

# American Medical Association Journal of Ethics

January 2016, Volume 18, Number 1: 33-39

## MEDICAL EDUCATION

### Creating Value with the Patient- and Family-Centered Care Methodology and Practice: What Trainees Need to Know, Why, and Strategies for Medical Education

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In 2006, Porter and Teisberg [1] noted that, in keeping with payment models in effect long before the Affordable Care Act of 2010, health care organizations focused on shifting costs, employing financial constraints on insurance coverage to keep patients from seeking health care services elsewhere, and limiting patients' options for accessing health care delivery. Such practices are incentivized in a system in which value is defined differently for patients, insurers, and clinicians and health care organizations, that is, a system in which stakeholders' incentives are not aligned. Porter and Teisberg pointed out that none of these efforts to be competitive created value for patients; instead, they resulted in today's fragmented and costly care delivery system, in which clinical outcomes and patient experiences got much too little attention [2, 3]. A response they suggested was redesigning care delivery models that create value for patients, where *value* is defined as *exceptional experiences and better clinical outcomes at lower cost* [1]. The redesign they proposed was to reform the nature of competition itself by making the competition all about value. So organizations that provide the best patient experiences and the best clinical outcomes at the lowest costs—and rigorously measure and report these results—will succeed. Earlier, in 1999, Pine and Gilmore [4] suggested that engaging customers in a memorable way is critical for creating value. Applied to health care, the idea, they said, is to create a more engaging experience. There is clinical evidence that increased patient and family engagement and partnership in patients' health care experiences are associated with improved clinical outcomes [5].

Neither *value in health care* nor *patient-centered care* (both of which are central tenets of health care reform) are widely taught in medical school curricula. Nor are the concepts that support these tenets, such as engaging with patients in clinician-patient partnerships, evidence-based design and co-design as mechanisms for viewing care through the eyes of patients and families, team-based care, patient activation, and close links between health care organizations' financial and clinical performance. Consequently, medical students don't learn any specific implementation mechanisms for achieving all of these goals. This paper discusses the conceptual and operational components of value and patient-centered care, the importance of introducing them to clinicians-in-training, and ways in which this can be accomplished.

## Is Patient- and Family-Centered Care Ethical?

Conceptually, [patient- and family-centered care](#) (PFCC) is health care that is compassionate and respectful of patients and their families, includes them as partners and collaborators, and acknowledges their dignity. It is also safe, effective, efficient, and equitable [3]. It's hard to imagine an ethical argument against these principles, but one common misconception is that collaborating with patients creates the risk of their making decisions that are detrimental to their health and well-being [6]. But collaboration, by its very nature, means that patients and families don't make decisions in a vacuum, without the input of clinicians; shared decision making is a continuum [7], not an all-or-nothing proposition.

We suggest that clinicians and health care organizations can apply Pine and Gilmore's prescription of creating an exceptional experience of care by partnering with patients and families to redesign care and can do so in a way that increases value by simultaneously improving clinical outcomes and decreasing costs. Experience includes everything that leaves an impression on the patient and family, from their viewpoint—for example, clinical outcomes and care quality, interactions with and among care professionals, transitions in care, the physical environment, safety, and costs. Accordingly, medical education must include (1) coursework that introduces these concepts and (2) a specific implementation mechanism with which to achieve and sustain (over time) focus on patients' experiences and on patient and family-centered care in clinical settings.

### The PFCC M/P

How can we move from PFCC *as concept* to PFCC *as operating system* and operationalize the concept in ways that are measurable? First, we need a way to understand the current state of care delivery, including what patients and families experience along their health care journeys in any setting. Second, we need a mechanism to close gaps between the current and the ideal state (from patients' and families' points of view). The mechanism by which these gaps are closed should create "aha" moments [8] each time it's used, so that its usefulness is apparent. Third, we need a mechanism that not only improves the experience of care but improves outcomes and reduces costs as well. This necessitates that we distinguish carefully between patient *experience* and patient *satisfaction*. A focus on experience, rather than on satisfaction, as we noted in our 2012 paper, "Integrating Patient- and Family-Centered Care with Health Policy: Four Proposed Policy Approaches" [9], is important because it prompts us to look differently at data. For example, patient satisfaction data, while important, "represents, almost without exception, after-the-fact recollections," [10] which makes root causes of problems with patients' experiences difficult to identify and challenging to address. Finally, tools must be easily understood and implemented by clinicians and organizational leaders; sustainable transformation requires a bottom-up-meets-top-down approach.

The PFCC Methodology and Practice (M/P) approach promotes these four things, combining a focus on patients' and families' experiences with tools that can and should

be not only used in clinical settings but also integrated into medical school curricula. Over the last ten years, the PFCC M/P has been [implemented](#) in hundreds of inpatient, outpatient, and pre- and post-hospital and office settings around the world to operationalize the concepts of PFCC [9, 11–20]. It has been implemented in such diverse areas as trauma services, life after weight loss, outpatient mental health, oncology, transplant, home health, diabetes care, and total joint replacement.

### **How the PFCC M/P Works in the Clinical Setting**

Table 1 (below) displays the six steps of the PFCC M/P. The first step is to define (with beginning and end points) the care experience you're setting out to improve in a given organization. This can be as narrow as a physician's office visit in a particular clinic or a particular presurgical test, or as broad as all of a hospital's trauma services from the time paramedics receive a call about an accident or injury all the way through the emergency room, the operating room, an inpatient stay, rehabilitation, home care, and the follow-up visits.

The second step is to form a small (three-to-four-person) strategic group of champions—the guiding council—to initiate and set the stage for these transformation efforts. One member of the guiding council should be a clinician, another should be an administrator (to help remove barriers), and one a coordinator to keep the effort organized.

One of the unique tools of the PFCC M/P—introduced during step 3—is shadowing, which is the direct, real-time observation of patients and families as they go through their health care journey. Trained shadowers (who can be students, interns, members of the care team, volunteers, new employees, and so forth) collect objective and subjective information: where the family members go; with whom they interact and for how long; and patients' and families' impressions, feelings, and reactions. Shadowing training takes less than 30 minutes and shadowing tools are provided to help the shadower take notes and create reports. Direct observation of patients and families as they make their way through the care experience defined in step 1 of table 1 fosters insight into the care experience, which not only helps to accurately and efficiently identify the current state of affairs and opportunities for improvement, but also creates a sense of urgency to drive change. As Tim Brown explains, direct observation creates an emotional connection with the people and processes being observed, which leads to insight and a sense of urgency to improve the care experience [8]. It has been our experience with many medical students that shadowing and observing patients' and families' experiences provides physicians-in-training with unique understanding of the experience of care from the viewpoints of patients and families [21, 22]. Teaching the process of shadowing in medical school can be (1) the initial introduction to the framework of the entire six-step PFCC M/P as well as (2) a valuable tool in its own right for medical students to have the opportunity to view care through the eyes of patients and families in a way that creates “aha” moments [8, 22].

At step 4, high-performance improvement teams composed of clinicians, managers, and leaders—called PFCC working groups and project teams—are organized. PFCC working groups include a representative from every touchpoint (locations to which patients and families go and specialties with which they interact) of the care experience that has been identified through shadowing—from parking attendants to physicians, from nurses to dietitians, from therapists and technicians to schedulers and finance representatives. The creation of these cross-functional and cross-hierarchical improvement teams (i.e., the PFCC working groups) that meet weekly ensures a consistent and permanent opportunity to communicate and collaborate and a forum in which to continually look at the health care experience through the eyes of patients and families. By breaking down silos, this collaboration allows each member of the working group to understand how each part of the care experience fits within the larger care experience from the patient’s and family’s point of view. It is important for students to learn about the importance of team-based care [23]; this step of the PFCC M/P is an example of how to achieve team-based care.

At step 5, these groups write an ideal “story” from the patient’s perspective using the input provided by patients and families during shadowing, and, at step 6, project teams with representatives from every touchpoint launch initiatives to close those experiential gaps identified and prioritized by patients and families.

**Table 1.** The six steps of the PFCC Methodology and Practice [20]

Step 1: Define the care experience for improvement, including the beginning and end points
Step 2: Create a PFCC Guiding Council to lead the effort and break down barriers
Step 3: Define the current state of the care experience through Shadowing, surveys, and other tools
Step 4: Expand the PFCC Guiding Council into a PFCC Working Group with representative from every “Touch point” of the care experience identified through Shadowing
Step 5: Write the ideal story, from the patient and family’s perspective and in first person
Step 6: Create PFCC Project Teams to close the gaps between the current and ideal state

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### Using the PFCC M/P to Create Fiscal Value

Currently there is no curriculum for medical students about differences between actual costs, charges, and reimbursement (the latter two [not being directly related](#) to actual

cost) and the need to drive down costs while preserving the quality of patients' experiences and outcomes. The PFCC M/P has recently been expanded into an approach called the Patient Centered Value System, in which shadowing can be used to identify not only the experience of care but also the actual cost of specific types of care such as total joint replacement, heart bypass surgery, chronic diabetes care, and so forth. This goal is accomplished by identifying the major cost drivers (personnel, space, equipment, and consumables) in each segment of care for a given clinical condition during shadowing. Knowing true costs (rather than charges or reimbursements) and their sources, and having the improvement implementation teams already developed within the PFCC M/P, allows clinicians and organizations both to drive costs down while protecting and improving experiences and outcomes and to avoid reducing costs in one segment of care delivery that will only increase costs in another [20]. This is a critical link that has been missing from process improvement until now.

### **Financial Incentives for PFCC?**

Change in health care delivery will be swifter and more widespread if we align clinicians' interests with those of patients and families. Trainees need to know that financial incentives can quicken the pace of adoption of PFCC concepts. As we also suggested in "Integrating Patient- and Family-Centered Care with Health Policy: Four Proposed Policy Approaches" [9], financial incentives could take the form of offering accountable care organizations an additional 10 percent of shared savings if they employ the PFCC M/P. Reallocating a portion of the cost reductions that result from employing the PFCC M/P to population health initiatives, such as wellness and prevention programs, would multiply the achievements of improved experiences and outcomes while further lowering costs.

It is time to implement an operational approach to patient- and family-centered care, and that requires viewing all care through the eyes of patients and families and evaluating performance from a patient-centered perspective. Introducing the concepts as well as the implementation mechanism of patient and family centered care will allow us to transform the health care delivery system to improve experiences and outcomes while decreasing costs—both a logical and an ethical pursuit. Medical school is the place to start. Training medical students in these concepts, teaching them a methodology, and providing the tools with which to achieve them, ensures that from the earliest interactions with patients and families, clinicians practice health care in a patient- and family-centered way.

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#### **Disclosure**

Anthony M. DiGioia discloses an affiliation with GoShadow, LLC.

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ISSN 2376-6980**