximately 2 hours a week - 1 hour dedicated to the PFCC Working Group meeting and the second to the Project Team meeting. Face-to-face meetings are not always possible so some Project Teams use creative ways to utilize their resources such as conference calling or emails.

Remember that Working Group members include all those who touch the patient and family so including frontline staff as well as managers and executive leaders is important – identifying members diagonally across the silos.

Choose a meeting time and day of the week where most people can attend and assign co-leads to share the responsibility.

Sustaining a Project

A primary suggestion: start small. The PFCC Methodology and Practice encourages pilot projects, ie a few patient rooms on a unit or a new process in one outpatient office to see how things work. If it goes well, the Project Team can look for another area to expand to; if it is not successful, much is still learned by the attempted implementation and because of its small scale, it's not going to be devastating to the group.

Incorporating Improvements on a Unit

Again, start small, incorporate a change on a pilot basis using a few rooms on a unit, and if the project is deemed successful, it can spread to other areas and the process should become operationalized.

Budget

Empowerment is a key concept of the PFCC Methodology and Practice and includes fiscal empowerment. Establishing a budget process is an important part and grants Working Groups the authority to act quickly. When there are a growing number of PFCC efforts the PFCC fund will accelerate the work being done by the Care Experience Working Groups and their Project Teams.

The PFCC Fund Procedure:

As PFCC Project Improvement Teams are formed, they have the authority to spend up to a certain amount on care transformation pilot projects, which allows them to start and complete projects efficiently.

- When funds are needed, the Project Team co-leads present the PFCC Proposal at the weekly PFCC Working Group meetings. The PFCC Proposal Request explains:

1. What is the project?
2. What the funds will be used for?

3. How much it will cost?
4. How it will measure its effectiveness after implementation?
5. What is the time frame of the Pilot Project (usually 3-6 months)?

- The PFCC Proposal is presented to the Working Group members who have the authority to vote “all in favor or not”. If declined, the Project Team will consider the suggestions from the Working Group members and search for other possible solutions.
- If the Pilot Project is successful to implement, future costs should be supported by normal operational processes.
- If the proposal is over the determined amount, the request would be voted on by the Working Group members using the same process, but would then need to be presented to the Executive Management Group by the PFCC Administrative Champion for final approval.
- Create a budget where PFCC dollars are easily tracked and reported.

*Of Note, very few dollars have been spent implementing PFCC pilot projects. In fact, in 2008 only \$24,214 was spent across 7 Working Groups and 5 facilities - averaging \$3,460 per PFCC Working Group. The same Working Groups in 2008 completed 103 projects, averaging just \$235 per project.

Questions on how Success is Measured?

There are as many varieties of ways to measure success, as there are projects. The PFCC Methodology and Practice strongly encourages the use of metrics to keep track of outcomes whether they are cost saving, time saving or patient satisfaction driven.

Questions on Metrics?

Gathering metrics is an important part of the PFCC Methodology and Practice. Below is a sample of the types of metrics gathered at both the Working group and Project Team levels.

Quantitative Metrics

- Clinical Outcomes
- Clinical Quality & Safety
- Patient Satisfaction (HCAHPS, etc.)
- Service Excellence
- Efficiencies
- Informal Focused Surveys
- Video Observations
- Program Evaluations
- Cost Analysis
- Care Giver Engagement
- Team Performance
- Care Giver Turnover
- Pre & post Comparison

Qualitative Metrics

- Patient and Family Stories
- Patient Letters
- Survey Comments
- Observation Reports from Shadowing

Process Flows

- Care Experience Flow Mapping
- Time Studies
- Predication Simulation

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