



Review of key attributes of high-performing person-centred healthcare organisations

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Summary

Person-centred care is widely recognised as a foundation for achieving safe, high-quality health care, contributing to better outcomes and experiences for patients, carers and families. Person-centred care also offers important potential to improve the value delivered by health services by achieving better outcomes at lower overall cost to health systems and the community. Person-centred care underpins the principles and expectations of the National Safety and Quality Health Service (NSQHS) Standards.

While there is a growing body of evidence and broad stakeholder recognition of the benefits of person-centred care, there are relatively few resources that provide practical guidance on its implementation in the Australian context. The Australian Commission on Safety and Quality in Health Care (the Commission) engaged Nous Group (Nous) to identify the key attributes of high-performing person-centred healthcare organisations. This report sets out Nous's findings and proposes a framework to guide health services towards better, person-centred care across a range of settings, systems and hospital types.

Nous's analysis drew on the published and grey literature, broader organisational performance principles, site visits and consultations with a diverse selection of health services in Australia and internationally. Nous sought to understand how person-centred care could be achieved by all organisations rather than focusing on high-profile, well known exemplars of person-centred care.

Patient journeys and patients' experiences of care are influenced by both the way patients are treated as people and by the way they are treated for their condition. The ultimate goal for person-centred care is to deliver an ideal experience for patients, their carers and families that achieves their goals and delivers the best outcomes. Health services that are successful in delivering person-centred care focus all aspects of their organisation toward achieving this ideal experience throughout the patient journey.

This review identified seven attributes of person-centred healthcare organisations, set out in **Figure 1**. These attributes are interrelated and mutually reinforcing. There is no definitive hierarchy of attributes and the relative importance of each will differ between organisations. But all are important to achieving person-centredness. The seven attributes are:

Comprehensive care delivery

This is based on person-centred values applied in every interaction with patients, their carers and families. Effective communication drives care and compassion; patients are actively involved in their care and decision-making is shared. Care is comprehensively coordinated across the team and guided by patients' goals and choices, while diversity and equity are respected and supported.

A clear purpose, strategy and strong leadership

Leadership drives the organisation to achieve exceptional person-centred care. Organisational commitment toward this goal is clearly stated in the organisation's purpose and articulated to the workforce and the community. Leaders at every level champion the importance of person-centred care across the organisation.

People, capability and a person-centred culture

These are focused on supporting the needs and choices of the individual. A long-term, systematic commitment to developing a person-centred culture is complemented by comprehensive training and capability development. Workforce wellbeing is prioritised and supported as a key enabler of great care.

Person-centred governance systems

Such systems involve consumers at all levels of the organisation. Consumer involvement is enabled by thorough training and support. Co-design and co-production are frequently used to enable meaningful consumer involvement and service improvement. There are clear accountabilities for individuals and teams at every level of the organisation. Management decisions, including resource allocation, explicitly consider and prioritise person-centredness.

Strong external partnerships

Strong partnerships are recognised as integral to coordinating services around the needs and preferences of individuals. Seamless transitions between care settings are enabled, with the organisation taking a leadership role in effecting system change and improvement.

Person-centred technology and built environments

These have a significant practical impact on experiences of care. While resources for both are often limited, good physical design principles and innovative digital technology are able to be applied in any organisational setting. Technology is used as an enabler for person-centredness and not a replacement for people, culture and capability.

Measurement for improvement

Achieving person-centredness requires an organisation-wide culture of continuous improvement, focused on measuring patient outcomes and experiences. High performers 'measure what matters' to get the outcomes that patients expect.

There is no set formula for achieving person-centredness. The attributes are manifested differently in every organisation. Collectively, the seven identified attributes provide an ideal organisational model for high-performing, person-centred care.

A strong common theme from the literature and case studies was that person-centred care is achieved through incremental change and requires a long-term commitment across all areas of an organisation. The seven attributes are presented in further detail in the main body of this report. Examples of leading practices, identified through Nous's site visits and consultations, are provided alongside our discussion of the attributes. The examples provide insights on what person-centred care looks like in practice.

A series of eight, more detailed case studies are included with this report. The case studies offer further detail on the ways in which a diverse range of Australian and international health services are developing their approach to person-centred care. Each has made important, yet distinctive, advances in person-centred care, yet all agree there is much more to be done to consistently achieve high performance for every patient.

Figure 1: Key attributes of high-performing person-centred healthcare organisations

Person-centred care requires an organisation-wide approach, with the achievement of multiple attributes across all aspects of an organisation



Comprehensive care delivery

- Patients are engaged as partners in their care
- Goals of care guide clinical decisions and the patient journey
- Diversity and equity are respected and supported
- Transparency is a core element of safety and quality care

Clear purpose, strategy and leadership

- A commitment to exceptional person-centred care is clearly stated in the organisations purpose and strategy
- Great leadership drives exceptional person-centred care, with the support of champions across the organisation
- A person-centred strategy is articulated to the workforce and the community and implemented across the organisation.

People, capability and a person-centred culture

- An organisational culture for person-centred care is built and maintained through long-term systematic approach
- The capabilities of all members of the workforce are continually developed through formal and informal learning
- The organisation regularly monitors and is dedicated to support workforce satisfaction and wellbeing

Person-centred governance systems

- Consumers and the community are involved in governance at all levels
- Consumers are trained and supported to meaningfully contribute
- Organisational structures and models of care are designed around the person
- There are clear accountabilities at all levels – from the board to the clinician
- Financial, strategic and operational decisions and processes are person-centred

Strong external partnerships

- Healthcare organisations have a comprehensive network of service partner and relationships
- There is a focus on seamless transitions and coordination of care
- Healthcare organisations operate as leaders in the system improvement
- Community volunteers are recognised and supported as critical partners in enhancing the patient experience

Person-centred technology and built environment

- Person-centred design principles are applied to the built environment
- Healthcare organisations are pragmatic and innovative where resources are limited
- Technology must enhance patient experiences and outcomes, but also not be relied upon alone

Measurement for improvement

- There is culture of learning and continuous improvement
- Measurement can be acted on to improve outcomes and reflects what patients and communities value

1 Introduction

1.1 Background

The Australian Commission on Safety and Quality in Health Care (the Commission) was established in 2006. The Commission's role is to lead and coordinate national improvements in the safety and quality of health care. The Commission works in partnership with the Australian Government, state and territory governments and the private sector to achieve a safe, high-quality and sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.

Person-centred care is widely recognised as a foundation for achieving high-quality, safe and value-based health care. Many studies have shown that person-centred care can contribute to increased patient satisfaction, improved health outcomes and reduced costs of care (see Section 2 for a summary of evidence on the benefits of person-centred care).

The Commission plays a key role in advancing person-centred care in Australia by providing guidance, information resources and other support to consumers, clinicians, managers, policymakers and healthcare organisations. Person-centred care represents both a means to achieve and an outcome of the National Safety and Quality Health Service (NSQHS) Standards.

Across Australia, healthcare organisations are increasing their focus on, and commitment to, delivering high-quality, person-centred care. This requires significant change at all levels of the organisation. While there is an extensive body of evidence on the benefits of person-centred care, there are fewer implementation resources designed specifically for Australian healthcare organisations. The Commission, therefore, engaged the Nous Group (Nous) to conduct a literature and policy review of the key attributes of high-performing person-centred healthcare organisations, with a view to inform the development of resources for Australian healthcare organisations.

1.2 Purpose and overview

The purpose of the review was to identify and understand the key attributes that enable a healthcare organisation to deliver high-quality person-centred care. It was designed to produce focused, practical and action-orientated information.

The review complements the NSQHS Standards. It aims to provide practical information to assist healthcare organisations to identify action that may help them meet the requirements of the NSQHS Standards, and move towards high performance in person-centred care.

The report is structured as follows:

- **Section one** (this section) provides background information on the purpose, structure and methodology for the review
- **Section two** summarises the evidence on the benefits of person-centred care and describes the current context for person-centred care in Australia
- **Section three** describes the ideal person-centred patient journey
- **Section four** describes key organisational attributes of a high-performing, person-centred organisation, with examples of best practice from Australia and overseas
- **Appendix A** outlines relevant actions from the NSQHS Standards (second edition)
- **Appendix B** presents eight case studies of hospitals and health services that are recognised for high performance in person-centred care
- **Appendices C and D** include the bibliography and references for this review.

1.3 Methodology

The review was conducted from April to August 2017. It consisted of an extensive literature review and site visits to eight high-performing healthcare organisations in Australia and overseas. An organisational architecture framework was used to identify the key features of person-centred care across all aspects of an organisation, from strategy, leadership, people and culture through to governance, technology and physical assets.

Figure 2 describes the main components of the review methodology.

Table 1 presents the organisations involved in the review.

The findings in this report are drawn from the desktop policy and literature review and insights generated through the site visits.

Figure 2: Core components of the review methodology



Review of more than 90 peer-reviewed publications and documents from grey literature. Peer reviewed publications included journal articles and systematic reports, frameworks and policy documents from health institutes, health services and government agencies in Australia and overseas.

Appendix C includes a list of articles and grey literature reviewed.

Site visits to four health services in Australia, two in the United States, one in Canada and one in Sweden, including a range of large, small, public, private, metropolitan and regional hospitals and health services. Site visits involved a short tour of the facilities and multiple interviews with managers, clinicians, patient representatives and other involved in person-centered care.

Appendix B includes case studies from the eight health services visited.

Table 1: Health services for the site visits

Australian organisations	International organisations
John Fawkner Private Hospital, Melbourne, Victoria	Carolinas Medical Center – Mercy, Carolinas HealthCare System, North Carolina, the United States
Riverland General Hospital and Country Health South Australia Local Health Network, Berri, South Australia	Jönköping Healthcare Service, Region Jönköping County, Sweden
Royal Prince Alfred Hospital and Sydney Local Health District, Sydney, New South Wales	Kingston Health Sciences Centre, Kingston General Hospital, Kingston Ontario, Canada
Sunshine Hospital and Western Local Health Network, Melbourne, Victoria	Sea Mar Community Health Centers, Washington State, the United States

2 The context and rationale for person-centred care

2.1 Defining person-centred care

Person-centred care involves healthcare that is respectful of, and responsive to, the preferences, needs and values of patients, their families and the community.¹ There are other terms used to describe similar concepts, such as people-centred care and patient and family-centred care, all of which are related to the attributes identified in this review.

The review has adopted a broad interpretation of person-centred care, which is reflected in definitions from the NSQHS Standards and World Health Organization.^{1,2} Both definitions emphasise the active role of consumers in decision-making about their care (see **Table 2**).

The concept of person-centred care is underpinned by partnerships with consumers (that is, the people who use healthcare services). Partnering with consumers is about healthcare organisations, healthcare providers and policy makers actively working with people who use the healthcare system to ensure that health information and services meet people’s needs.³

Table 2: Definitions of patient-centred and people-centred care

National Safety and Quality Health Service Standards (second edition), 2017	World Health Organization Framework on integrated, people-centred health services, 2016
<p>Patient-centred care: an approach to the planning, delivery and evaluation of health care that is founded in mutually beneficial partnerships among clinicians and patients. Patient-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of patient-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care.</p>	<p>People-centred care: an approach to care that consciously adopts individuals’, carers’, families’ and communities’ perspectives as participants in, and beneficiaries of, trusted health systems that are organised around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment.</p>

2.2 Key evidence on the benefits of person-centred care

There is a growing body of evidence that person-centred care contributes to positive outcomes and experiences for patients, the workforce and health services. While the evidence base remains relatively immature, the potential benefits of person-centred care are widely recognised.⁴

Numerous studies and evaluations have found that the implementation of person-centred initiatives and practices can lead to significant improvements in patient satisfaction, as well as improved perceptions of healthcare organisations from the community.⁵⁻⁷ Studies have also shown that person-centred approaches can lead to improvements in workforce attitudes, job satisfaction, emotional stress and overall workforce wellbeing.^{8, 9}

Many studies have found that patient satisfaction and person-centred care is associated with improvements in safety, quality and clinical outcomes. This includes improved mortality, decreased readmission rates, decreased healthcare-acquired infections, reduced length of stay and improved treatment adherence.¹⁰⁻¹³ Studies of person-centred care in primary health settings have found that improved communication and collaboration between patients and providers has been associated with a reduction in diagnostic tests and referrals, and improvements in treatment adherence, patient satisfaction and patient enablement.¹⁴⁻¹⁶

There is also evidence that person-centred care can improve efficiency and reduce costs of health care. Several studies and evaluations of person-centred care initiatives implemented by healthcare organisations have found that the initiatives led to shorter lengths of stay, lower costs per case, better utilisation of low- versus high-cost workforce members, and other cost savings.^{5, 6, 17}

Figure 3 summarises the evidence on the benefits of person-centred care.

Figure 3: Benefits of person-centred care



2.3 The context for person-centred care in Australia

Despite growing recognition and increased evidence in support of person-centred care, many aspects of the Australian healthcare system act as barriers to its achievement:

- **System fragmentation:** Funding and regulatory separation of key elements of the care system, particularly the divide between the Commonwealth primary care system and the state/territory public hospital systems, often limit the coordination and continuity of patient care
- **A relative focus on hospital care:** A disproportionate level of investment in acute hospital funding and access has limited the development of other elements of the healthcare system, including sub-acute care, primary care and preventative health care
- **Overlapping public and private systems:** Australia's unique mixed-model of public and private care creates additional complexity for patients choosing private care
- **Output-based funding models:** At all levels of the system, the majority of healthcare services are funded on an output basis, encouraging a transactional approach to care that is organised around diseases and procedures rather than the needs of patients.

Clinicians, health services and policymakers at all levels have more recently sought to address these barriers through both system-level reform and local action.

However, more work is needed if a shared ambition of person-centred care is to be consistently achieved across a complex and often fragmented system.

2.4 The Commission's role in advancing person-centred care

The Commission recognises the vital link between person-centred care and the fulfilment of its vision for consistently safe, high-quality care for all patients across the Australian healthcare system. The benefits of person-centred care now emerging in the literature align with, and reinforce, the Commission's four strategic priority areas: patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide safe and high-quality care.¹⁸

Supporting and enabling better person-centred care therefore forms an important part of the Commission's role and its activities. Through publications such as this, the Commission seeks to equip consumers, clinicians, health services and policymakers with the resources, insights and innovations to achieve practical changes that benefit patients and the system.

2.5 Person-centred care and the National Safety and Quality Health Service Standards

Person-centred care is embedded throughout the NSQHS Standards (second edition), reflecting its importance to the safety and quality of health care. Person-centred care extends well beyond the focus of the Partnering with Consumers Standard and the Comprehensive Care Standard. It is acknowledged across all of the NSQHS Standards and is particularly central to a range of actions and approaches that form the basis of the Clinical Governance Standard and Communicating for Safety Standard.

A list of actions in the NSQHS Standards and associated actions that are relevant to person-centred care is provided in **Appendix A**.

3 Understanding the ideal person-centred patient journey

The patient’s journey, as well as their experience of care, is influenced by both the way they are treated as a person and by the way they are treated for their condition. Both are important but they are delivered differently. Treatment outcomes are facilitated by the organisation and delivered by the care team; the patient experience, meanwhile, is delivered and influenced by a range of individuals, including clinicians and the non-clinical workforce with whom the patient interacts.

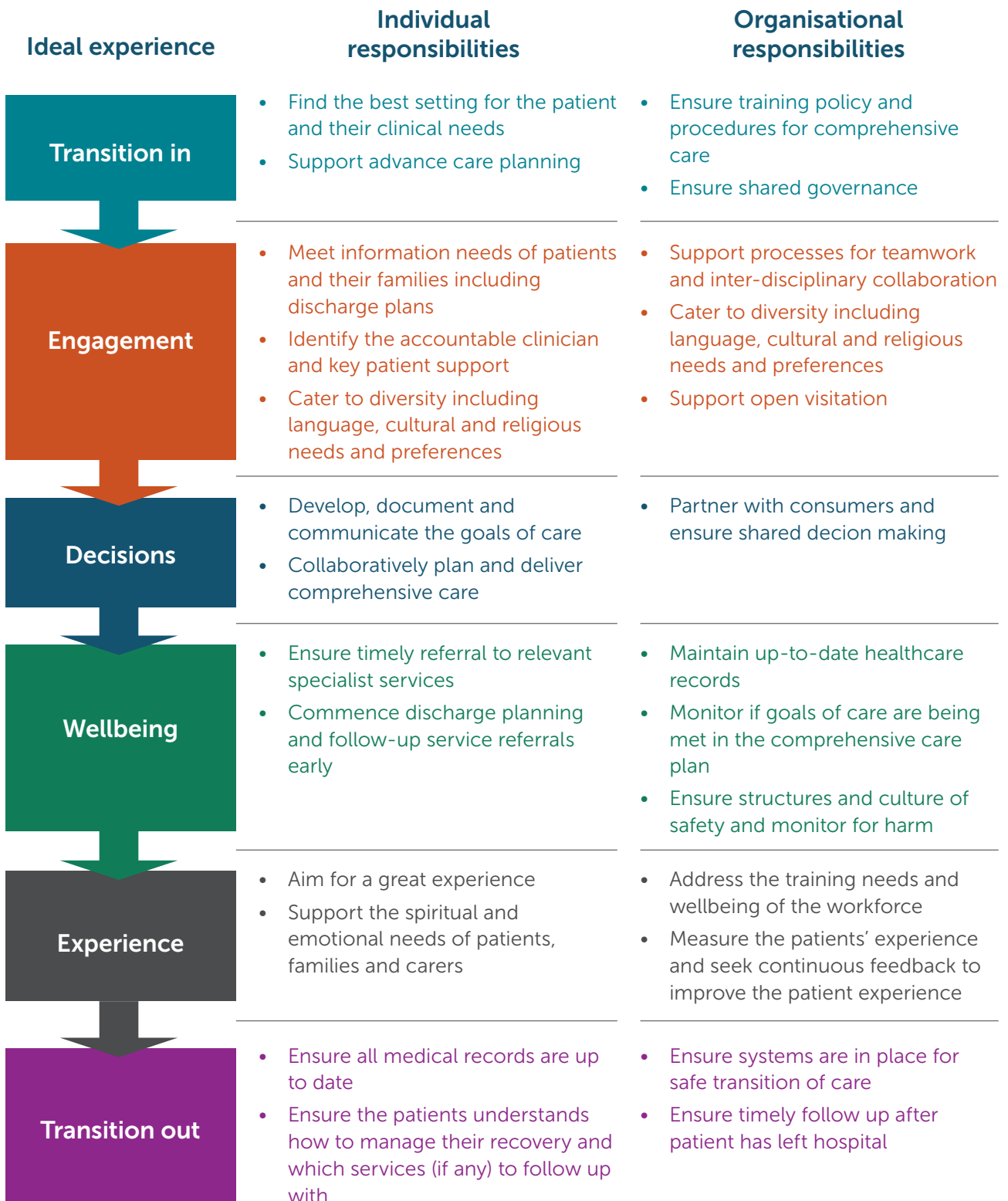
The element that most strongly influences a patient’s experience of the hospital and how well they were cared for is the interactions between individuals at any stage in their journey. Quality and safety outcomes of care are largely guided by structures and processes, but it is how they are implemented by individuals that determine the patient experience and outcome.

The following patient journey in **Figures 4a and 4b** articulates the ideal patient experience and identifies key elements that ensure the delivery of that ideal.

Figure 4a: The ideal person-centred patient journey



Figure 4b: The ideal person-centred patient journey



4 Key attributes of high-performing person-centred healthcare organisations

A number of attributes characterise a high-performing person-centred healthcare organisation. These attributes are manifested differently in every organisation depending on its operational context. While there is no set formula for achieving person-centredness, a strong common theme from the literature and case studies was that person-centred care is achieved through incremental change and requires a long-term commitment across all areas of an organisation.

The review identified seven attributes of person-centred care, which are outlined in **Figure 5**. These attributes are holistic, interrelated and connected. All are important to achieving person-centredness. There is no definitive hierarchy of attributes and the relative importance of each will differ between organisations. However, purpose, strategy and leadership; comprehensive care delivery; and people, capability and culture were consistently identified in the literature and case studies as especially vital to achieving person-centred care.

Each attribute is discussed in the following subsections. For each attribute, the review describes the key elements of the attribute and provides best-practice examples of how it has been applied based on the case studies and literature review.

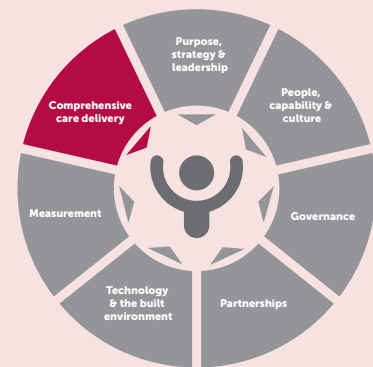
Figure 5: Seven attributes of high-performing person-centred healthcare organisations



4.1 Comprehensive care delivery

Comprehensive care delivery is based on person-centred values applied in every interaction with the patient, their carers and family. Care is comprehensively coordinated across the team and guided by the patient's goals and choices. There are four key elements of comprehensive care delivery:

- 4.1.1 Patients are engaged as partners in their care
- 4.1.2 Goals of care guide clinical decisions and the patient journey
- 4.1.3 Diversity and equity are respected and supported
- 4.1.4 Transparency is a core element of safety and quality care



4.1.1 Patients are engaged as partners in their care

Through effective communication an organisation lets patients and their families know that they are important partners in planning and decision-making about their care. Acknowledgement and integration of a patient's expertise about their situation, their priorities and desired health outcomes into care planning is seen as a hallmark of high-performing person-centred organisations and is frequently referred to in the literature. It is a key part of establishing a shared understanding and formulating goals of care with the patient and carer.

Shared decision making is a practical, core requirement of person-centred care. While it is a structural component of care, it requires a person-centred attitude and culture to be truly effective.

Examples of strategies to enable partnerships and shared decision making in care include:

1. Ensuing communication is effective, respectful and tailored to the patient
2. Asking 'What matters to you?'
3. Explaining care options and supporting patients to choose the best option for them
4. Supporting patients to participate in communications about their care, including through inclusive bedside handovers and communication boards.

"I am the expert in me!"

Patient,
Carolinas Medical
Centers – Mercy

1. Ensuing communication is effective, respectful and tailored to the patient

Members of the workforce across all levels of high-performing person-centred organisations identify the quality of communication within the organisation as a key enabler of high-quality care. This is represented in both formal and informal settings where the workforce at all levels exhibit empathy and respect for patients and families, and for co-workers. Core elements to support effective person-centred communication are outlined in **Box 1**.

Box 1: Core elements to support effective person-centred communication



- Every member of the workforce who comes in contact with the patient, family or carer is respectful, acknowledging the dignity of the patient, family and carer
- The clinical workforce is responsive to preferences, values and needs as defined by the patient, family and carers. All care providers are compassionate and caring, exhibiting empathy and respect in their interactions with patients
- Employment strategies identify workforce members with strong interpersonal skills and provide ongoing training and review, making person-centred behaviours actionable
- The workforce is given time to care, training to care and appropriate resource allocation and incentives to engage with patients.

Communication should be tailored to the needs, preferences and capabilities of the patient and their family. Providing useful information and supporting patients' health literacy are prerequisites for encouraging meaningful partnerships with patients and their families. Information and knowledge allows patients and their families to make informed decisions, navigate the system, and manage and share in their care – the essence of person-centred care.

Some examples of good practice include:

- Providing patients with access to their own medical records and information
- Ensuring easy to understand information is shared and readily accessible, utilising different formats and technologies
- Co-designing and producing information with consumers, and translating into the primary language of the patient.

2. Asking 'What matters to you?'

Asking the patient what matters to them shifts from a transactional condition-focused discussion, to a values-based interaction that clarifies what the patient is seeking to functionally achieve when they return to their day-to-day life. It allows clinicians to find out what is important to the patient, which is the crux of delivering person-centred care.

Case Study

Jönköping Healthcare Service, Region Jönköping County, Sweden



What matters rather than what is best

Jönköping has had a culture of constantly reflecting on 'What is best for Esther?' with Esther being their code for all patients. They have recently determined that asking 'what is best' is too deterministic and hierarchical. They are now asking 'What matters to Esther?'

3. Explaining care options and supporting patients to choose the best option for them

Effective shared decision making is reliant on clinicians taking the time to explain clearly and plainly to consumers the options that are available to them, including the risks and benefits of those options. Information provided needs to be unbiased and evidence-based, and discussions and decisions need to include considerations of the patient's values, needs and preferences.

“Person-centred care is about creating the conditions where a patient can be the expert in their own needs and care.”

Executive,
Riverland General Hospital

4. Supporting patients to participate in communications about their care

Patients and their families should be encouraged and supported to engage in communications about their care with clinicians. Two strategies that are commonly used by high-performing person-centred healthcare organisations to involve patients in communications about their care are known as inclusive bedside handovers and communication boards.

- **Inclusive bedside handovers** reflect the commonly used policy ‘Nothing about me without me’, meaning that no decisions or discussions of care can happen without the patient being present. For nursing handovers at shift change, it is an extension of the ward rounds approach, and ensures the patient and carer are included and have the opportunity to understand what is happening and contribute to the care team. Several consumer representatives raised concerns about privacy when the patient is in a shared ward during the site visits. The workforce needs to be sensitive of privacy concerns when they discuss a patient's care on the ward.
- **Communication boards** (which are identified by different names) can be electronic screens or whiteboards situated near the patient's bed. Depending on the setting, they will have different content but the same base level of information covering the patient's preferred name, the name of their clinician, the changing names of people who are providing daily care, the anticipated date of discharge, and appointment times. Patients and carers can contribute to the boards. This may include, but is not limited to, asking a question that they don't want forgotten or sharing something about themselves. Some systems have the capacity to provide families and carers with real-time information regarding the patient's progress through procedures or surgery.

4.1.2 Goals of care guide clinical decisions and the patient journey

The patient's goals of care should inform planning and decision-making about their care. High-performing person-centred organisations ensure that the goals of care direct the care provided.

In these organisations, goals of care are elicited, documented and communicated to the patient and carer, the care team, and external partners in care post-discharge. They remain front and centre to all team considerations for the delivery of patient care.

Goals of care are determined through effective communication and engagement with the patient and family, and include exploration of advance care plans and an understanding of ‘what matters’ to the patient. A shared understanding of goals of care supports clinicians to partner with patients, families and carers; align the care process to best address the health outcomes that matter to the patient; and engage the family and carers as integral members of the care team.

High-performing healthcare organisations ensure that the goals of care are reflected in healthcare processes and systems such as:

- **Medical records** identify the presence of an advance care plan and these are flagged in emergency departments and at admission
- **Discharge planning** begins early, ensuring the patient and carer are reassured about what to expect for the duration of their care and beyond
- **Food and room preferences** are facilitated.

Case Study

Kingston Health Sciences Centre, Ontario, Canada



An 'Interprofessional Collaborative Practice Model of Care'

Kingston General Hospital (part of Kingston Health Sciences Centre) has developed an 'Interprofessional Collaborative Practice Model of Care' which sets out a team approach to caring, with patients and their families as part of the team. The model was implemented over a three year period in inpatient units and ambulatory clinics.

An evaluation of the model and feedback found it contributed to improvements in improved patient satisfaction, quality of care and improved workforce and physician collaboration and job satisfaction.

The model has also resulted in improved communication and shared decision making, not just with patients and their families, but also among the different professionals involved in the patient's care. It has also contributed to a greater sense of equality among patients and families as they are involved in decisions that previously have been limited to healthcare providers.

4.1.3 Diversity and equity are respected and supported

High-performing healthcare organisations understand the different needs of diverse populations in the community and ensure these are documented and addressed appropriately. To deliver person-centred care, the organisation and its workforce need to understand, address and support the different attitudes, desires, characteristics and languages of the community's demographically and culturally diverse groups. The workforce needs resources and training to support them to tailor their communication and care delivery to different groups.

A sophisticated segmentation of patient populations, and a thoughtful workforce, also allows for patients who wish to be known for who they are, not what they are. This often requires the clinical and non-clinical workforce to provide cultural and multilingual support, including through the use of interpreters. Many moments in a day do not require an interpreter, and in these moments communication is facilitated by finding a member of the workforce who can comfortably engage with the patient and carer. However, this should in no way replace the formal engagement of an interpreter. Rather, it is a reflection of a culture where the assurance and comfort for the patient is paramount.

High-performing person-centred organisations also have a strong commitment to equity. This requires an understanding of the social determinants of health that impact on people in the community, as well as the barriers that stop some population groups from accessing health care.

Equity is particularly important for **Aboriginal and Torres Strait Islander populations**, who often report experiences of stigma and discrimination by health workers. It is important that organisations partner with local Aboriginal and Torres Strait Islander community representatives and ensure that their workforce have adequate training and resources to provide culturally appropriate care and address barriers in access to care.

Equity is also important for **people with disabilities**, who can have complex comorbidities and often make a high proportion of complaints regarding poor care and disrespectful communication. Healthcare organisations should have training and processes in place to ensure people with disabilities are:

- Treated with respect
- Empowered and supported to participate in shared decision making
- Provided appropriate and holistic care that takes into account any other disabilities or other health conditions that may impact on their health outcomes.

This ensures that they receive the same high standard of care as other patients.

Case Study

John Faulkner Private Hospital, Melbourne, Victoria



Cultural sensitivity

At John Faulkner Private Hospital, a consumer representative with an armed forces background is notified when a veteran has been admitted and appears to need someone to talk to.

In addition, multilingual cleaners and maintenance staff willingly assist with simple daily tasks such as translating meal selections. The patients are appreciative and the staff member is recognised for their contribution to person-centred care.

4.1.4 Transparency is a core element of safety and quality care

Transparency in the delivery of care is critical to ensure safety, quality and person-centredness. In high-performing person-centred healthcare organisations, the workforce and management are transparent and honest with patients about their care, even when things go wrong.

Transparency about care involves making sure patients and their families fully understand the options that are available to them and how their care is being delivered. This is achieved through effective communication about options, shared decision making and engaging patients and their families as partners, which are described above in Section 4.11 - patients are engaged as partners in their care.

Transparency also involves acknowledging mistakes and finding ways to rectify them. This can take many forms depending on the nature of the mistake. The patient should be fully informed of what has happened and why, and the organisation takes a person-centred approach to providing redress. This includes understanding what matters to the patient and what can be done to prevent the mistake for future patients. High-performing person-centred healthcare organisations recognise that **open disclosure** is a critical process to allow open discussion between healthcare professionals and patients and their families about mistakes that result in harm to the patient.

There is a nuanced aspect to a commitment to transparency when addressing a significant harm. Significant harms must be thoroughly investigated. The capacity of an organisation to identify the facts of a situation is reliant in the promise of **clinical confidentiality**. While patients and carers are invited into the investigation, key players are offered confidentiality in order to gain their insights into what went wrong and why.

Transparency of care requires that both complaints and compliments are acknowledged and addressed. It is important to acknowledge and share achievements and good practice, as well as being transparent about areas for improvement. Each can be described as follows:

- **Complaints** can be described as an ‘expression of grievance’ and ‘dispute within a healthcare setting.’¹⁹ Complaints often reflect a process or concrete element of care that has not met the patient’s expectations.
- **Compliments** can be described as an expression of praise for something that happens within a healthcare setting. Compliments often reflect a process or concrete element of care that has exceeded the patient’s expectations, such as an interpersonal engagement or a moment of courtesy and compassion.

High-performing person-centred organisations have processes for responding to all complaints and compliments in a timely manner, some of which are described in **Box 2**.

Box 2: Managing complaints and compliments



- There is a culture of review and reflection on complaints and compliments
- Boards receive specific examples and summaries of complaints and compliments
- The workforce reflect on complaints and compliments, and use them to improve their approach to patient care and celebrate what they do well
- Consumers are involved, and seen to be involved, in co-designing responses to identified issues.

Case Study

John Faulkner Private Hospital, Melbourne, Victoria



Embracing complaints

The wards pay attention to patient compliments and complaints. The workforce has learnt to see patient feedback as a learning opportunity. Feedback is shared openly; they turn complaints into an improvement for the next patient and avoid a culture of blame.

Celebrating compliments

The clinical and non-clinical workforce is sensitive to patient needs. They are often mentioned by patients in written compliments. There are monthly awards, voted by patients, which have been won by members of the clinical workforce and cleaners.

4.2 Clear purpose, strategy and leadership

Clear, strong direction from the top of the organisation is essential for the delivery of exceptional person-centred care. There are three key elements that define a high-performing person-centred organisation's purpose, strategy and leadership:

- 4.2.1 A commitment to exceptional person-centred care is clearly stated in the organisation's purpose and strategy
- 4.2.2 Great leadership drives exceptional person-centred care, with the support of champions across the organisation
- 4.2.3 A person-centred strategy is formulated, articulated and implemented



4.2.1 A commitment to exceptional person-centred care clearly stated in the organisation's purpose and strategy

For many high-performing health services, their organisation's primary reason-for-being is centred on delivering exceptional person-centred care. High-performing person-centred organisations have a clear, simple message that unifies the organisation to a common cause. Their commitment to exceptional person-centred care starts in the organisation's purpose and vision, written in language that is easy to understand and relatable to patients, families, the workforce and the broader community.^{20, 21}

Everyone in the organisation is aligned to the purpose of working to facilitate exceptional person-centred care. They are recruited and trained around a set of shared values and goals that embrace person-centred principles.

Some organisations ascribe an aspirational vision, such as 'moving from healthcare, to health and wellbeing'. This inspires a strategic direction to not only provide immediate care, but also to facilitate and protect life-long person-centred healthcare for their community.

Case Study

Western Health Local Health Network, Melbourne, Victoria



Best Care: A clear and simple strategic direction

Western Health has developed a 'Best Care' framework, which provides a clear strategic direction for the whole health service. It explains how person-centred care is embedded in every aspect of the organisation. The framework was co-designed with patient and community representatives. Western Health has focused on keeping the framework simple, short and clear. It is written so that everyone can understand it, including patients and the community.

The executive team at Western Health were wary of making person-centred care overly bureaucratic and complicated. Instead, they aim on delivering a clear and focused message to their frontline workforce about what they need to do to deliver person-centred care using the Best Care framework.

4.2.2 Great leadership drives exceptional person-centred care, with the support of champions across the organisation

Leaders are critical to creating a change in organisational culture. For sustained cultural change there needs to be a long-term commitment to the shared values and goals of person-centred care from the whole organisation, along with the structures that support the delivery and culture of person-centred care.

Leaders play a critical role in driving performance, with managers accounting for up to 70 per cent of variance in employee engagement.²²

Good leadership encourages a culture of workforce ownership and responsibility for providing great person-centred care. Organisations that manage their culture effectively outperform similar organisations that do not.²³ The importance of organisational culture to person-centred care is discussed further in Section 4.3 - people, capability and person-centred culture.

Leaders of high-performing patient-centred organisations exemplify the approach that everyone in the organisation should take. They set the vision and model the behaviour.

“The culture of a company is the behaviour of its leaders. Leaders get the behaviour they exhibit and tolerate. You can change the culture of a company by changing the behaviour of its leaders.”

Larry Bassidy,
Former CEO, Honeywell

There are two key leadership behaviours found in high-performing person-centred healthcare organisations:

1. **Leading by example:** being regularly present at all levels of the organisation and setting the cultural tone
2. **Decisions and resource allocation** by leaders signal their level of commitment to support person-centred care to be successful and sustainable.

While leadership is absolutely necessary at the top of the organisation, leadership can be practised anywhere. Champions of person-centred care are needed throughout an organisation. In high-performing person-centred organisations, the executive and Board are seen as champions of person-centred care. Champions can also be individuals or teams, appointed to guide the implementation of person-centred care activities across administrative, research, and clinical areas. Of particular importance is the role of doctor and nurse champions to lead, advocate and exemplify person-centred care to their peers.^{24, 25}

Case Study

Carolinas Medical Centers – Mercy, North Carolina, the United States



Physician and nurse champions ‘talk the talk and walk the walk’

At Carolinas Medical Center, physician and nurse champions have played a critical role in promoting person-centred care throughout the organisation. They not only promote this culture among their workforce, but practice person-centred care delivery when they care for patients (i.e. they not only talk the talk, they walk the walk). A physician and nurse champion have been important components to building buy-in, particularly in 2008 as Mercy began to design and implement its person-centred care program.

4.2.3 A person-centred strategy is formulated, articulated and implemented

High-performing person-centred organisations have a clearly articulated strategy describing how they will ensure the care they deliver is person-centred. This strategy is communicated across the organisation and to consumers by:

- Explicitly including the strategy in organisational documents and processes, such as business plans, key performance indicators, individual performance plans, clinical guidelines and public communications materials
- Communicating and modelling by leaders, managers and champions, so that all members of the workforce know the person-centred purpose, vision and strategy, and understand what they need to do to implement it.

Some organisations identify a goal of investment in their workforce, acknowledging that the experience of their workforce determines the experience of their patients. A caring and compassionate person-centred culture starts with the workforce, and is essential for delivering high-quality person-centred care. Organisational culture is discussed further in Section 4.3 - people, capability and person-centred culture.

There are a number of components within the development and implementation of a comprehensive person-centred strategy:

- **Person-centred care is stated in the strategic direction**
It is a way of doing business, not a project or an add-on. It is identifiable in work plans for departments, units and individuals
- **Person-centred care is communicated by the Board**
The Board set the cultural tone with dedicated time for patient stories, and quality and safety²¹
- **Shared governance is embedded**
Patients, families and consumers are represented on committees throughout the organisation^{20, 21, 25, 26}
- **A right attitude is built into the workforce**
Recruiting practices align with person-centred care values. Workforce recognition is tied to person-centred care. Poor behaviour at any level of the organisation is not tolerated^{20, 21, 25, 27}
- **Practice is benchmarked against other organisations**
Person-centred care has developed differently in different fields – high-performing healthcare organisations strive to learn from each other and from other sectors
- **Accreditation is sought**
Accreditation of person-centred care practice is emerging as a lever to drive improvement and maturity of practice
- **Leaders communicate the outcomes of delivering person-centred care**
These can include:
 - changes in culture such as workforce retention, workforce satisfaction and reduced stress
 - improvements in care such as better alignment between patient goals and care goals, improved safety and reduced readmissions
 - lower health costs associated with more appropriate spending, improved efficiency and appropriate length of stay.²⁰

Case Study

Carolinas Medical Centers – Mercy, North Carolina, the United States



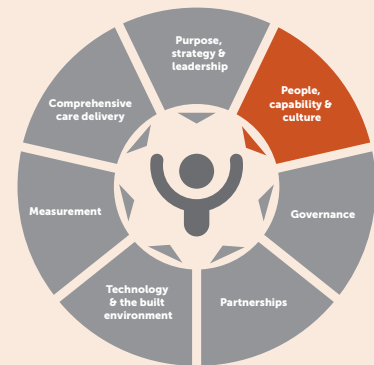
Planetree designation for person-centred care

In 2008, Mercy leadership decided to seek Planetree Person-Centred Care designation. This designation represents the highest level of achievement in person-centred care based on evidence and standards. The program provides a structured, operational framework for evaluating the organisational systems and processes necessary to sustain organisational culture change. Through a set of experience-based and evidence-based criteria, the program converts the aspirational aim of becoming more 'patient-centred' into something that is defined, attainable and measurable.²⁵

4.3 People, capability and a person-centred culture

An organisation's people and culture are among the most important areas for ensuring person-centred care. This section discusses three elements associated with people, capability and person-centred culture:

- 4.3.1 An organisational culture for person-centred care is built and maintained through a long-term, systematic approach
- 4.3.2 The capabilities of all members of the workforce are continually developed through formal and informal learning
- 4.3.3 The organisation regularly monitors and is dedicated to supporting workforce satisfaction and wellbeing



4.3.1 An organisational culture for person-centred care is built and maintained through a long-term, systematic approach

Organisational culture is consistently identified in the literature as a critical attribute for achieving person-centredness. Culture is a broad concept. The United States Department of Veterans Affairs provides a definition that is useful in the health care context as it captures the influence of culture across all functions of a healthcare organisation:

Organisational culture is a set of values, expectations, formal and informal practices, and behaviours that define the unique corporate environment. Culture is deeply ingrained in the fabric of organisational life; it determines how the organisation conducts its business, treats its employees, evaluates its leaders, serves its customers, and handles productivity and performance.²⁸

An organisation's culture is a good predictor of the extent to which the organisation is person-centred. According to Harding et al, 'peer behaviours and workplace culture are major factors to move from aspiration to established practice.' In order to achieve person-centred care, an organisation must actively seek and grow a person-centred culture.²⁹

There are a number of characteristics of a person-centred culture that emerged from the literature and case studies (see **Table 3**). A person-centred culture impacts on the way in which employees relate to each other and consumers. It includes the shared mindsets and behaviours that set the expectation about what is important and valued in the organisation.

Table 3: Characteristics of a person-centred culture^{24, 25, 29-31}

Understanding of and respect for patients' needs and preferences among the workforce and leaders
Strong workforce capabilities to deliver person-centred care
Systematic and informal accountabilities, rewards and incentives for person-centred care
Support and openness to change, learning and continual improvement
Commitment to professional values and ethics
Open and respectful interaction, teamwork and collaboration between the workforce, including between leaders and the workforce
Sensitivity to non-medical and spiritual dimensions of care
Respect for equity and diversity among the workforce and among patients and the community

Building a person-centred culture requires a long-term, systematic approach. Culture change is generally achieved through incremental change over a number of years, with consistent commitment and effort from leaders and the workforce.

There are a number of strategies for achieving culture change which need to be applied over a long time-period:

- **Leaders, managers and champions** in the organisation should drive and model a person-centred culture and associated behaviours, such as respect, initiative, teamwork and empathy³²
- The organisational culture must be clearly and regularly **communicated to the workforce and articulated in organisational documents**, including through strategies, work plans, policies, procedures, clinical guidelines, signage and face-to-face interactions between members of the workforce, managers and leaders^{24, 25}
- **Workforce processes**, including recruitment practices and on boarding programs should prioritise person-centred attributes and ensure new and existing members of the workforce and leaders embody a person-centred culture. Personal attributes that are strongly correlated to person-centred care include initiative, teamwork, empathy, courtesy and communication.³¹

Case Study

John Fawkner Private Hospital, Melbourne, Victoria



A strong culture that cares for patients as part of the family

John Fawkner Private Hospital is widely recognised for its strong organisational culture by its workforce and community members alike. Members of the hospital's workforce treat each other and their patients as though they were part of the family and are friendly, compassionate and respectful. A strong element of the hospital's culture is teamwork. The workforce enthusiastically helps and supports each other, and they work as a team to care for patients. The hospital's leaders and its workforce have worked hard to maintain this culture during periods of growth and change, such as recent upgrades to its buildings and technology.

4.3.2 The capabilities of all workforce members are continually developed through formal and informal learning

Person-centred care requires a range of skills and personal attributes. While some relate to inherent personal qualities (such as interpersonal skills), all can be learnt and encouraged in formal and informal learning. Key skills and personal attributes that emerged from the literature and case studies are presented in **Table 4**.

Table 4: Person-centred skills and personal attributes^{29, 33}

Person-centred skills	Person-centred personal attributes
<ul style="list-style-type: none"> • Clinical and technical competence (i.e. the skills required to conduct the job) • Interpersonal • Communication • Shared decision making • Teamwork • Cultural competence 	<ul style="list-style-type: none"> • Empathy and compassion • Respectfulness • Authenticity • Self-awareness • Commitment to patient care • Commitment to personal development • Strong professional values



Note: This table has been adapted from the Australian College of Nursing’s Person Centred Care Position Statement, with further attributes added from the literature.

International evidence suggests that the effectiveness of person-centred education in medical and nursing degrees and other education programs can be poor and lead to gaps in the capabilities of the health workforce to deliver person-centred care. This was reiterated by some interviewees in the site visits conducted for this review. Capability gaps identified in Lévesque et al and Harding et al include communication skills, shared decision making and empathy.^{29, 34} There has been an increasing push from education institutions in Australia and overseas to increase the focus on person-centredness in curriculums and teaching, however, this is yet to translate in a systematic way to new generations of the healthcare workforce.^{29, 34}

It is critical that healthcare organisations provide regular learning opportunities for all members of the workforce to progressively develop their capabilities to deliver person-centred care. High-performing healthcare organisations foster a culture of learning through formal education programs and informal learning opportunities.²¹

Examples of initiatives to build workforce capabilities are outlined in **Table 5**.

Table 5: Formal and informal education initiatives

 Formal education programs and courses	 Semiformal and informal learning opportunities
<ul style="list-style-type: none"> • Internal and external training programs, including on: <ul style="list-style-type: none"> - person-centred values - communication skills - shared decision making - customer service - leadership skills - cultural competency • Team training programs, in which multi-disciplinary teams of clinicians and other workforce members participate in training together to build the capacity of the whole team • Support for the workforce to enrol in relevant accredited university and vocational education courses • Support for the workforce to seek further training and qualifications 	<ul style="list-style-type: none"> • Coaching, mentoring and buddying relationships between members of the workforce • Clinical supervision of healthcare professionals, with a focus on person-centred healthcare delivery • Grand rounds and other walk-arounds by the clinical and non-clinical workforce, including leaders and managers, to take them through the patient experience • Patient feedback reviewed by the workforce and used to tailor professional development for individuals and teams • Use of patients to educate the workforce on how they experience treatment, effective communication and how to provide care that meets their needs and preferences

Case Study

Jönköping Healthcare Service, Region Jönköping County, Sweden



Esther the virtual patient and real-life educator

Jönköping Healthcare Service has developed a virtual patient called Esther to improve organisational processes and educate the workforce about the needs and preferences of patients. Esther is a fictional older woman with a chronic condition and occasional acute needs.

By following Esther’s patient journey, Jönköping has been able to better educate the workforce and substantially improve practices and processes. During the initial three-year Esther project, there was a significant reduction in hospital admissions, waiting times for referral appointments and hospital days for certain conditions.

4.3.3 The organisation regularly monitors workforce satisfaction and is dedicated to supporting the wellbeing of its workforce

Maintaining high levels of workforce satisfaction and wellbeing is increasingly recognised as critical for person-centred care. Various studies have found that organisations with high levels of workforce satisfaction have higher levels of patient satisfaction, as well as better clinical outcomes and lower mortality^{27,35,36}. Cornwell notes that in annual workforce surveys of the United Kingdom National Health Service (NHS), hospitals that performed well also performed well in patient surveys. Conversely, low workforce satisfaction has been associated with low patient satisfaction.²⁷

“Staff who are well and resilient can provide better patient-centred care”
Executive staff,
Sydney Local Health District

Workforce wellbeing is particularly important in the healthcare context. Research shows that clinicians experience higher levels of physical and mental health issues, stress and burnout than other professions. This is compounded by safety concerns. For example, in the 2016 NHS staff survey, it was found that 15% of the staff reported they had experienced physical violence from patients, relatives or members of the public in the previous 12 months. Lack of workforce wellbeing is often manifested in absenteeism, high workforce turnover and lower-quality care.^{27, 37}

High-performing person-centred organisations look beyond workforce satisfaction and focus on supporting the overall wellbeing and morale of its workforce. Cornwell lists seven variables that determine the workforce wellbeing. These are presented in **Figure 6**.

Figure 6: Variables of workforce wellbeing²⁷

1 Local work group climate	2 Co-worker support	3 Organisational climate	4 Job satisfaction	5 Perceived organisational support	6 Low emotional exhaustion	7 Supervisor support
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Ensuring workforce wellbeing requires a commitment from senior leaders and managers, and recognition of the impact of workforce wellbeing on care for patients. There are a number of attributes that contribute to workforce wellbeing that emerge from the literature (see **Box 3**).

Box 3: Attributes associated with workforce wellbeing^{27, 38}



- Senior leaders are known to frontline caregivers and engage with them
- The workforce are involved in the design of organisational processes and decision making
- Teamwork is valued and nurtured
- There are well-structured systems for appraisal and performance review
- The workforce are offered support for personal and career development
- Line managers are trained in people management
- The workforce are provided time and space to reflect

High-performing person-centred organisations regularly monitor the satisfaction and overall wellbeing of their workforce. This enables them to identify instances of low wellbeing and implement changes to rectify them. This is particularly important when trends emerge and when a large group of the workforce is affected by the same issue. Workforce wellbeing can be monitored and measured in a number of ways, including:

- Organisation-wide workforce surveys
- Analysis of data on absenteeism, workforce turnover and other workforce data
- Analysis of workforce complaints, exit interviews and other forms of feedback
- Regular formal and informal check-in meetings between managers and members of their workforce.

Case Study

Carolinas Medical Centers–Mercy, North Carolina, the United States

**Schwartz Rounds – a safe place for health workers to discuss their work**

Carolinas Medical Centers–Mercy places a significant emphasis on supporting the emotional wellbeing of its workforce. The hospital holds Schwartz Rounds for all members of the workforce, regardless of role at the hospital. Schwartz Rounds are designed for healthcare professionals as a means to help them openly and honestly talk about issues that they encounter in their work day. With the increasing demand in health care to do more, faster, with fewer resources, healthcare professionals are experiencing increasing rates of stress, anxiety, and frustration. Schwartz Rounds create a safe environment where healthcare professionals can engage in interdisciplinary discussions about their experiences. The objective is to help the professional better understand his or her own responses and feelings, so that he or she is better prepared to connect with patients.

Case Study

Sydney Local Health District, New South Wales

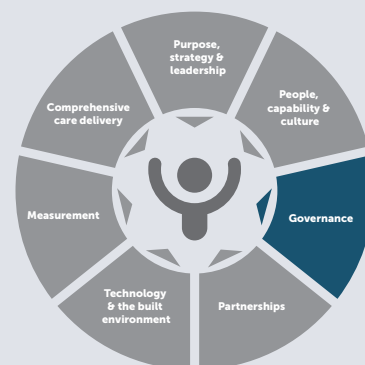
**Meditation and wellbeing programs for its workforce**

Sydney Local Health District has a strong commitment to ensuring the wellbeing of its workforce, particularly for nurses and midwives, who make up almost half of the 11,000 workforce members at the health service. The district offers a number of meditation and wellbeing programs for its nurses and midwives, and encourages managers and its workforce to look after their physical, emotional and mental health.

4.4 Person-centred governance systems

High-performing organisations partner with patients, families and consumers, applying and embedding a person-centred perspective to their systems and processes at all levels of the organisation. The following elements of governance are detailed in this section:

- 4.4.1 Consumers and the community are involved in governance at all levels
- 4.4.2 Consumers are trained and supported to meaningfully contribute
- 4.4.3 Organisational structures and models of care are designed around the person
- 4.4.4 There are clear accountabilities at all levels – from the Board to the clinician
- 4.4.5 Financial, strategic and operational decisions and processes are person-centred



4.4.1 Consumers and the community are involved in governance at all levels

Partnering with patients, families and consumers in the planning, design, implementation and evaluation of services is a core enabler of person-centred care. In high-performing person-centred healthcare organisations, patients, families and consumers are integrated as active partners in governance at multiple levels throughout the organisation.²¹

- At an organisational level, consumers contribute to governance, policies and planning.
- At a department and program level, consumers are partners in the planning of programs, services and their environments, contributing to the design, implementation and subsequent evaluation.

Person-centred governance at the organisational level

In high-performing person-centred organisations, boards and management lead by example, practising and promoting a person-centred perspective. They explicitly identify person-centred care principles in their strategic statements, in their personal and group behaviours, and in their meeting practices. They ensure governance systems embrace a person-centred approach and that resources are allocated to sustaining person-centred care principles and practices.

In high-performing person-centred organisations, clinical governance and quality and safety processes include partnerships with patients, families and consumers as part of the way their systems and processes operate. This includes several key components:

- Meaningful governance roles for consumers
- Addressing and co-designing for issues arising from complaints
- Partnering in investigations when looking at adverse events or mistakes.

Boards are required to consider person-centred outcome and experience measures equitably alongside financial performance, and make decisions on resource allocation that can encourage person-centred care.

Case Study

Sea Mar Community Health Centers, Washington State, United States

**51% patient representation on the Board of Directors**

Sea Mar was founded in 1978 by a group of Latino community leaders. This connection to the community has not been lost over time but has strengthened and incorporated more communities and cultures. Sea Mar works in partnership with communities to identify needs and find creative ways to address those needs. Emblematic of their commitment is Sea Mar's Board of Directors being comprised of 51% patient representation. This helps assure that the patient experience is always front and centre in governance.

Person-centred governance at the department and program level

High-performing person-centred organisations also involve consumers in the departmental and program levels of the organisation to plan, design and evaluate the implementation of healthcare services. Their involvement helps ensure these services support respectful and compassionate patient-clinician interactions, shared decision making and goals of care, and promote self-care and management to the degree that is chosen by the patient.²⁵ Their involvement includes activities such as:

- Consumers on interview panels
- Developing patient information, forms and health literacy information
- Surveying patients, and measuring and evaluating service performance
- Planning and designing services and the environment for their delivery
- Developing workforce training modules and sharing patient stories.

At a service level, the clinical and non-clinical workforce in high-performing organisations expect to have a consumer on their committees, recognising the contribution delivered by patients, families and consumers via committee involvement. Organisations with strong consumer representation through, and across, all levels of governance, have a workforce that has an enhanced understanding of, and respect for, their responsibility to patients, families and carers.

4.4.2 Consumers are trained and supported to meaningfully contribute

High-performing person-centred organisations recognise it is not enough to just include a consumer in a committee. Consumers must be engaged in a meaningful way in governance decision-making processes.²⁵ Quality recruitment, education and ongoing support are essential for consumers to be able to meaningfully contribute and for the workforce to embrace the processes involved when partnering with consumer representatives.

High-performing organisations respect and value the role of the consumer representative and ensure they have instituted quality recruitment processes. These are professionally run, identifying the individual's skills and perspective, and where they can most effectively contribute to the organisation. They seek representation from the full spectrum of the community they serve.

Consumer representatives are provided with professional orientation, training and ongoing support regarding their role within the organisation, which includes:

- Governance and decision-making roles
- Organisational issues as relevant
- Co-design and evaluation processes.

Critically, the consumer perspective is incorporated into workforce training, and includes how to recognise, engage and support partnerships with patients, families and consumers in the governance and design of the organisation.

Case Study

Riverland General Hospital, Country Health South Australia



Training consumer advocates

Riverland General Hospital and Country Health South Australia more broadly provide training, mentoring and other support for consumers on governance committees.

They recently partnered with the Consumer Alliance to deliver professional training for patients and community representatives on consumer advocacy. The aim is to enhance the capabilities of consumers to represent their community and contribute to improvements in their local health service.

They have also actively recruited Aboriginal consumer representatives, to increase input from local Aboriginal communities in the design and running of the health services.

4.4.3 Organisational structures and models of care are designed around the person

In high-performing organisations, all teams in the organisational structure have clear responsibilities for person-centred care, from clinical leads to security and corporate services.

Where possible, healthcare units and wards provide integrated care that is organised around the patient and their goals of care, rather than being driven by the medical discipline.²⁶ This is becoming increasingly necessary for patients with complex co-morbidities. A common enabler of integrated care is the use of multidisciplinary teams that are organised around the patient. Team members work collaboratively to achieve the goals of the patient.

Patients contribute to the design, delivery and evaluation of the models of care. Those who are the users of the space are engaged from the beginning in identifying the needs and priorities for its future design. Involvement of patients and families in service design not only operates to improve their experience, but helps to remove unnecessary steps and improve efficiency.²⁶

Consumers co-design, co-produce and user-test patient information to ensure patients are provided with information they actually need, not what clinicians consider they need. Information for patients, that they can comprehend and addresses their concerns, improves clinical effectiveness, safety and the patient experience.²⁶

Case Study

Western Health Local Health Network, Melbourne, Victoria

**Innovative methodologies to co-design services with consumers**

Western Health has utilised co-design methodologies to design several services and processes with consumers and the local community. The health service has also commissioned a co-design expert to provide training and ongoing mentoring to its workforce on how to use and implement co-design methodologies. A key methodology has been experience-based co-design, which draws on the lived experiences of patients and their families.

The health service recently conducted pilots to co-design a range of quality improvement projects, including:

- A peer support program with intensive care unit survivors
- A new model of integrated care in the community called Health Links
- Planning for a new women's and children's hospital.

4.4.4 There are clear accountabilities at all levels – from the Board to the clinician

In high-performing organisations, accountability for person-centred care is linked to the roles and responsibilities of everyone in the organisation, from the board through to the clinical and non-clinical frontline workforce. Person-centred care should be embedded in the quality framework of the organisation and included in the board strategy. To support this, board scorecards and dashboards should typically include patient experience metrics for review as a key performance indicator.²¹

Executive sponsorship is a key driver for success and sends a clear message to the organisation about commitment to this approach.^{24, 39} In addition, an individual (or team) could be appointed to guide implementation of activities that advance organisational progress toward person-centred care goals. This individual (or team) functions as, or reports directly to, a senior executive in the organisation.²⁵

“...if you want to have better care, you have to have people accountable for it. It's not rocket science – it's just basic management”

Healthcare organisation CEO,
(Cited in Luxford et al, 2015)

Individual position descriptions and performance review processes (including performance management, and reward and recognition) should include accountability for delivery (or enabling delivery of) person-centred care.^{25, 40} This should explicitly state what the role is, and hence what the individual is accountable for – this will differ by role, but will be linked. This applies to both clinical and non-clinical roles. In some organisations, patient feedback is incorporated with other employment metrics and linked to remuneration.²¹

Case Study

Sydney Local Health District, New South Wales



Members of the workforce at all levels are clear on expectations and accountabilities

At Sydney Local Health District, the CEO takes the time to meet with all members of the workforce (including engineers, security, cleaning) to ensure they understand how integral they are to patient and family centred care. It is important that members of the workforce at every level understand their accountabilities, and that this is appropriately managed. This includes having difficult performance discussions when needed and ensuring that the workforce is supported to learn and do better.

4.4.5 Financial, strategic and operational decisions and processes are person-centred

In high-performing person-centred organisations, one of the key considerations in financial decision-making is the influence of decisions on patients and the patient experience. Management decisions on budgets and resource allocation are informed by an assessment of their impact on the patient and carer experience. Investments that benefit the patient and carer experience are made alongside those that drive better clinical outcomes and organisational efficiency.

Organisations acknowledge the long-term benefit of supporting person-centred care principles over short-term efficiencies and outputs. Technical cost-efficiency in hospital processes can come at the expense of choice, flexibility and patient experience. Acceptance of the additional resource requirements, to allow for flexibility and tailoring care to the individual, seeks to achieve both better experiences and more cost-effective outcomes.

Strategic and operational decision making considers patient experience

In every decision about the health service, the patient experience is considered. Improved clinical outcomes and organisational efficiency is assessed against the effect on the patient experience. Strategic decisions are focused on embedding person-centred care across the organisation. Operational decisions consider how actions and processes impact the patient experience.

Organisational processes are co-designed and consider patient experience

Patients, families and consumers contribute to the design, implementation and evaluation of operational processes.²⁶ This includes human resources and workforce training, administration, communications, quality and safety, facility management, security, catering and research.

Representatives and experience is drawn from the full spectrum of patients and families, and appropriate education and training is provided to ensure meaningful and integrated processes.

Case Study

Sydney Local Health District, New South Wales



Starting meetings with a patient story and putting quality and safety first on the agenda (and not finance)

At Sydney Local Health District, Board, committee and operational meetings generally start with a story from a patient. This encourages operational managers to stay connected with the patient experience in the remainder of the meeting. These meetings also usually put quality and safety first on the agenda, ahead of finance. This means more time is spent on strategic discussions about improving healthcare delivery and less time is spent on financial and administrative issues.

Case Study

Kingston Health Sciences Centre, Ontario, Canada



Engaging the workforce in supporting patient and family centred care

Hotel Dieu Hospital (part of Kingston Health Sciences Centre) created its Patient and Family-Centred Care Grant, which is small grant available annually that targets enhancing patient and family centred care at Hotel Dieu Hospital. These can support any number of one-time projects or initiatives such as refreshing spaces, adding artwork, supporting educational materials and more.

Hotel Dieu staff can apply for the grant for projects that enhance dignity and respect for patients and families, information sharing with patients and families, participation of patients and families in care and decision-making or collaboration between patients, families and care providers. A maximum of \$2,000 total per year is available. In each grant cycle up to \$1,000 is awarded, which may consist of several smaller grants or one larger grant. Applications are reviewed by a group of no fewer than three Patient Experience Advisors with the final decision about whether and what to grant made by this group.

4.5 Strong external partnerships

High-performing organisations recognise the need for close connections within and across health care settings and other sectors. Partnerships with other service providers are critical to coordinate services around the needs and preferences of individuals, and to ensure person-centredness. This section discusses four elements associated with partnerships:

- 4.5.1 Healthcare organisations have a comprehensive network of service partners and relationships
- 4.5.2 There is a focus on seamless transitions and coordination of care
- 4.5.3 Healthcare organisations operate as leaders in system improvement
- 4.5.4 Community volunteers are recognised and supported as critical partners in enhancing the patient experience
- 4.4.5 Financial, strategic and operational decisions and processes are person-centred



4.5.1 Healthcare organisations have a comprehensive network of service partners and relationships

Person-centred service delivery should be coordinated around the needs and preferences of the patient.² This requires partnerships of healthcare providers within and across health care settings; development of referral systems and networks among levels of care; and also broader linkages between health and other sectors. High-performing person-centred healthcare organisations value and foster these partnerships.

Broader linkages across the community provide the mechanism for change at the population health level. For instance, high-performing organisations may partner with other community organisations (such as housing authorities, religious institutions, law enforcement, schools, social services) to address social determinants that may impact individuals' access to care, health and wellbeing. The local community should play a critical role in driving and supporting these inter-sectoral linkages, and optimising local use of resources.

Case Study

Jönköping Healthcare Service, Region Jönköping County, Sweden

**A population-based regional approach to service planning and delivery**

Region Jönköping County has a population-based vision for its citizens of 'a good life in an attractive city'. To deliver this vision it has taken a broad population-level approach to planning and delivering services across the region. The County uses whole of region surveys to collect population-level data to segment and respond to the needs of different population groups. Professionals from different sectors are brought together to design and implement new approaches to improving people's health across each of these groups. The Executive Director of Kultorum, responsible for quality improvement across the region, sits on executive and planning committees with regional executives from health and other sectors.

Case Study

Sea Mar Community Health Centers, Washington State, the United States

**Responding to underpinning community needs – three examples**

1. **Affordable Housing:** Understanding the 'housing first' principle, Sea Mar has responded to the affordable housing crisis in parts of Washington State by developing affordable housing in three of the communities it serves. Through its work with patients and its deep involvement with communities, Sea Mar determined that the best way to help the population was to develop affordable housing. Through a unique public-private partnership, Sea Mar has developed affordable housing communities in three locations in the State of Washington.
2. **Intergenerational programs:** The community needed affordable child care and also a safe, culturally sensitive nursing home. Sea Mar responded by opening the Sea Mar's Child Development Center and the Community Care Center, and then implementing the intergenerational program so that the seniors of the community interact with the children of the community.
3. **Integrating mental health:** Sea Mar has a partnership with the Community Health Plan of Washington (CHPW), a payer within the Medicaid program, called the Mental Health Integration Program (MHIP). Through MHIP, CHPW partners with Sea Mar to pay for a behavioural health clinician who serves as a care coordinator. Through this program, Sea Mar has a behavioural health clinician embedded in a primary care setting. This allows a primary care provider to make a real-time referral to a behavioural health clinician while a patient is at the primary care clinic to begin an assessment of behavioural health needs and develop a care plan that incorporates both primary care and behavioural health. CHPW provides Sea Mar with MHITS, an electronic medical record where assessments and care plans are developed and monitored. This program is a value-based care arrangement, as care coordinator performance is monitored against specific performance metrics and payment to Sea Mar for the care coordinator is adjusted according to this payment.

4.5.2 There is a focus on seamless transitions and coordination of care

Coordination of care is not a single activity. It needs to be considered as a range of strategies that can help to improve continuity of care and enhance the patient's experience. Examples of strategies to improve continuity and coordination of care include:

- Care pathways
- Referral pathways
- Health navigators
- Case management
- Team-based care
- Improved information flows.

The focus for improvement is on the delivery of care to the individual, with services coordinated around their needs and those of their families.²

Coordination does not necessarily require the merging of different structures, services or workflows. Instead the focus is on improving the delivery of care through the alignment and harmonising of the processes and information among the different services.²

Case Study

Sea Mar Community Health Centers, Washington State, the United States



Intentional patient workflows

Sea Mar has spent the last three years developing a synchronised patient flow that is standardised across the multiple care sites that Sea Mar has. This allows for patients to be seen quickly (which is a priority of patients), but also to receive comprehensive care (they are seen for all of their care needs, not just the one they came to the clinic for that day). Sea Mar also has introduced many ancillary services into their clinics (labs, X-rays, pharmacy) so that the clinic becomes a one-stop shop for patients.

4.5.3 Healthcare organisations operate as leaders in system improvement

High-performing person-centred healthcare organisations can act as leaders in system improvement. Healthcare organisations can be the larger partner in collaborative improvement efforts and so can act as a co-ordinator or facilitator of inter-sectoral collaborations, and deliver support and training to community organisations. Healthcare organisations can also provide the 'meeting place' (either within or outside of the service) to foster these relationships.

Healthcare organisations also contribute to health system improvement through research, education and innovation. This includes in teaching person-centred skills and knowledge to new generations of healthcare workers. Person-centred healthcare organisations often contribute to research and innovations in person-centred care, and the development of best practice. This can inform improvements in other healthcare organisations and across the whole system.

Case Study

Jönköping Healthcare Service, Region Jönköping County, Sweden



Qulturum is the heart of improvement and development work in Jönköping

Qulturum strives to be a leading meeting place for innovative thinking, creative collaboration, method development and skills development. The centre is a free resource that offers help and support in the work of changing systems. It is a meeting place for anyone who wants to participate in and develop and improve Swedish health care. There are open working spaces that are available for anyone to use, have conversations and develop relationships, and the house is known as the place to go to share lessons, hold conferences and events and learn about latest practice. The space is well utilised. For example, the Improvement Director of Medical Services chooses not to have an office in the main hospital and rather deliberately uses the Qulturum space when needed to ensure continuing exposure to new and system level ideas and thinking.

4.5.4 Community volunteers are recognised and supported as critical partners in enhancing the patient experience

Partnering with volunteers plays an important role in improving patient experience, addressing health inequalities, and building a closer relationship between services and communities.⁴¹ Volunteers play multiple roles within healthcare organisations including assisting with activities such as:

- Wayfinding
- Information booths and centres
- Transport services
- Meal drop-offs
- Tea rounds
- Recreational activities (such as arts and crafts)
- Pastoral support
- Cultural activities and support
- Building and garden improvements
- Medical records and other administration
- Communications materials
- Patient surveys
- Fundraising.

These services make a significant positive contribution to the patient experience and generally receive consistent positive feedback from patients.

High-performing healthcare organisations do not just wait for volunteers to approach. They actively support and enhance the role of volunteers in a number of ways. It is also important to recognise and reward the important role played by volunteers – this can take a number of forms (see **Box 4**).

Box 4: How healthcare organisations enhance the role of volunteers



- Engaging with the community to actively recruit volunteers
- Supporting volunteers to organise themselves into formal structures
- Providing training, resources and other supports to assist volunteers in their role
- Offering spaces for volunteers to rest in the hospital (such as a tea room)
- Openly acknowledging the importance of volunteers, including through volunteer appreciation events, awards and communication materials (such as newsletters).

Case Study

Riverland General Hospital, Country Health South Australia



The importance of community partnerships and volunteers in enhancing care

In Country Health SA, Riverland General Hospital, the 1,700 volunteers in the region and 70 volunteers in the hospital play a critical role in enabling better care both outside (including transport services, meals) and inside the hospital (including patient wayfinding, medical records, tea rounds and administration). The community is also an important financial contributor, with Health Advisory Councils and other community organisations raising significant funds for the community health services (\$1.2 million raised in 2015–16). As a result, communities are extremely invested in their hospitals and there is a sense of community ownership of the service.

Case Study

Western Health Local Health Network, Melbourne, Victoria



Volunteers are respected and treated like they are part of the workforce

The 600 volunteers across Western Health are involved in a range of tasks including collecting patient experience data, and maintaining gardens and rooms. Volunteers are respected and treated like members of the workforce, and every six months a lunch is put on to thank volunteers for their support.

4.6 Strong external partnerships

The healthcare environment and how technology is used can have a significant impact on the delivery of person-centred care. This section will discuss the following elements:

- 4.6.1 Person-centred design principles are applied to the built environment
- 4.6.2 Healthcare organisations are pragmatic and innovative where resources are limited
- 4.6.3 Technology must actually enhance patient experiences and outcomes



4.6.1 Person-centred design principles are applied to the built environment

The right environmental design can facilitate greater communication and contribute to the perceived culture of an organisation by its workforce, patients and the community. Environmental design can also support enhanced delivery of person-centred care. **Table 6** outlines key features of the environmental design of a high-performing person-centred organisation.²⁰

Investment in upgrade and design of the built environment should be done in line with person-centred principles and patient input. Resourcing improvement of the quality of the physical care environment strongly correlates with improved patient experience and other health and business outcomes. When considering new healthcare facilities, or when renovating or reviewing existing facilities, organisations should consider person-centred principles and seek patient adviser input.

Case Study

Sydney Local Health District and Royal Prince Alfred Hospital, New South Wales



Consumer led wayfinding initiatives

Sydney Local Health District has been working with its Patient and Family Centred Care facility group and consumer representatives to improve wayfinding across its facilities. For larger facilities, wayfinding kiosks have been implemented. For smaller facilities, work has been done to improve naming conventions on signs and painting different levels in different colours to give patients more confidence they are in the right place. The service will be also be introducing electronic wayfinding at four different entry points within the Royal Prince Alfred Hospital – an initiative that has come from the Patient and Family Centred Care facility group.

Table 6: Features of a person-centred built environment

Feature	Description
The built environment takes a holistic approach to health and wellbeing	<ul style="list-style-type: none"> • Access to natural light • Promotion of outdoor spaces and opportunities to access them – e.g. grounds, breakout spaces, gardens, drink stations, courtyards • Rooms are designed to support patient modesty and dignity
The built environment is welcoming and feels safe	<ul style="list-style-type: none"> • There is barrier-free and convenient access to building(s) • Wayfinding supports and tools are in place, and give clear and understandable directions for patients/residents and visitors to their destinations. Wayfinding supports and tools consider the patient journey in its entirety, and aims for consistency in approach, naming conventions etc. • There is appropriate security where that is required
Spaces are designed to facilitate patient and family engagement	<ul style="list-style-type: none"> • Incorporation of spaces that comfortably accommodate the presence of family and friends. For example, designing patient rooms with ample space, seating, and overnight accommodations to encourage a family's presence • Use of space and meeting places to promote patient and family engagement and involvement in improvement activities
Design of spaces promotes partnership and equality between patients and care teams	<ul style="list-style-type: none"> • Organising consultation spaces to 'level the playing field' between doctors and patients by replacing traditional big desks that create distance with couches, small tables, or arm chairs that promote connection
Physical barriers are minimised to promote communication	<ul style="list-style-type: none"> • Adopting decentralised, open nursing stations that increase the visibility and accessibility of personnel
The environment empowers patients and feels like 'their own'	<ul style="list-style-type: none"> • Patients are able to freely move around the site (particularly important for longer-term or regular visitors) • Patients and families are involved in environmental design

Case Study

Jönköping Healthcare Service, Region Jönköping County, Sweden



Innovative use of space to empower and support patients and families

Jönköping Healthcare Service thinks creatively about how the environment can be used to empower and support. Four examples are:

- Patients have security swipe passes into the self-dialysis unit, storage facilities are unlocked, and staff do not have to be onsite for patients to access the unit – empowering people to fit their dialysis into their life, not the other way around
- Patients designed the physical space – including lay-out, colour and choice of furniture – and were also involved in selecting the dialysis machines and chairs to be used
- The House of Heart, a recovery centre for cancer patients is deliberately set up in a house rather than a meeting room; it is on the grounds, but set apart from the main hospital and runs on a no-referral, no-reservations basis
- Kulturum runs quarterly ‘Esther cafes’ to share patient stories and design improvement initiatives – these are run in cafes off the hospital grounds in ‘neutral space’ to encourage equal contribution between patients and the workforce, and to ‘level the playing field’.

4.6.2 Healthcare organisations are pragmatic and innovative where resources are limited

Investment and state-of-the-art buildings are not necessary to deliver person-centred care effectively.

The environmental features of high-performing person-centred healthcare organisations, where resources are limited, focus less on the surface-level aesthetics of a space. Instead, they ‘make the most of what they have’ and focus more so on how innovative use of existing physical space can increase patient and family engagement, promote partnerships between patients and care teams, and enhance patient empowerment.

“It’s not the physical appearance that seems to matter the most. It is how patients and staff are treated and supported”

Staff member,
Carolinas Medical Center – Mercy

Implementing many of the principles above does not have to be resource intensive – for example, wayfinding initiatives and use for colour, re-organising of furniture in consulting spaces, and more innovative ways of involving security as part of the core team.

Case Study

Sydney Local Health District and Royal Prince Alfred Hospital, New South Wales



An environment that feels safe

At Sydney Local Health District, the security department is part of the clinical stream, and included in decision-making about certain patients. Having security as part of that team is beneficial to the patient and the workforce. Security interacts directly with patients, members of the workforce and executive about any issues, and how to create a better environment that keeps them safe. Current initiatives are exploring how to de-identify security so they are not mistaken for police, and instead look more a part of the clinical team. The hospital has just finished trialling security staff wearing suits instead of a uniform, which has seen a decline in confrontations as a result.

Case Study

Carolinas Medical Centers – Mercy, North Carolina, the United States



A low cost, but soothing environment

One of the ways that Carolinas Medical Centers – Mercy creates a soothing environment is through art. The building has a great deal of art throughout. While investment in art can be very expensive, it need not be. One of the ways that Mercy obtains its art is through employees. There are contests for photos, but also for paintings and other artwork. Staff whose art is selected receive a monetary award (\$100) and the art is displayed in the hospital, along with a plaque explaining who the artist is. This is not only a way to create a soothing environment, but also an example of how they support their staff and further staff commitment to the organisation.

4.6.3 Technology must actually enhance patient experiences and outcomes

Technology has huge potential to drive, enable and enhance person-centred care.⁴² Used well, it can enable new types of information-sharing, development of innovative care models and facilitate patient involvement and leadership over their own care.² It is critical that use of technology is driven by the goal of improving patient experience and outcomes – as opposed to use of technology for technology's sake, which does not contribute to better care.

Technology interventions have been shown to increase patient empowerment (in other words, to support patients to take an active part in their health care and the decision-making process), and improve physical condition, quality of life, and health-related quality of life.⁴³ From an organisational perspective, it has also been shown to positively impact on organisational cost and efficiency.⁴³ Simply adding technology to existing delivery models is not the answer to improving experience and outcomes. Organisations should consider four core elements of technology that enhance delivery of high-quality person-centred care:

1. Robust digital foundation
2. Enabling care and collaboration
3. Enhancing the patient experience
4. Digital healthcare (part of treatment).

1. A robust digital foundation

At an organisational level, there is a basic requirement to have secure and reliable technology systems (online and mobile phone) in place – including high-speed internet, all-staff intranet and communication platforms, and data / information management and reporting systems. Robust information, data management systems and infrastructure are critical enablers of supporting effective accountability and measurement (see Section 4.4.4 - clear accountabilities at all levels, and Section 4.7 – measurement for improvement).

2. Enabling care and collaboration

With the basic systems in place, technology can facilitate transparency and information-sharing, greater co-ordination and collaboration, and reduced duplication between clinicians. The clearest example of this is an electronic health record that can be accessed by patients and service providers across the system.

Case Study

Sea Mar Community Health Centers, Washington State, the United States



Information transparency and secure messaging

Sea Mar has a patient portal – FollowMyHealth – that patients can use to access their electronic medical record, but also to send secure messages to their healthcare providers. In 2014-15 (most recently available data), more than 8,000 patients at Sea Mar used the FollowMyHealth patient portal. There were 63,250 online visits; 803,051 lab test results were reviewed, and 373,397 prescriptions were refilled. The patient portal has significantly increased access to care and improved patients' participation in their health.

Sea Mar's Chief Medical Officer discussed a recent experience with one of his most complex patients. The patient has multiple chronic conditions and is struggling with a number of social determinants of health. The patient also smokes. The patient started using FollowMyHealth. When he arrived for a recent appointment, he understood that his diabetes and COPD were in need of improvement, based on the information in FollowMyHealth. He talked with the doctor about his willingness to work on losing weight, but he made clear to the doctor that he was not prepared to stop smoking. He understood, because of the information in his patient portal that he needed to do so, but was able to articulate to the doctor what he is prepared to do and what he is not. Because he was informed, the patient was able to actively participate in his care, explain to his doctor what he believes he could and could not accomplish, and to make decisions about his care.

3. Enhancing the patient and family experience

Technology can improve the way that patients and families interact with health services – from time of initial booking (such as online bookings and text message appointment reminders), time on site (such as electronic wayfinding and live updates of wait times), and during follow-up (such as text message treatment reminders and remote monitoring). As noted, use of technology needs to have a demonstrable positive impact on patient experience. The risks of technology not being implemented properly and/or the workforce not being trained adequately to use technology, and hence there being a negative impact on patient experience, also need to be understood and managed.

Case Study

John Faulkner Private Hospital, Melbourne, Victoria



'Live tracking' of patient journeys

The ability for families to follow an electronic patient journey through a 'patient finder' for patients in surgery allows family to track when an individual is going into and coming out of surgery. This initiative has reduced family anxiety and resulted in fewer enquiries (and hence less disruptions).

4. Digital health care

Digital health (as part of treatment) has arguably the greatest potential to enhance person-centred care. This is in a context of increasing information and data availability, rapid technological advances and increasingly empowered consumers. Digital health facilitates greater flexibility and person-centredness in receipt of services (such as through telehealth) and also empowers greater independence and self-management (such as through use of apps for education and self-management of chronic disease). There is great future potential to enhance person-centred care across the scope of patient interactive technology.

Case Study

Riverland General Hospital, Country Health South Australia



Telehealth in rural areas

Virtual Clinical Care (VCC) is a short term (usually 6–12 week) program for patients with chronic diseases who are struggling with self-management of their condition. Through an individualised case management approach, patients are provided equipment to monitor their symptoms at home. This information is monitored by a chronic care nurse and can be sent to the patient's specialist or local GP. The patient receives training so they can better understand and self-manage their condition, with guidance from their chronic care nurse. Members of the healthcare team communicate with each other and with their patient through teleconferencing, with occasional face-to-face appointments when needed. This allows patients in rural areas to be treated at home, working closely with their local GP and hospital, rather than having to travel to a different town or city to see the specialist.

The VCC has received very positive feedback from clinicians and at least 85% of patients reported they were 'very satisfied' with the program – including patients who took longer to learn how to use the equipment. There has been a slight reduction in re-admissions and the length of admissions.

Technology cannot be relied on as a substitute for other person-centred attributes

High-performing organisations understand the limitations of technology, and do not allow technology to be used as an alternative or excuse to not deliver against the other attributes outlined in this report. Use of technology can also have unintended negative consequences on patient experience – and operate as a barrier to personal connection between patients and clinicians. Further, organisations need to be aware of the need to build workforce willingness and capability to use new technologies. Communicating better person-centred care as the driver or rationale for change (for example, implementation of electronic medical records) can be an effective way to build workforce buy-in and willingness to adapt to new technologies and processes.

Case Study

Sea Mar Community Health Centers, Washington State, the United States



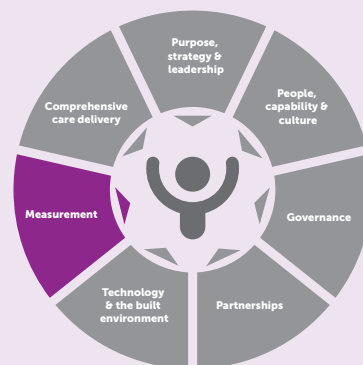
Technology can also be a barrier to good person-centred care

At Sea Mar all of the providers at the clinics use electronic health records and as a result, bring laptops into the exam rooms. However, Sea Mar has initially seen a negative effect on patient satisfaction scores as a result of this practice. Providers tend to focus on the computer screen and did not communicate using eye contact with the patient. This is an example of technology getting in the way of providing good person-centred care. In response, Sea Mar is working with its clinicians to help them understand the importance of communication, body language, eye contact, etc., but is also providing support to the providers so that they can focus on the patient. For example, a Medical Assistant will join the physician in the exam room with the patient and record the information in the medical record.

4.7 Measurement for improvement

Delivering excellent person-centred care means understanding the current state, taking a quality improvement approach and using measurement to track improvement. Two key elements include:

- 4.7.1 There is a culture of learning and continuous improvement
- 4.7.2 Measurement can be acted on to improve outcomes and reflects what patients and communities value



4.7.1 There is a culture of learning and continuous improvement

High-performing person-centred organisations embrace and foster learning, evaluation, and continuous improvement as core to their culture. Part of being a learning organisation and embracing a culture of continuous improvement is information transparency.

In high-performing organisations this is about transparency for improvement rather than transparency for blame. A learning organisation is one that uses its data and information about patient experiences – both positive and negative - to inform improvement. There is a no blame culture and mistakes are used as an opportunity to improve systems and services.

Practical ways that high-performing organisations demonstrate this include:

- Reporting on improvement activities in executive and senior management meetings – this includes reporting on both key patient safety statistics and patient stories
- Opening all meetings with a patient story – both positive stories and those that were less positive
- Seeking and using complaints data and patient surveys to inform improvements needed
- Celebrating and sharing successes
- Using evidence of improvement activities to drive enthusiasm and support for change.

“It is about being authentic and brave in the conversations about where we don’t do well, accountability but not blame. We are using our complaints as a learning mechanism and being more proactive in seeking out feedback... how do we genuinely listen and learn from negative feedback”

Executive staff,
Riverland General Hospital

4.7.2 Measurement can be acted on to improve outcomes and reflects what patients and communities value

Measurement needs clear objectives to be useful and impactful in influencing decisions and changing practice. High-performing person-centred healthcare organisations emphasise the need to collect data that can be acted on to improve patient outcomes, and reflects what is important to patients and communities.

Information is collected on a number of dimensions.

According to the OECD, ‘Information on patient reported experiences and outcomes is necessary to ensure that health services are shaped around patients’ needs, preferences and values’.³² Patient satisfaction alone is now seen as an inadequate way of capturing information and is prone to a number of biases. The patient’s actual experience and outcomes provides richer and more actionable information.

This can be done through emphasis on patient-reported metrics in measurement frameworks.³² There are four main features and five dimensions of person-centred care from the literature that can be measured in the acute setting, as shown in **Table 7**.

Table 7: Features and domains for measuring person-centred care^{4, 20, 26, 44}

Features	Understanding: Examining understanding and awareness of what person-centred care means and what it entails – for both patients and clinicians	Preferences: Examining the type of care the patients wanted and the attitudes and values of health professionals	Experiences: Examining the extent to which care was person-centred	Outcomes: Examining the impact of person-centred care
Domains	Sense of courtesy and caring Reports of pain Respect for dignity and privacy Patient-reported outcomes Complaints and compliments			

Case Study

John Faulkner Private Hospital, Melbourne, Victoria



Better understanding the patient experience

At Jönköping, the healthcare service has designed and implemented a new patient survey that better interrogates patient experience and outcomes. The survey measures dimensions including:

- Patient confidence in care
- Were patients afraid during their interaction?
- To what extent did you participate in care decisions and delivery?
- Were you served well?
- Did you trust the service?
- Would you recommend the health service?

These measurements are not just about numbers, they are also about stories. In addition, members of the workforce are undertaking monthly patient interviews in each ward and sharing those stories at department meetings.

Case Study

Kingston Health Sciences Centre, Ontario, Canada



Patient and family-centred standards for its workforce

Patient and family-centred standards for its workforce

Kingston General Hospital (part of Kingston Health Sciences Centre) has developed five standards of patient and family-centred care in which its workforce are monitored and measured on. The five standards are:

1. Use of identification badges consistent with Kingston General Hospital policy
2. Communication (introduction and explanation)
3. Completion of white boards
4. Purposeful hourly rounding
5. Patient Feedback Forums

None of these standards are new to the hospital, but they provide a framework to make sure each one is being implemented in the same way across the hospital.

Managers and others conduct monthly audits of inpatient units and other areas of the hospital. For units, disciplines, or areas of the hospital not meeting the 80% corporate goal, improvement cycles are initiated by managers to identify opportunities for improvement and to support people in meeting the standards.

Measuring multiple dimensions mean a range of qualitative and quantitative methods are required – ranging from individual patient stories and interviews through to real-time data capture through electronic devices.

However, a critical part of ‘measuring what matters’ is the need to avoid excessive and overly burdensome measurement, or inconsistent external measurement mandates that do not actively inform or change practice.

Measurement is effectively integrated in care and care planning

Measurement and feedback of the patient experience needs to be effectively integrated into their care. Measurements are most effective when collected and considered in real time. Measurement tools need to be designed for everyday use.^{29, 33}

Case Study

Sydney Local Health District and Royal Prince Alfred Hospital, New South Wales



Using patient reported outcome measures (PROMS)

In working with more vulnerable families, the health service is looking at PROMs and trying to understand what services are working for these cohorts and why. PROMs are providing useful and immediate information that is being used to tailor services. Using PROMs and other patient-reported measures is recognised by the health district as an important area for future development.

At a state and national level, there is value in promoting standardised approaches to measurement. Providers would like to see greater alignment of quality measurement requirements so that an integrated, aligned set of measures is being consistently used.

Conclusion

This report has provided information about the key attributes of high-performing, person-centred healthcare organisations, identified through the literature, interviews and observations of a range of organisations that excel in person-centred care.

Person-centred care is widely recognised as a foundation for achieving safe, high-quality health care, contributing to better outcomes and experiences for patients, carers and families. Person-centred care also offers important potential to improve the value delivered by health services by achieving better outcomes at lower overall cost to health systems and the community.

The ultimate goal for person-centred care is to deliver an ideal experience for the patient, their carers and family that achieves the patients' goals and delivers the best outcomes. Health services that are successful in delivering person-centred care focus all aspects of their organisation toward achieving this ideal experience throughout the patient journey.

The organisational framework of seven interdependent attributes, set out in this report, can be applied by health services across a range of care settings, systems and hospital types. Yet the seven attributes are manifested differently in every organisation and there is no set formula for achieving person-centredness. Development of the attributes and achievement of consistent high performance in person-centred care is achieved through incremental, sustained and committed action. It requires a long-term commitment across all areas of an organisation.

The organisations involved in this report have each made important achievements and advances in person-centred care for their patients and communities. Their achievements and insights have informed development of the organisational framework. Equally, all agree that there is much more to be done to consistently achieve high performance across all seven attributes and truly excel at person-centred care.

This report provides a practical resource, tailored to the Australian health system context, for health services, clinicians, policy makers, system stakeholders and consumers. The framework and attributes provide a structure and a basis to discuss, assess, and improve person-centred care.

Appendix A: Person-centred care and the NSQHS Standards

The key attributes of high-performing person-centred healthcare organisations reflect multiple standards within the NSQHS Standards. This appendix outlines the standards and associated actions from the NSQHS Standards (second edition) that are relevant to person-centred care.¹

Table 8: Person-centred standards and actions in the NSQHS Standards (2nd ed.)

Standard	Actions relevant to person centred care			
 Clinical Governance Standard	1.1 1.2 1.4 1.5	1.8 1.9 1.10 1.11 1.13	1.14 1.15 1.20 1.21	1.29 1.30 1.31 1.32 1.33
 Partnering with Consumers Standard	all actions in the Standard			
 Preventing and Controlling Healthcare-Associated Infection Standard	3.3			
 Medication Safety Standard	4.4 4.11 4.12			
 Comprehensive Care Standard	5.3 5.4 5.5 5.7	5.8 5.9 5.13 5.14 5.17	5.20 5.23 5.26 5.29	5.30 5.31 5.32 5.34
 Communicating for Safety Standard	6.3 6.7 6.8 6.9	6.10		
 Blood Management Standard	7.3			
 Recognising and Responding to Acute Deterioration	8.3 8.6 8.7			

The full text of the NSQHS Standards (2nd ed.) is available at www.safetyandquality.gov.au

Appendix B: Case studies

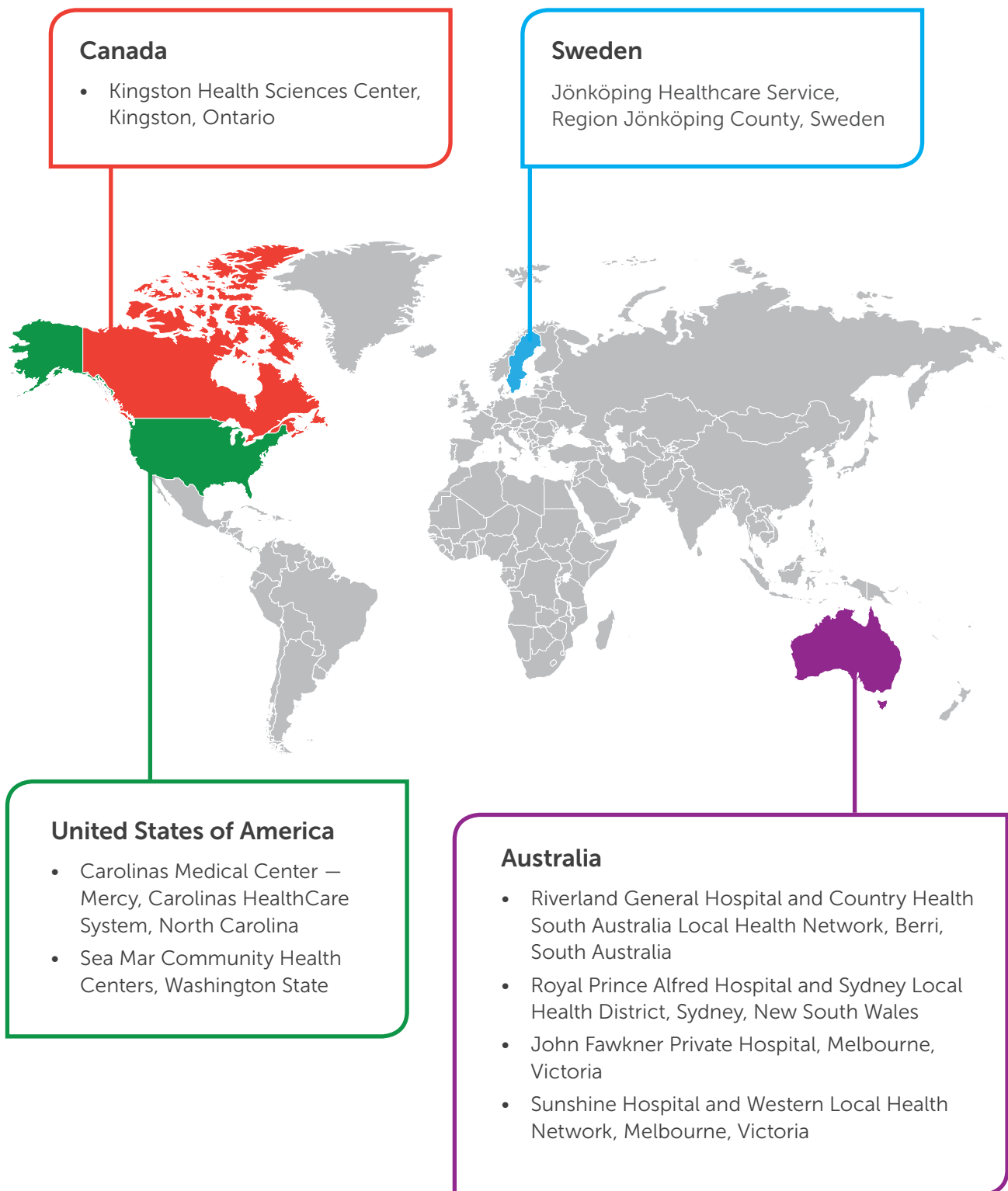
About the case studies

The review includes case studies of eight person-centred healthcare organisations. This appendix presents eight case studies of hospitals and health services that are recognised for high performance in person-centred care. These organisations were selected based on their strong reputation and achievements in the delivery of person-centred care, and because they represent a range of different types of healthcare organisations. They included a range of large, small, public, private, metropolitan and regional hospitals and health services in Australia, the United States, Canada and Sweden. The reviewers and their overseas-based associates visited each organisation. The site visits consisted of interviews with people from across the organisation, a short tour of the facilities and a desktop review of key organisational documents. Those interviewed included executives and managers, clinicians, non-clinical staff and patient representatives.

Key findings from the case studies

Person-centred care requires incremental change across all areas of the organisation. The case studies highlight key examples of person-centred care in each organisation, with several common themes. For all organisations, person-centred care was being achieved through a long-term process of incremental changes and initiatives implemented across multiple areas of the organisation. This was generally underpinned by a clear articulation of person-centred care in strategy documents and strong commitment from leaders and the workforce. While no organisation felt they had achieved systematic and comprehensive person-centred care, they each display attributes of person-centred healthcare organisations and provide strong examples of best practice from which other healthcare organisations can learn. The organisations included in the case studies are provided in **Figure 7**.

Figure 7: Case studies



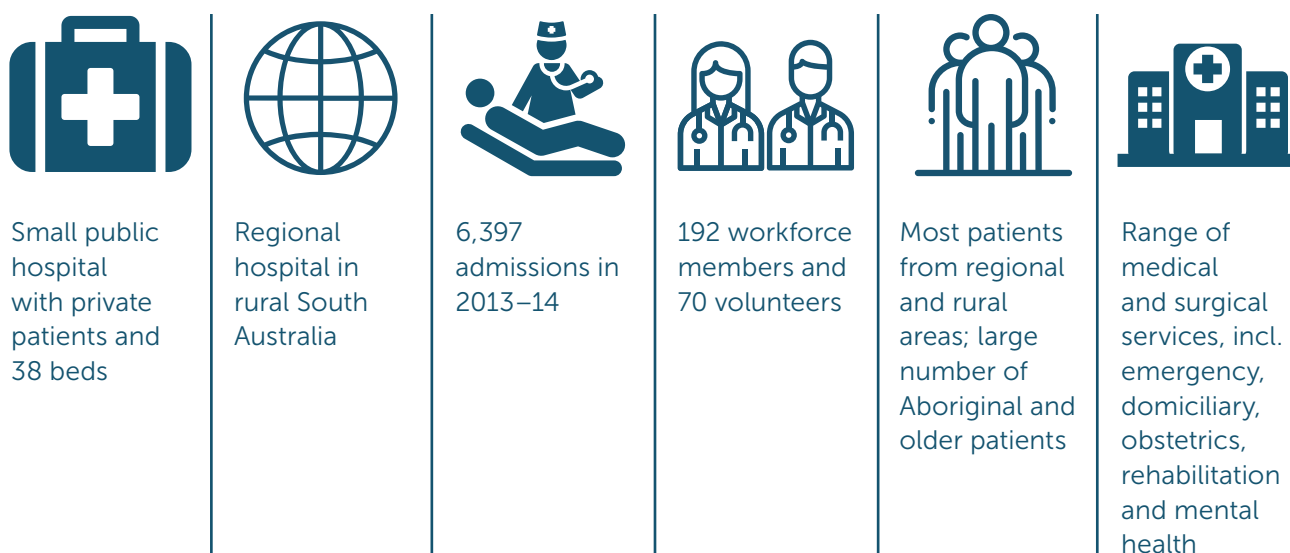
Riverland General Hospital and Country Health South Australia Local Health Network, South Australia

Overview of the organisation

Riverland General Hospital is a 38-bed public hospital in the regional town of Berri, South Australia. It provides a range of medical and surgical services to patients from the Riverland Mallee Coorong region and from across rural South Australia. The hospital works with Royal Adelaide Hospital (the closest large metropolitan hospital) and other regional and primary health services across rural South Australia, to care for patients and deliver telehealth services.

Riverland General Hospital is part of the Country Health South Australia Local Health Network ('Country Health SA'), which is the only non-metropolitan health network in South Australia. This health service covers a population of over 470,000 people across a geographic region of close to one million square kilometres.

Figure 8: About Riverland General Hospital



Person-centred care at Riverland General Hospital

Riverland General Hospital has a strong commitment to embedding person-centred care across the organisation. Key planning documents for the hospital and Riverland Mallee Coorong Region, Country Health SA outline a number of strategies to improve person-centred care, including involving consumers in decision-making, improving customer service, and supporting multidisciplinary, multi-location teams to deliver tailored services for patients. In 2013, Riverland General Hospital underwent a major upgrade, which included a new mental health unit, rehabilitation unit, chemotherapy facilities and an onsite pharmacy. This was accompanied by an enhanced focus on person-centred care.

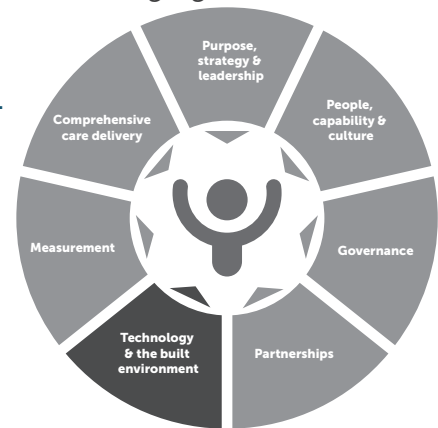
The workforce at Riverland General Hospital say they are only part-way through the ‘person-centred care journey’ and have a long way to go. Key challenges include: ensuring people in rural areas can access quality, safe, person-centred care; delivering integrated services across a large geographic area, with specialists often based in capital cities that visit periodically; engaging with Aboriginal patients, who have higher rates of self-discharge and often indicate a lower level of trust in local health services; and funding mechanisms that incentivise activities rather than health outcomes. Despite these challenges, the efforts of Riverland General Hospital and the Riverland Mallee Coorong Region, Country Health SA have led to substantial improvements and innovations in person-centred care, with examples of excellence in rural health service delivery.

Key features of person-centred care

Riverland General Hospital, Riverland Mallee Coorong and Country Health SA have many attributes that support the delivery of high-quality, person-centred care. This case study is not intended to be comprehensive account of all these attributes. Rather, it seeks to highlight some key examples that other health services can learn from.

Telehealth supports multidisciplinary teams and person-centred service delivery in rural areas

Riverland General Hospital and Country Health SA offer a range of telehealth and telemonitoring services. Within the hospital, videoconferencing rooms and mobile videoconferencing units allow specialists in other locations to treat patients at the hospital, with the support of onsite clinicians. Home-monitoring equipment allows patients and GPs to share patient data with clinicians or elsewhere.



Telehealth plays a particularly important role in supporting multidisciplinary teams to collaborate across locations – often with the specialist in Adelaide, physicians, nurses and allied health workers based at hospital and GPs in local towns.

Riverland General Hospital has identified a number of lessons learned on telehealth:

- Patients need to be front and centre of the service design and delivery
- Telehealth requires culture change for clinicians, who must understand the benefits
- Teamwork and connections with community health services are critical for success
- The technology needs to be relatively simple – even people who have never used a computer or mobile phone will be willing to learn if the technology is simple
- Internet connectivity is a key challenge – SIM cards are more reliable than wifi.

Two key telehealth programs are outlined in **Box 5**. The hospital also provides telehealth services in the Mental Health Unit and has initiatives to improve access to telehealth for Aboriginal and culturally and linguistically diverse communities. These services enable tailored service delivery for people in rural areas, at the preferred location of the patient rather than the clinician.

“It empowers the patient to be in charge of their disease”
VCC manager

Box 5: Selected telehealth programs

Chronic disease

Virtual Clinical Care (VCC): Home monitoring service for chronic diseases

Overview: VCC is a short term (usually 6–12 week) program for patients with chronic diseases who are struggling with self-management of their condition. Through an individualised case management approach, patients are provided with equipment to monitor their symptoms at home. This information is monitored by a chronic care nurse and can be sent to the patient’s specialist or local GP. The patient receives training so they can better understand and self-manage their condition, with guidance from their chronic care nurse. VCC is in its first phase, with plans to scale up and work more closely with GPs in Phase two.

Results: The VCC has received very positive feedback from clinicians and at least 85% of patients reported they were ‘very satisfied’ with the program – including patients who took longer to learn how to use the equipment. There has been a slight reduction in re-admissions and the length of admissions.

Cardiology

iCCnet: Telehealth program for high-risk cardiology patients

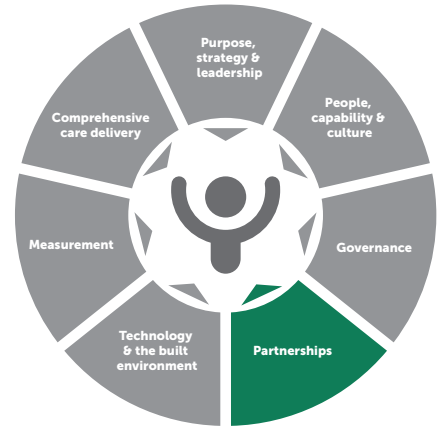
Overview: iCCnet supports specialists, GPs and nurses to manage acute patients in their local area. The program aims to improve local management of cardiology conditions and reduce the need for patient transfers to Adelaide. Under the service, local GPs and nurses manage patients, conduct exercise stress tests and add patient data to a centralised database. Patients have appointments with a specialist (usually based in Adelaide) via videoconference, with a local GP or nurse present. The next phase of iCCnet will include secondary prevention and tele-cardiac rehab services.

Results: An evaluation of the ICC-net program found mortality for Acute Myocardial Infarction decreased by around 25%. There has been very positive feedback from GPs and patients – who strongly prefer to be treated in their local area than travel to Adelaide – and strong uptake from Aboriginal patients.

The hospital engages closely with and is highly accountable to the local community

As with many regional hospitals, Riverland General Hospital is a central part of the community and a major contributor to the local economy. Most of the hospital's workforce live locally and engage regularly with patients and their families in their daily lives. The community provides significant support to the hospital through fundraising, volunteering and other activities.

With this comes a stronger accountability to community, which is particularly felt by the hospital's workforce. Local community members expect the hospital to consult them, respond to their feedback and deliver a high standard of customer service. News of mistakes or poor service spread quickly and community members are often quick to issue a complaint or lobby for change.



The Country Health SA Riverland Mallee Coorong 'Consumer and Community Engagement Action Plan 2016-2018' outlines a clear strategy for increasing community engagement. In line with this plan, the Riverland General Hospital has utilised its close relationship with the local community to improve person-centred care in a number of ways.

"Relationships (with the community) are absolutely critical"

Executive staff

Box 6: Riverlands General Hospital's engagement with the local community



Community consultation and advisory committees to inform continual improvement

The hospital consults the local community on major changes to the health service, as well as on an ongoing basis through the Community Network, Health Advisory Council and other consumer advisory committees (these committees are discussed further in the section below). For example, it conducted an extensive consultation process on the hospital upgrade – including road shows, open days, stalls in shopping malls, local advertisements – which led to a number of changes.



Community fundraising to enhance hospital facilities and services

The Health Advisory Council and other community organisations have raised significant sums of money for the hospital, with \$1.2 million raised in 2015–16 alone. This has helped fund palliative care relatives lounge, chemotherapy chairs and equipment, grounds landscaping, maternity patient's family lounge, art and a community wall project is currently in progress.



Volunteers to support patients, families and the workforce

Over the past four years, the hospital has sought to significantly expand its volunteer program – affectionately called the 'Meri Bunch'. Since 2012 when there were 10 volunteers, it has recruited 78 volunteers across the hospital, with more than 1,700 volunteers across Country Health SA. These volunteers play a particularly important role in rural and remote settings and assist with transport services, meal drop-offs, medical records, patient surveys, wayfinding and tea rounds.



Communications and accountability mechanisms to support transparency and continual improvement

The hospital promotes a culture of accountability (but not blame) and encourages transparency around mistakes and areas for improvement. It has an open disclosure policy and encourages feedback and reporting of complaints from patients and community members. It provides regular updates to the community on its performance. For example, every month the hospital provides safety incidence data to the Health Advisory Council and it has a 'Communications Board' on public display with information on hospital activities, performance and consumer feedback. The hospital also publishes newsletters for consumers.



Aboriginal youth engagement to improve health outcomes and reduce self-

discharge Under the Country Health SA Consumer and Community Engagement Action Plan, Riverland General Hospital is working with young Aboriginal people to develop an Aboriginal Youth Engagement Strategy. This has involved extensive consultation with Aboriginal young people to build relationships and develop the strategy. The strategy aims to involve Aboriginal young people to improve health services and reduce self-discharge for Aboriginal people.

The hospital is increasing the breadth and capabilities of its consumer advisory bodies to provide a 'voice' to consumers and inform service improvements

Consumer advisory committees play a number of important roles at Riverland General Hospital, including (but not limited to):

- Providing advice to the hospital on service design and delivery
- Providing advice to patients, families and communities on hospital services
- Collecting and monitoring consumer feedback through formal mechanisms (such as patient surveys) and informal mechanisms (such as verbal feedback)
- Representing patients, families and local communities on hospital governance bodies
- Fundraising for the hospital.



Riverland General Hospital has undertaken a number of initiatives to both increase the size and number of its consumer advisory committees, and to provide training and mentoring to committee members in their functions. Both recruitment and training have been critical to ensure these bodies are effective. This is part of the hospital's work to implement the Partnering with Consumers Standard.

Table 9 lists Riverland General Hospital's consumer advisory bodies and networks and their role in improving person-centred care.

Table 9: Riverlands General Hospital's consumer advisory bodies and initiatives

Name	Description	No. consumers	Year established
Health Advisory Council	Main consumer and community advisory body, established under the <i>Health Care Act 2008</i> . Provides advice on local health service needs and priorities. Members include consumers, families and the general public	11	2009
Consumer Advisor and Consumer Safety and Quality Advisor	These consumer advisor positions sit on various governance committees of Riverland General Hospital and Country Health SA and receive specific training based on their role	9	2014
Friends of Mental Health Group	Provides input and advice on mental health services to the hospital as well as patients, their families and the public. Members include consumers, families and a select number of mental health workers, including an Aboriginal Cultural and Mental Health Worker	12	2016
Riverland Mallee Coorong Community Network	A register and network that allows community members to provide their viewpoints on local health services and provides them with updates on Riverland General Hospital and other hospitals in the area. Members can choose different levels of engagement, from receiving information only through to sitting on various local health service governance committees	22	2016

Royal Prince Alfred Hospital and Sydney Local Health District, Sydney, New South Wales

Overview of the organisation

Sydney Local Health District (SLHD) is a network of public hospitals and other health facilities in the centre and inner west of Sydney. The health service covers a population of around 640,000 people, 43% of whom speak a language other than English at home. SLHD is one of the best-performing health districts in New South Wales. Its performance at accreditation consistently exceeds national standards.

Royal Prince Alfred Hospital is the largest of five hospitals within SLHD. As a quaternary referral hospital, it provides an extensive range of services to more people in New South Wales than any other hospital. The hospital is recognised as a worldwide leader in healthcare excellence and innovation.

Figure 9: About Sydney Local Health District



Person-centred care at Sydney Local Health District

In 2012, SLHD outlined a commitment to ‘develop a renewed emphasis on ‘patient and family centred care’ in its Strategic Plan. Patient and family centred care is seen as critically important to achieve SLHD’s vision of ‘excellence in health and healthcare for all’ and is explicitly referenced in the district’s mission: ‘ensuring the community has equitable access to high quality patient and family centred care...’⁴⁵

SLHD has focused on embedding patient and family-centred care as ‘core business’ across all areas of the organisation. In March 2014, SLHD established a Patient and Family Centred Care Steering Committee, with working groups for each domain of the health service: 1. Facilities; 2. Staff; 3. Organisation; 4. Services; 5. Community; 6. Research; and 7. Education. Each group is responsible for developing their own initiatives to enhance patient and family centred care across the organisation as it relates to their relevant domain.

While SLHD has made great progress, it faces a number of challenges common to most health services. The high volume of admissions, combined with pressure to meet key performance indicators, mean the workforce often struggle to balance the shift to person-centredness approaches with other priorities. The workforce must tailor their care to an extremely diverse patient cohort with different needs and preferences. There are opportunities to strengthen integration of care between service units. There is also the continual tension of balancing patient preferences with the need to provide safe, evidence-based care.

Members of the SLHD workforce recognise that embedding person-centred care is a long-term and ongoing commitment. SLHD’s organisation-wide approach, underpinned by strong leadership and a clear strategic direction, is widely recognised as best-practice. In the future, the evolution of technology is expected to have a major impact on services. The district aims to ensure technology and other advancements in health service delivery are optimised as enablers, rather than barriers, to person-centredness.

“It is like painting the harbour bridge. It is an ongoing journey that required”

Executive staff

Key features of person-centred care

SLHD and Royal Prince Alfred Hospital have many attributes that support the delivery of high-quality, person-centred care. This case study is not intended to be a comprehensive account of all these attributes. Rather, it seeks to highlight some key examples that other health services to learn from.

A person-centred culture is modelled and clearly articulated by leaders and managers across all areas of the organisation

SLHD leaders and managers propagate a strong culture of person-centredness. Leaders and managers across the organisation model the culture and behaviours that they expect of their workforce. They try to create a caring environment with respectful communication and a customer service mentality.

SLHD has implemented a number of initiatives to promote a culture of customer service. This includes an emphasis on customer service in recruitment, customer service training for its workforce and rewards for members of the workforce who display strong customer service. Several of these initiatives were informed by advice sought from Service NSW, a government service provider that is widely recognised for excellence in customer-focused service delivery.



“Patient and family-centred care is completely linked to the culture of the organisation”

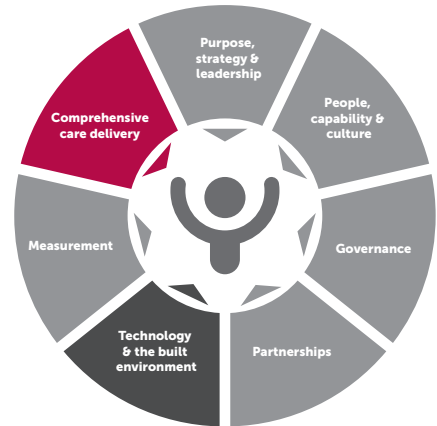
Executive staff member

SLHD has also taken steps to formally articulate its person-centred culture. The executive team have developed a set of eight ‘Patient and Family Centred Care Key Messages’ which are shared with its workforce and consumers across the organisation. These messages clearly explain how the workforce and consumers should support and experience patient- and family-centred care at SLHD.

Person-centred care is embedded as ‘core business’ for all members of the workforce, as exemplified by security and environmental services

Patient- and family-centred care is seen as ‘core business’ at SLHD. It is embedded in each area of the organisation through the working groups of the Family and Person Centred Care Steering Committee (see further above). Each area of the organisation clearly understands their responsibilities in terms of supporting patient and family centred care. Of note is the work of security, facility management and other corporate services to enhance person-centred care.

Key examples from the security department and environmental services at SLHD are highlighted in **Box 7**.



Box 7: How person-centred care is supported by security and facility management



Security staff are formally part of the clinical stream at SLHD. This reflects the expectation that security are there to help patients and the workforce. The security department has implemented a number of initiatives to support a safe and friendly environment:

- **Trial of security staff wearing suits instead of uniforms**, which resulted in a decline in confrontations and is likely to be rolled out across the organisation
- **Training for security staff on how to de-escalate situations** through communication, which has reduced the number of physical takedowns
- **Training for security staff in customer service**, to improve interactions and rapport between security staff and patients and their families.



Facility managers have mapped the patient journey to create ‘healing environments’

While SLHD has a number of major capital works projects, other initiatives are less expensive. By following a patient journey, the environmental services team were able to identify and make improvements across the organisation’s built environment. This includes:

- **Wayfinding** – addressing gaps in current wayfinding and trialling electronic wayfinding
- **Signage** – use of commonly recognised name conventions and multi-lingual signs
- **Amenities** – healthy snacks and non-violent TV shows in waiting rooms
- **Buildings** – renovations and artwork informed by consumer groups.

The workforce is recruited and supported to deliver person-centred care through training, wellbeing programs and workforce-led initiatives

SLHD executive and managers recognise that the capabilities and wellbeing of its workforce are critical to support them deliver patient- and family-centred care. Members of the workforce in hospitals and other health services in the district face multiple competing priorities, diverse patient cohorts and high patient numbers, which all impact on their ability to deliver person-centred care.

Table 10 presents some key initiatives at SLHD to support a person-centred workforce.

Table 10: Key initiatives to support a person-centred workforce

<p>Recruiting for customer service skills</p>	<p>Learning from the success of Service NSW, SLHD is increasingly prioritising customer-service skills in recruitment and workforce planning. Key examples include:</p> <ul style="list-style-type: none"> • Position descriptions: Patient- and family-centred care is built into position descriptions, to clearly articulate the position’s responsibilities in this area • Recruitment criteria: While candidates must have the prerequisite qualifications, the recruitment process prioritises customer-service skills, communication and interpersonal skills and other attributes that indicate a strong capacity for person-centred service delivery. This applies to the clinical and corporate workforce • Consumers on interview panels: Consumers are often on interview panels for key positions, to ensure consumer perspectives inform recruitment decisions.
<p>Ongoing training and professional development</p>	<p>SLHD has multiple training opportunities for its workforce across the organisation to increase their capacity to deliver person-centred care, provide high levels of customer service, and cater to diverse patient cohorts. Key examples include the following:</p> <ul style="list-style-type: none"> • Inclusion of patient- and family-centred care in all workforce education programs • Routine customer service training for its frontline workforce, including staff in environmental services, security, cleaning, catering and other corporate areas • Training for its clinical and corporate workforce on managing complaints and escalating issues where there is concern for a patient’s care • Training in cultural competency and communication with diverse patient cohorts.
<p>Wellbeing programs for the workforce</p>	<p>SLHD has a strong focus on workforce wellbeing, recognising that members of the workforce who are well and resilient are able to deliver better person-centred care. Senior clinicians say that you cannot achieve person-centred care without investing in the wellbeing of the workforce.</p> <p>The health service has a range of meditation and wellbeing programs for its nurses and midwives. These programs largely focus on nurses and midwives who make up almost half the 11,000 workforce members at SLHD.</p>

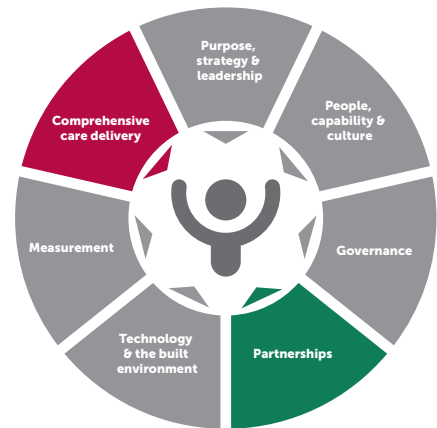
Workforce led initiatives to improve service delivery

Under the NSW Health Essentials of Care program, Nursing Unit Managers and the nursing workforce have received guidance and support to develop programs for their wards to improve care delivery. These programs not only improve workforce capacity but also empower the workforce to develop and implement their own person-centred initiatives. The results of these programs are closely monitored through clinical data, patient surveys and other measures. Key programs implemented by nurses at Royal Prince Alfred Hospital include:

- **Productive ward program:** In a cardiology ward, members of the workforce identified a range of actions to increase ward productivity, which led to significant time savings for nursing staff
- **Intentional rounding:** In a cancer ward, nurses visit members of the workforce every hour to assess their condition and needs, which has led to a reduction in adverse incidents and complaints
- **Information-sharing:** In a cancer ward, members of the workforce identified ways to improve communication and information-sharing with patients, including the provision of information packs to staff, with positive feedback from patient satisfaction surveys.

Health care is coordinated with other services and tailored to support the holistic needs of diverse communities

SLHD recognises that person-centred care often involves integration with other services to meet the holistic needs of patients and their families. This is underpinned by a strong commitment to equity and tailoring services to support diverse population cohorts. Many people living in the district face multiple levels of social, economic and health-related disadvantage. For these people, achieving health outcomes often requires a variety of other supports, beyond just health care.



SLHD partners with other service providers to deliver a range of community and population health services. This includes health promotion, community-based prevention, early intervention, assessment, acute/post-acute treatment, health maintenance and continuing care services designed to improve or maintain the health and wellbeing of individuals and communities.

Table 11 provides key examples of initiatives to integrate and tailor services to meet the diverse needs of consumers.

Table 11: Examples of partnerships and initiatives for diverse and disadvantaged cohorts

<p>Healthy communities projects with community and family service providers</p>	<p>Transformation of antenatal clinic with culturally and linguistically diverse cohorts</p>	<p>Connecting dental patients with healthcare cards to other services</p>
<p>Sydney LHD has partnered with the Department Family and Community Services and local service providers to deliver holistic programs in the community.</p> <p>The programs aim to improve the overall health and well-being of the community, particularly for disadvantaged groups.</p> <p>Programs focus on a range of areas including mental health, child health and well-being, and Aboriginal health.</p>	<p>Canterbury Hospital conducted a project to transform their antenatal clinic. The hospital is located in a highly culturally and linguistically diverse (CALD) area.</p> <p>With input from community organisation and consumers, the clinic was transformed to focus on patients and equip staff with the resources to support CALD patients. The transformation has seen improvements in staff and patient satisfaction scores and is expected to be rolled out to other facilities.</p>	<p>Sydney Dental Hospital has a high proportion of patients with healthcare cards, many of whom are experiencing multiple forms of disadvantage.</p> <p>Hospital staff often identify other service needs when they treat patients and will connect and refer patients to GPs, community services, legal services and other service providers. For many patients, the Dental Hospital is a gateway to other services they desperately need.</p>

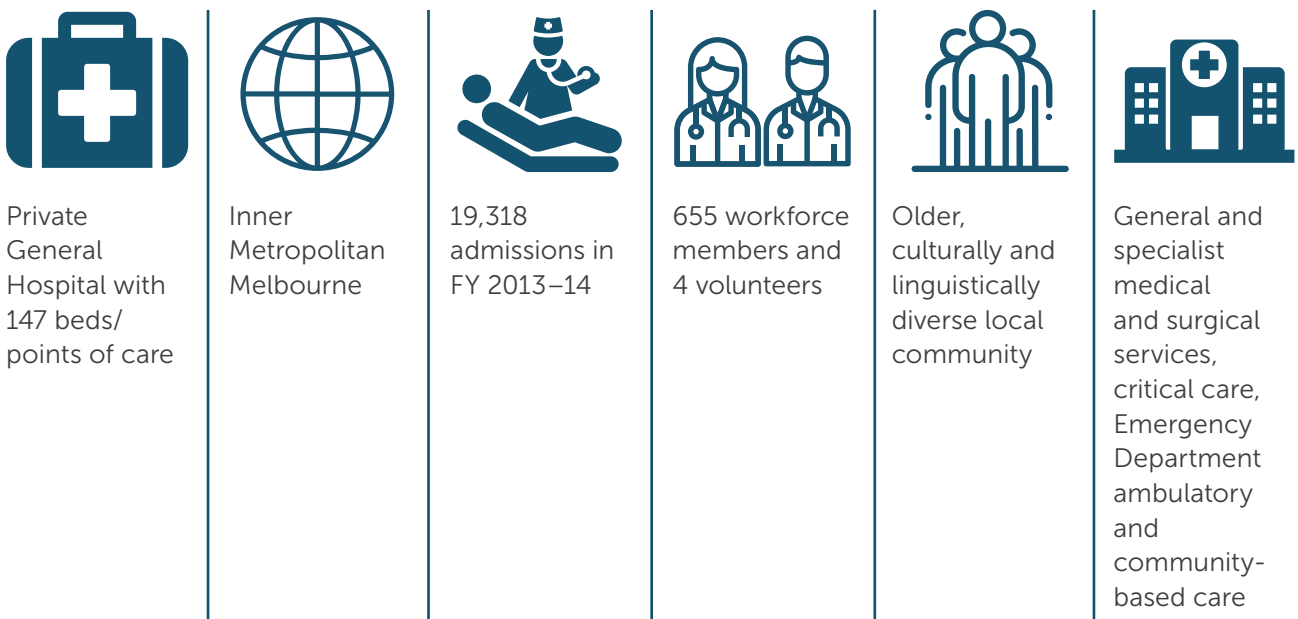
John Fawkner Private Hospital, Melbourne, Victoria

Overview of the organisation

John Fawkner Private Hospital (JFPH) is a 147-bed private general hospital located in the inner northern suburbs of Melbourne. JFPH provides a broad range of general and specialist medical and surgical services, including critical care and emergency care. JFPH is part of Healthscope, a leading private healthcare provider comprising 45 hospitals and 48 medical centres across Australia.

JFPH was established in 1939 by the Missionary Sisters of the Sacred Heart and operated as the Sacred Heart Hospital until its transfer to commercial ownership in 1992. A strong local identity and connections with the community continues to be a feature of JFPH and its approach to person-centred care today. JFPH cares for privately insured patients from a broad range of cultural and linguistic backgrounds, reflecting the diversity of Melbourne’s inner north. With a relatively older local population, an increasing proportion of JFPH’s care is focused on chronic and complex conditions.

Figure 10: About John Fawkner Private Hospital



Person-centred care at John Fawkner Private Hospital

Within one of Australia’s largest national networks of private hospitals, JFPH has developed a reputation as a leader in person-centred care. JFPH has overcome the challenges of an ageing physical facility and the space constraints of an inner urban location through the development of a person-centred culture, strong leadership and a distinctive model of consumer involvement that works in a private hospital context.

JFPH’s achievements in person-centred care have been recently recognised by being asked to participate in an Australian Council on Healthcare Standards Exemplar Award Pilot for Consumer Involvement.

The team at JFPH recognise there are many more opportunities for improvement and are ‘not there yet’ on their person-centred care journey. As the organisation looks forward to a major facility redevelopment and expansion, the team is enthusiastic about the benefits that an improved physical environment and new technologies can add, while also being alert to the need to protect its strong culture and sense of ‘family’ during the transition.

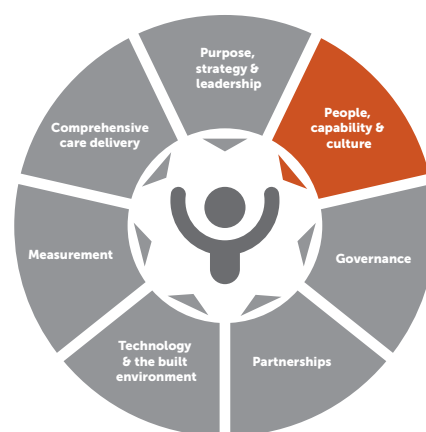
During these important changes, the workforce and management recognise that it will be vital to maintain and further develop the culture, teamwork and leadership attributes which have underpinned JFPH’s achievements in person-centred care so far.

Key features of person-centred care

JFPH has many attributes across the organisation that support the delivery of high-quality, person-centred care. This case study is not intended to be a comprehensive account of all these attributes. Rather, it seeks to highlight some key examples that other health services can learn from.

A strong team and person-centred culture cares for patients as ‘part of our family’

Members of the workforce from all areas of JFPH identify a positive culture and great teamwork as being fundamental to their approach to person-centred care. Everyone understands they are working towards a shared goal and that each member of the workforce has an important role to play in the experience and outcomes of every patient at JFPH. They value the contribution made by each of their colleagues and celebrate the positive feedback received from patients and families. The person-centred culture and team approach evident at JFPH has been developed over many years. A relatively small workforce size (compared to larger tertiary hospitals) and a high retention rate are identified as contributors to the current environment. A range of programs are in place to sustain and advance teamwork and culture, these are set out in **Table 12**.



“Communication comes first – it means the patient sees a unified team with a consistent message”

Manager

Table 12: How JFPH builds team and culture

Shared ownership of person-centred care	Hospital leadership consistently communicate the importance of a team in person-centred care.
Recognition of great person-centred care	JFPH has partnered with Australia’s largest private health insurer as part of the BUPA Patient Choice Awards. Based on patient experience feedback, the program recognises members of JFPH’s workforce who are delivering great patient care. The monthly award-winners are acknowledged and celebrated by JFPH and the Healthscope group.
‘Happy team, happy patient’	A comprehensive workforce wellbeing program is in place, including individual supports and services, team events and social programs.
Comprehensive training	All members of the workforce are involved in training on person-centred care to equip them with appropriate skills. A growing number of e-learning packages are tailored to align with the culture and values. Extensive support is provided for further training and skills development.
Inclusive team structures	Support staff are incorporated into each clinical unit. Unit meetings are open to all members of the workforce to attend, ask questions and share ideas. Complaints and compliments are shared and discussed with Visiting Medical Officers.
Values-based recruitment	Recruitment and selection processes emphasise the importance of alignment with values and cultural fit equally with the need for technical skill and experience.

Leadership is practical and supportive

Senior management have a strong commitment to person-centred care that is evident to all members of its workforce. A visible presence in clinical settings, regular communication of key messages and the explicit prioritisation of patient needs in management decision-making reinforce this commitment. Leaders are readily accessible and supportive of the frontline workforce on issues concerning patient experience.

At all levels, members of the workforce value their capacity to engage with the leadership team, and note the leaders daily engagement with practical patient care decisions, which support the workforce to provide high-quality care.

Equally, the senior leaders are consistent in taking action and making difficult decisions where performance or behaviour does not meet expectations for person-centredness. Important examples of person-centred leadership identified at JFPH are summarised in **Table 13**.



“Our managers are very collaborative and hands-on, staff feel supported and this translates to patient care”

Clinician

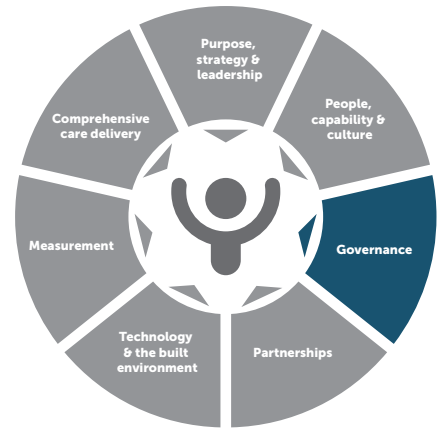
Table 13: How the leaders at JFPH inspire person-centred care

Executive rounding	Senior management engage frequently with patients, carers and families at the point of care to gain a first-hand appreciation of the patient experience. They participate regularly in key clinical meetings and take an active role in resolving patient complaints and concerns.
‘Secret shoppers’	Group management visit the hospital to experience the patient journey, first-hand. They recognise good experiences equally with the opportunities for improvement.
Person-centred decision making	Management decision-making processes and resource allocation explicitly considers and prioritises the improvement of person-centred care.
An open door	There are a minimum number of organisational layers between the General Manager and the patient. The General Manager is accessible to all members of the workforce on issues concerning patient satisfaction.

Consumers are involved in the private hospital setting

Involvement of consumers has often been more limited in a private-hospital setting, yet JFPH has established extensive involvement through the establishment of Consumer Consultant positions with a broad range of responsibilities.

Three Consumer Consultants, each bringing different consumer perspectives and experiences, are involved throughout the hospital governance structure, including monitoring and performance, improving care and planning future services. The collaborative culture at JFPH means that they are approached by members of the workforce to get involved informally in all aspects of the organisation.



The establishment and ongoing development of the Consumer Consultant positions have been championed by the JFPH Quality Manager. Clearly defined roles, responsibilities and work plans have been developed for each Consultant, aligning with their skills and capabilities.

The contribution of the Consumer Consultants is widely recognised across the organisation and has been acknowledged externally by the Australian Council on Healthcare Standards Exemplar Award Program. **Table 14** summarises key areas of involvement for the JFPH Consumer Consultants

“Our role is respected and valued by the patients and the staff. Together we’ve achieved a lot in the last few years”

Consumer Consultant

Table 14: Consumer Consultant initiatives at JFPH

	<p>Health literacy resources Consumer Consultants work with members of the workforce to develop and review patient education materials to ensure language is easily understood and accessible.</p>
	<p>Person-centred care training Consumer consultants are involved in the production of training materials that provide insight to the workforce on the patient perspective. Recent materials include e-learning videos on bedside handover.</p>
	<p>Involvement in patient experience improvement projects Consumer consultants contribute to reviewing issues and implementing improvements in areas such as complaints management, customer service improvement and the physical environment.</p>

Sunshine Hospital and Western Local Health Network, Melbourne, Victoria

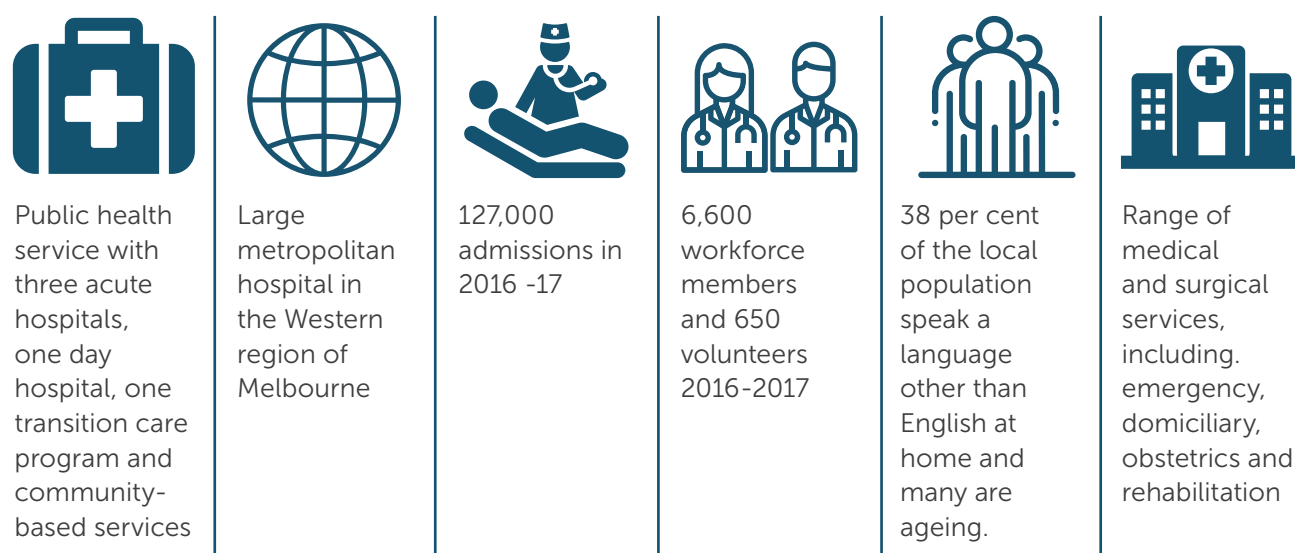
Overview of the organisation

Western Health is a major public health service in Melbourne. It covers a population of over 800,000 people in one of the fastest growing and most culturally and linguistically diverse (CALD) areas of Australia.

Western Health offers a comprehensive and increasingly integrated range of healthcare services – ranging from acute tertiary services in areas of emergency medicine, intensive care, medical and surgical services, obstetrics and paediatrics through to sub-acute care and specialist ambulatory clinics.

Sunshine Hospital is one of three public hospitals in Western Health. It has 600 beds and its services include cardiac care, women's and children's services, surgical, medical, mental health, aged care and rehabilitation. Sunshine Hospital has one of the busiest emergency departments in Victoria and the third largest number of births of any hospital in the state.

Figure 11: About Western Health Local Health Network



Person-centred care at Western Health

Western Health has embarked on a major journey to improve performance and embed person-centred care in recent years. The health service previously had a mixed reputation in the community with moderate performance. It is now recognised as a well-performing health service with a strong rapport in the local community and growing reputation for best practice in person-centred care.

Person-centred care has been embedded in Western Health through the Best Care Framework, introduced in late 2013 and the beginning of 2014. This is the health service's framework for quality, safety and improved patient experience. The intent of the framework is to achieve the best outcomes for every patient through four dimensions: person-centred care; co-ordinated care; right care; and safe care.

“The challenge for the leadership team is to make person-centred care simple for the frontline”
Executive

Embedding the Best Care Framework has had a number of challenges, including resistance among some clinicians, implementing change alongside major growth in the size of the health service and securing resources for ongoing implementation. Western Health has made strong progress embedding person-centredness in the leadership and management team; however, there has been mixed progress in relation to frontline clinicians, with examples of excellence among some and resistance to change from others.

The Western Health executive team recognise that embedding person-centred care requires a concerted, organisation-wide effort over a long time period. Their achievements to date are widely recognised in the community and in the broader health system. The health service is strongly committed to continuing its transformation under the Best Care Framework.



Key examples of person-centred care

Western Health has many attributes that support the delivery of high-quality, person-centred care. This case study is not intended to be a comprehensive account of all these attributes. Rather, it seeks to highlight some key examples that other health services can learn from.

A clear and simple strategy for person-centredness is well communicated and implemented across the health service

Western Health has focused on developing a strategy that is both simple to understand and well communicated across the organisation. The Best Care Framework provides a clear strategic direction for the health service on how to deliver care that is personal, coordinated, safe and right for patients’ needs. Person-centred care is both a domain of the framework and embedded in other domains. Of note, the Best Care Framework sets out the specific expectations and responsibilities of all people in the health service, from patients through to the Board (see **Table 15**). The framework was developed through a detailed consultation process with patients and their families, the workforce and the Board, to ensure it was highly relevant to and easy to understand for both the community and people working for the health service.

Table 15: Western Health’s Best Care Framework

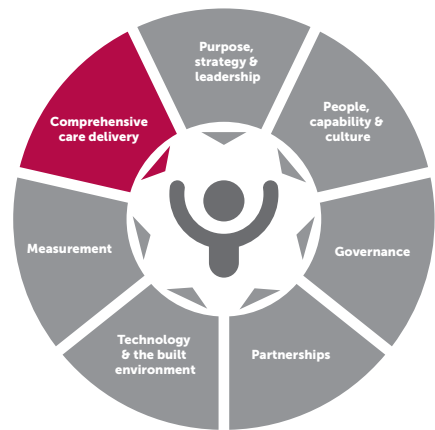
PATIENTS To receive the best care...	FRONT LINE STAFF To provide beset care...	MANAGERS & SENIOR CLINICIANS To lead best care...	EXECUTIVE & BOARD To govern best care...
<ul style="list-style-type: none"> • I am seen and treated as a person • I receive help, treatment and information when I need it and in a coordinated way • I receive care that makes me feel better • I feel safe 	<ul style="list-style-type: none"> • I communicate with patients and their families and am sensitive to their needs and preferences • I am an active team player and look for ways to do things better • I am competent in what I do and motivated to provide the best care and services possible • I keep patients from harm 	<ul style="list-style-type: none"> • I engage with and put patients first when making decisions • I look for ways to support staff and work efficiently as part of a team • I guide, engage and support staff to provide best clinical care • I promote a culture of safety 	<ul style="list-style-type: none"> • I oversee the development, implementation and ongoing improvement of organisation-wide systems supporting Best Care

Leaders and managers at Western Health put considerable ongoing effort and resources into articulating and implementing the Best Care Framework. A dedicated Best Care Committee is responsible for implementing the framework, with support from *Person-Centred Care, Right Care, Coordinated Care and Safe Care* Committees. The framework is embedded in strategy, clinical and organisational documents and reinforced through ongoing capacity building, leadership training and communications with the workforce and patient representatives. As a result, the framework is well understood and has become part of the everyday language of the workforce and patient representatives.

Services and processes are often co-designed with patients and the community

Western Health has utilised co-design methodologies to design several services and processes. Co-design reflects Western Health’s commitment to the principle of ‘Doing It With Us – Not For Us’, which is a strategy of the Department of Health and Human Services, Victoria. Western Health has used co-design methodologies on a number of services, systems and processes. Of note, the health service recently conducted pilots to co-design several quality improvement projects. This includes:

- **A co-designed peer support program with Intensive Care Unit (ICU) survivors.** This pilot used a novel methodology – ‘experience-based-co-design’ – to develop a peer support program to improve recovery of survivors of critical illnesses and their families
- **Health Links – a new innovative model of integrated care.** This pilot builds on advanced discharge programs and aims to provide integrated care in the community to keep patients at home as much as possible
- **Planning for the new Joan Kirner Women’s and Children’s Hospital.**



Western Health has also commissioned a co-design expert to provide training and ongoing mentoring to its workforce on how to use and implement co-design methodologies. Co-design has been used in a limited number of initiatives, and it has led to the development of services, systems and processes that better meets the needs and preferences of its diverse patient cohort. Co-design is complemented by broader efforts to partner with consumers and engage their input into service design and delivery.

“People need to stop designing the solution and start co-designing the solution.”
Executive

Feedback and transparency is promoted through organisation-wide processes

Western Health recognises that feedback and transparency are key requirements of person-centredness, safety and quality. The health service has implemented a number of mechanisms to increase its accountabilities to patients and the community, and to increase transparency in all aspects of its performance (see Table 16). This includes mechanisms to gain patient feedback and share it across the organisation.



“A strength is that we are pretty honest as an organisation – we’re honest when there are complaints”
Senior clinician

Table 16: Initiatives to promote feedback and transparency at Western Health

<p>Encouraging feedback</p>	<ul style="list-style-type: none"> • Trained patient representatives to seek feedback • Training for members of the frontline workforce to receive and respond to feedback • Feedback forms and boxes • Dedicated feedback email address and 1800 phone number
<p>Managing complaints</p>	<ul style="list-style-type: none"> • Trained patient representatives to provide complaints and advocacy services • Benchmarking of responses to complaints through the Health Roundtable • Complaints shared with the workforce to increase awareness, learning and co-design solutions
<p>Transparency on the patient experience</p>	<ul style="list-style-type: none"> • Regular collection of patient experience surveys – including internal surveys (Patient Experience Dashboard) and the Victorian Health Experience Survey • Patient Story Program and sharing of patient stories at Board meetings, governance committee meetings and within local services • Patient experience dashboards, with data on patient compliments and complaints • Best Care Committee responsible for analysing and responding to patient Experience dashboard data, and sharing information across the organisation • <i>'Knowing how we're doing'</i> boards on public display in wards, with information on how the ward is performing and patient experience

The health service actively caters to its diverse local community

Western Health is located in one of the most diverse areas of Melbourne, with a population that speaks more than 135 different languages and dialects. The health service recognises that providing person-centred care requires an understanding of the people who they care for and ability to provided culturally-sensitive, safe and tailored care. Western Health has implemented a range of initiatives to cater to its diverse community. Key examples are provided in **Table 17**.

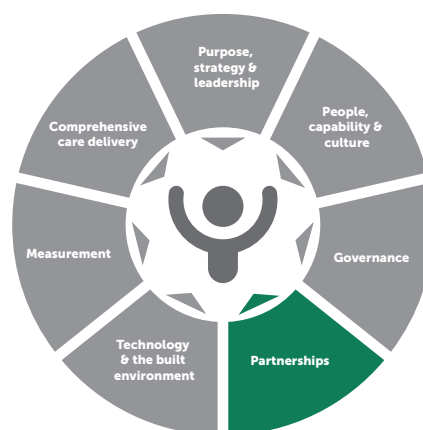






Table 17: Examples of Western Health initiatives to respond diversity

 <p>Culturally and linguistically diverse populations</p>	 <p>Lesbian, gay, bisexual transgender and intersex (LGBTI) populations</p>	 <p>People with disabilities</p>	 <p>Aboriginal and Torres Strait Islander communities</p>
<p>Western Health provides accredited interpreters for those patients who need one. The health service has increased the number of interpreters and implemented an improvement program to increase the use of interpreters for inpatients.</p>	<p>Western Health is using the Rainbow Tick Audit Guide to review its systems. The Rainbow Tick Standards and associated resources were developed by Gay and Lesbian Health Victoria and Quality Innovation Performance and support organisations to develop inclusive practices for the LGBTI community.</p>	<p>Western Health is committed to understanding the experiences and needs of people with disabilities. One way the health service does this is to deliver Disability Awareness Education each year to graduate nurses. The sessions are delivered in partnership with a patient at Western Health.</p>	<p>Western Health is implementing the Victorian Government’s Improving Care for Aboriginal and Torres Strait Islander Patients Program. Key initiatives include the development of an Aboriginal Health Roadmap, cultural awareness training for the workforce, partnerships with Aboriginal health services and organisations and Aboriginal employment initiatives.</p>

Carolinas Medical Center – Mercy, Carolinas HealthCare System, North Carolina, United States

Overview of the organisation

Carolinas Medical Center – Mercy (CMC–Mercy) is a full-service community hospital that provides general medicine and emergency care, but specialises in care of seniors, complex orthopaedic surgery, bariatric surgery, and women’s pelvic health.

The hospital has been in the community for over 100 years, having been founded by the Sisters of Mercy and supported by the Catherine McCauley MERCY Foundation, a Catholic charity and healthcare organisation with hospitals and other facilities around the world. In 1995, the Sisters sold Mercy to Carolinas HealthCare System and in 2012, Mercy joined the same licence as Carolinas Medical Center. Through these changes, Mercy became part of a large integrated health system.

Figure 12: About CMC–Mercy



Person-centred care at CMC–Mercy

In 2008, CMC-Mercy leadership decided to pursue the Planetree Person-Centered Care designation. In doing so, the hospital built on the foundation of providing care and compassion that was established by the Sisters of Mercy. As a result, person-centred care is the culture of the hospital. It is not something they do, it is who they are.

Mercy received Planetree designation as a person-centred care site in 2011 and has maintained it through two cycles of redesignation. Person-centred care is a core component of the organisation’s identity. It is infused in strategic, business, and operational decisions. When making decisions, the leadership, management, and the workforce ask themselves: ‘Is this in the best interest of the patient?’ If the answer is yes, the leadership, management, and members of the workforce implement the decision in the most effective way possible. This directly affects programs, service offerings, staffing, and investment of resources.

CMC–Mercy has made significant progress in becoming a high-performing person-centred care organisation. However, challenges to providing a high level of person-centred care exist. These include:

- Shortages of key professionals, in particular, nurses
- Difficulty finding qualified candidates that also understand and desire to work in an organisation with a strong culture of person-centred care
- Effectively using finite resources, whether financial or otherwise, to put in place programs and services that will benefit patients and further the hospital’s objective to provide person-centred care
- Maintaining leadership that understands, supports, and is committed to the hospital’s culture of person-centred care.

CMC–Mercy is committed to the delivery of person-centred care and will focus on identifying new and innovative ways to continue to do so. The leadership at CMC–Mercy is very supportive of innovation and those interviewed find the leadership open to new ideas and willing to pursue innovations that will benefit patients.

Key features of person-centred care

CMC–Mercy has many attributes that support the delivery of high-quality, person-centred care. This case study is not intended to be a comprehensive account of all these attributes. Rather, it seeks to highlight some key examples that other health organisations can learn from.

Leader’s actively nurture and model a person-centred culture

CMC–Mercy’s culture of person-centred care was cultivated, strengthened, and supported by its leadership. This includes the executive leadership of the hospital, but also through physician and nurse champions. These champions not only support the delivery of person-centred care in concept, but practise person-centred care delivery (in other words, they not only talk the talk, they walk the walk). A physician and nurse champion are important components to building buy-in and were particularly important in 2008 as CMC–Mercy began to design and implement its program.



In addition to executive leadership, CMC–Mercy has a team dedicated to the advancement of person-centred care goals within the organisation. This team consists of a dedicated Director of Patient Centered Care Programming, who is a physician, and a Patient Experience Coordinator. The Patient Experience Coordinator is responsible for monitoring performance. She analyses the performance data and works with leadership to address any areas in need of improvement, as well as identifies what is working well so that it can be maintained. The Director serves as the Physician Champion and helps guide the person-centred care program.

About five years ago, the leadership structure at CMC–Mercy changed, with many of the most senior leaders moving to the large, acute care facility, Carolinas Medical Center. This change in leadership structure and integration with the larger facility left many staff at CMC–Mercy feeling like they had lost some of their identity, which affected the culture.

The leadership structure had recently changed and is similar to how it was previously. Many individuals interviewed viewed this as a highly positive change, particularly since the new facility executive is one of the influential leaders that helped to drive Planetree person-centred care designation and has been committed to delivering high-quality person-centred care since its early inception. These changes highlight the significance of leadership in creating, maintaining, and improving a person-centred care organisation.

“There is a lack of bureaucracy here and an openness to innovation”

Director

Innovative programs support and empower patients and care partners

CMC–Mercy has put in place a number of innovative programs that support person-centred care (see Table 18). Many of these innovations do not require significant resource investment, but some do. For example, in 2008, the hospital made a \$90 million investment in upgrading the facility, modernising it and designing the hospital so that it has a calm and open feeling. While the physicality of the building is important, many interviewed noted that what matters the most is how people are treated while they are in the building.

A fundamental part of providing person-centred care at CMC–Mercy is transparency and communication. A key objective for the healthcare providers at CMC–Mercy is to set clear expectations for patients, provide communication along the care pathway, and then follow through on what the patient was told would happen. In addition, CMC–Mercy strives to care for the ‘whole person’ and not just the medical condition. This is seen through the many programs put in place to support patients, including integrative services and through the Spiritual Care and Education program (see Table 18). In addition to caring for the patient, CMC–Mercy strives to make family and friends feel supported. Family and friends are openly communicated with and included in decision-making (subject to patient agreement).

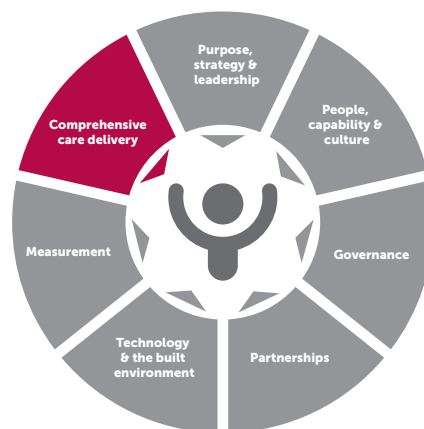


Table 18: CMC–Mercy innovative Programs

<p>Patient and Family Guide</p>	<p>CMC–Mercy has developed a patient and family guide that is available on the website and is provided to patients and care partners. This guide provides important information about what to expect during the stay, visitor information, patient rights, and contact information for offices and departments within the hospital.</p>
<p>Open medical records</p>	<p>CMC–Mercy shares the patient’s complete medical record with the patient upon request. Family and friends may also review the record with authorisation from the patient. If the patient has questions about what appears in his or her record, the physician or other care provider discusses the issues at the next visit with the patient, usually during the patient’s stay. This helps patients take an active role in their health.</p>
<p>Bedside journal</p>	<p>A complimentary journal is provided to the patient or care partner. This journal can be used to write down questions, symptoms, etc. that a patient or care partner wishes to discuss with the care team. The patient or care partner can also write down information received from the care team.</p>
<p>Bedside report</p>	<p>The daily bedside report occurs at the patient’s bedside as nurses transition shifts. The bedside report includes the patient or care partner’s details and presents an opportunity to speak with the nurse about the plan of care and ask questions.</p>
<p>Care partner program</p>	<p>CMC–Mercy acknowledges that family and friends (loved ones) are a vital part of a patient’s healing and support. Once admitted, the staff ask the patient if they want to designate someone as his/her care partner – someone who will assist the patient with his/her care during the hospital stay. If so, the care partner is included in discussions with the patient and the patient’s care team. The care partner receives a care partner badge, is oriented to the clinical area, and receives a discount in the hospital cafeteria.</p>

Table 18: CMC–Mercy innovative Programs (continued)

Care partner lounge	<p>CMC–Mercy invested in care partner lounges on each floor of the hospital. This is a comfortable area, separate from the patient’s room and the other areas of the hospital floor, where family and friends can take a few moments for themselves. The area has comfortable chairs, drinks, and snacks.</p>
Opening visiting hours	<p>The hospital has open visiting hours, meaning someone can visit a patient at any time of the day or night, including staying with a patient overnight. Visiting hours are open for patients on the Intensive Care Unit (ICU), except 6pm to 8pm.</p>
Spiritual care	<p>This program is led by a Director and has volunteers and members of the workforce who work with patients to assure that their spiritual needs are addressed. This is not a program focused on religion, but is intended to help patients feel spiritually or emotionally supported. Chaplains are available to patients to address their spiritual or emotional needs, whether that is through prayer or just through listening.</p>
Integrative services	<p>CMC–Mercy provides a variety of integrative services that are designed to address the whole-person-needs of patients. These include aromatherapy, massage therapy, healing touch, and pet visitation from certified pet therapy dogs.</p>
Patient and Family Advisory Committee (PFAC)	<p>The PFAC is a committee that consists of previous CMC–Mercy patients, family or friends of patients, and members from the community surrounding the hospital. The PFAC serves many roles, but the most important is to put themselves in the position of the patient and think about things from the patient perspective and then use that knowledge to help inform decision-making at the hospital. This includes, for example, reviewing written materials that will be provided to patients and providing feedback to assure that the materials are informative and understandable.</p>

The workforce is integral to high-performing patient-centred care

Another influential attribute that all interviewees acknowledged is the workforce. From the time of hiring, Mercy looks for candidates who will be a good fit for the culture.

The leadership at Mercy believes firmly that the workforce cannot provide person-centred care if they do not feel cared for and supported. As a result, the hospital emphasises training, education, support, and acknowledgement. This occurs in many ways:

- Members of the workforce, regardless of position or role, are referred to and treated as team mates; this helps contribute to the feeling that everyone in the hospital is part of a team and that they are in it together
- Members of the workforce receive orientation and training on person-centred care and the Planetree program
- Wellbeing programs and supports are put in place, such as ‘Schwarz Rounds and HeartMath training (see Table 19)
- Members of the workforce are recognised for their good work through appreciation days and performance awards.



Table 19: Support programs for the workforce

HeartMath training	Schwartz Rounds
<p>When CMC–Mercy launched its patient-centred care program, the hospital brought all members of its workforce through HeartMath training. This was based on the idea that they need to address their own wellbeing in order to provide high-quality person-centred care to others.</p> <p>HeartMath is a program that endeavours to help people connect their heart, mind and emotions so that they are prepared to engage in transformation.</p> <p>Given the transformation CMC–Mercy was going to engage in, setting this foundation was a priority. All members of the workforce participated in the training at an offsite location over a two-day period.</p>	<p>CMC–Mercy holds Schwartz Rounds for hospital staff only. All members of the workforce, regardless of role at the hospital, are welcome to participate.</p> <p>Schwartz Rounds are designed for healthcare professionals as a means to help them openly and honestly talk about issues that they encounter in their work day. With the increasing demand in health care to do more, faster and with fewer resources, healthcare professionals are experiencing increasing rates of stress, anxiety, and frustration.</p> <p>Schwartz Rounds create a safe environment where healthcare professionals can engage in interdisciplinary discussions about their experiences. The objective is to help the professional better understand his or her own responses and feelings, so that he or she is better prepared to connect with patients.</p>

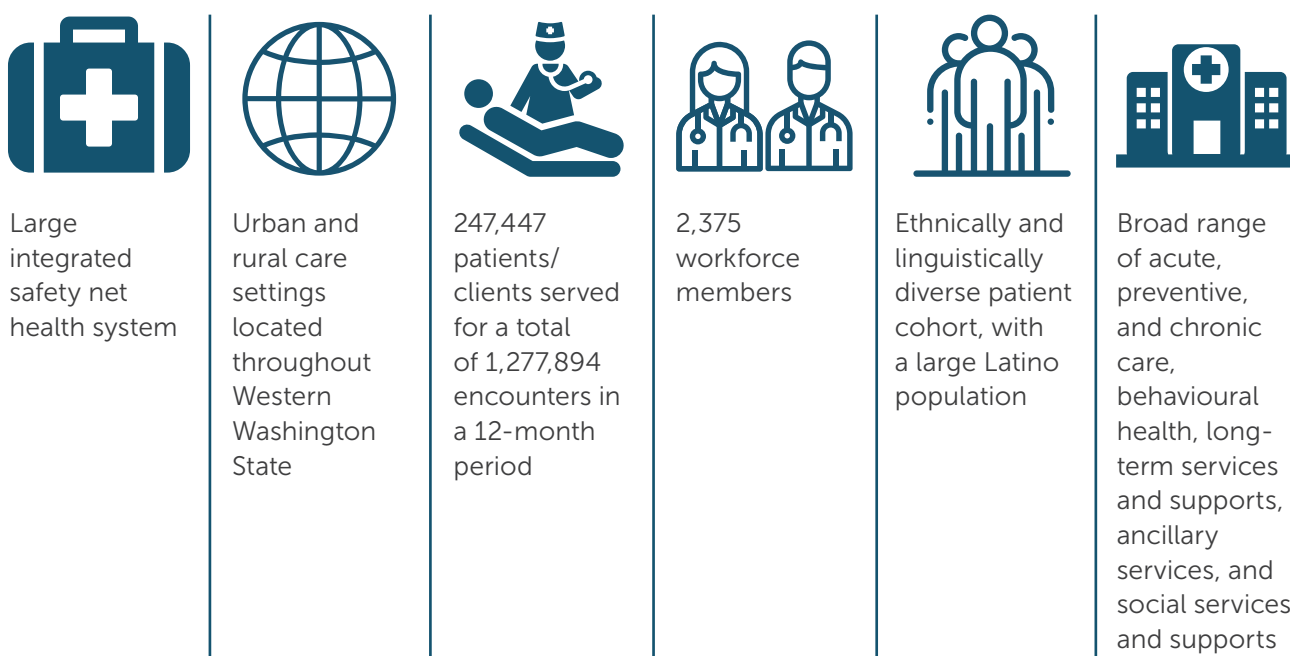
Sea Mar Community Health Centers, Washington State, United States

Overview of the organisation

Sea Mar Community Health Center (Sea Mar) is a large integrated community-based health system in Washington State (US). Sea Mar includes more than 90 medical, dental, behavioural health clinics, inpatient substance abuse treatment centres, skilled nursing and long-term care facilities. Sea Mar also provides a range of social and educational services, and affordable housing to the communities it serves.

Sea Mar is a Federally Qualified Health Center, which is a community-based health care organisation charged with providing health care and social services to underserved populations, including those who are homeless.⁴⁶ Sea Mar is accredited by the Joint Commission and has received the Gold Seal of Approval, demonstrating its delivery of safe and high-quality care.

Figure 13: About Sea Mar Community Health Center



Person-centred care at Sea Mar

Sea Mar was founded on the principles of social justice and a mission to meet the unmet needs within the community. Sea Mar strives to always put the patient first and to understand the communities where they provide services.

Most of Sea Mar's medical clinics are Patient-Centred Medical Homes (PCMHs) recognised by the National Committee for Quality Assurance. PCMHs are a model of care that puts the patient first and uses team-based care, data and information to deliver evidence-based care to patients, and care management and coordination to ensure that patients receive the right care at the right time. The model is supported through continuous quality improvement, including focusing on creating a positive patient experience.

While Sea Mar is a national leader in providing high-quality, integrated, person-centred care, they do face certain barriers. These include:

- Continuing to provide quality, person-centred care when the organisation is rapidly expanding to meet significantly increased patient demand from the expansion of health insurance coverage under federal law
- Providing truly integrated, person-centred care when funding is fragmented and comes with limitations and restrictions
- Availability of appropriately trained professionals, in particular nurses and bi-lingual/bi-cultural professionals
- Educating and informing a highly diverse patient population so that they can be active participants in care, rather than passive recipients
- Responding to external mandates that do not necessarily align with patients' needs and expectations.

Sea Mar is a solution-driven organisation. They do not see barriers as reasons not to do something; instead barriers are seen as an opportunity to think creatively. In the coming years, Sea Mar will focus on behavioural health integration into primary care, further integrate continuous quality improvement into the operations of the company, and continue to strengthen and refine its services and programs.

Key features of person-centred care

Sea Mar has many attributes that support the delivery of high-quality, person-centred care. This case study is not intended to be a comprehensive account of all of these attributes. Rather, it seeks to highlight some key examples from which other health services may learn.

Sea Mar strives to assure a positive patient experience

A core value of Sea Mar is that everyone deserves to be respectfully treated in a way that preserves dignity and enhances self-worth. One way in which Sea Mar strives to fulfil this value is through assuring a positive patient experience for every person, every time.

In 2015, Sea Mar embarked on a campaign, Improving the Patient and Employee Experience, to provide employees with the tools they need to provide exceptional service and to improve the patient experience. Sea Mar's goal is to have 100 per cent of patients rate their experience as Excellent. This is a multi-year process that includes many components (see **Table 20**).

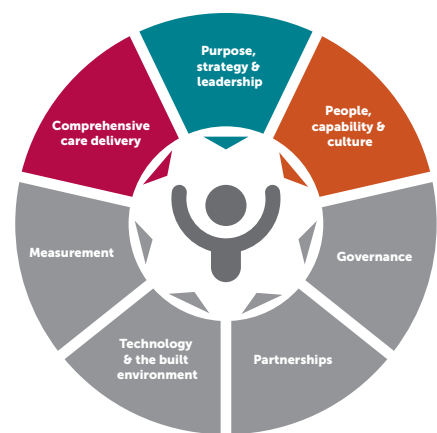


Table 20: Components of the Improving the Patient and Employee Experience campaign

Leadership	Established the Improving Patient and Employee Experience Committee, which consists of patient experience professionals and serves as a patient experience advisory resource for Sea Mar initiatives.
Employee Engagement	Conducted a survey to learn from employees what tools they need to provide exceptional service. The survey led to implementation of key initiatives including: AIDET Customer Service training, changes to the new employee orientation, new employee recognition programs for exceptional customer service, and continued focus groups to learn from employees how to improve the patient and employee experience.
Patient Engagement	Using a standardised, validated patient satisfaction and experience survey, ⁴⁷ Sea Mar measures the patient satisfaction and experience of care directly with patient feedback. Sea Mar also conducts patient focus groups to learn how to continuously improve the patient experience. Additionally, Sea Mar has introduced new technology and processes to ease access to care, increase patient participation, and improve patient/provider communication.
Continuous Quality Improvement (CQI)	Using the data obtained from the patient satisfaction and experience survey, Sea Mar uses CQI processes to identify areas in need of improvement and initiatives that could lead to improvement.

Sea Mar is deeply integrated with the community

Sea Mar was founded in 1978 by a group of Latino community leaders. This connection to the community has not been lost over time, but, instead has strengthened and incorporated more communities and cultures. Sea Mar works in partnership with communities to identify needs and find creative ways to address those needs. Sea Mar takes several approaches to remain connected with the communities:

- Employing professionals and staff directly from the communities where clinics and other care settings are located**
 Sea Mar employs bi-lingual/bi-cultural staff whenever feasible. Staff and providers who look like, speak the same language, and understand and respect the culture of the populations, are better able to engage patients in care, especially those who are not typically accepting of modern medicine.



- Conducting community focus groups to hear directly from the communities about what needs the community has and how they think Sea Mar can help meet those needs**
 For example, a recent focus group found that the community would benefit from an adolescent health clinic.
- Use of data to identify needs within the community**
 For example, Sea Mar providers found that when they referred patients to specialists, the patients were often not able to get appointments. When patients were able to see the specialist, the specialist did not often share the information with the provider at Sea Mar. These incomplete referrals and lack of information sharing led Sea Mar to develop its own multi-speciality clinic so that specialists work within the Sea Mar system.

This close connection to the community allows Sea Mar to provide innovative, community-focused programs and initiatives (see Table 21).

“We’re about empowering underserved communities”
 Senior Vice President

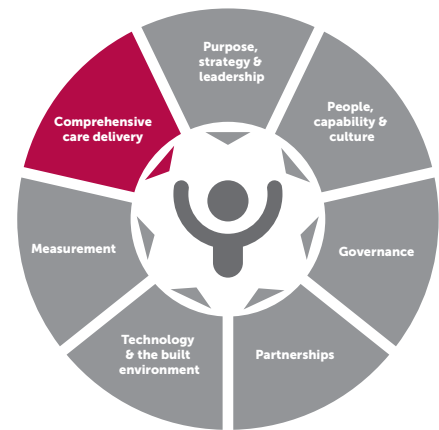
Table 21: Sea Mar’s Innovative Community Programs and Services

<p>Affordable Housing</p>	<p>Understanding the ‘housing first’ principle⁴⁸, Sea Mar has responded to the affordable housing crisis by developing affordable housing in three of the communities it serves.</p>
<p>Sea Mar Radio</p>	<p>A live radio program that is intended to help listeners achieve a better quality of life. The program includes topics on health education and prevention, community affairs and challenges, and other useful information intended to inform the listener.</p>
<p>Sea Mar Community Center and Latino Cultural Museum</p>	<p>A multi-purpose complex that includes an Education and Community Centre and Latino Cultural Museum. The centre provides meeting and office space, classrooms, art room, and athletic centre, which is home to Sea Mar’s youth boxing program. The Museum tells the story of Latinos in the Pacific Northwest and their unique story of migrating to the region.</p>
<p>Child Development Center</p>	<p>A child care and preschool program, providing a bilingual Spanish/English curriculum for children in the community. Includes an intergenerational program in partnership with Sea Mar’s Community Care Center, where residents of the Community Care Center interact regularly with the children at the Child Development Center, providing social skills and shared experiences for both children and seniors.</p>
<p>Community Care Center</p>	<p>A licensed skilled-nursing facility providing 24-hour supervised nursing care, personal care, therapy, nutrition management, organised activities, social services, room, board, and laundry. Includes a specialised Alzheimer’s Living Center.</p>

Using team-based care and standardised, synchronised patient flows, Sea Mar provides efficient, person-centred care

A core element of the Patient-Centred Medical Home is a team-based care approach. Through this approach, members of the care team are able to work to the top of their licence, care is more efficient and effective, and the patients' full scope of needs can be addressed. Sea Mar has spent a great deal of time and resources investing in a care team approach.

Of note, Sea Mar has spent the last three years developing a synchronised patient flow that is standardised across Sea Mar's multiple care sites. This allows for patients to be seen quickly (which is a priority of patients), but also to receive comprehensive care. Sea Mar also has introduced many ancillary services into their clinics (labs, X-rays, pharmacy) so that the clinic becomes a one-stop shop for patients. Key features of the synchronised patient flow are outlined in **Table 22**.



“We try to understand the patient and be a partner with them”

Physician

Table 22: Key features of team-based care at Sea Mar

The care team	At Sea Mar Seattle Medical Clinic, one of Sea Mar's largest clinics, the care team consists of the Primary Care Provider, two Medical Assistants, Nurse, Care Coordinator or Care Manager, and, if appropriate, a Behavioural Health Integration Specialist. At the centre of the team is the patient.
Gap analysis and care plan	The Medical Assistant runs what is referred to as a gap analysis report for each of the patients that the Primary Care Provider (PCP) is scheduled to see the next day. Through this process, the Medical Assistant identifies all of the patient's outstanding care needs, not just the specific reason the patient is coming in the next day. This could include vaccinations or cancer screening. Using this information, the Medical Assistant develops a care plan for the patient. When the patient arrives the next day, the patient is greeted at the reception desk, undergoes the check-in process, and is given the proposed care plan. The information is provided to the patient in his or her primary language.
Clinic set up and patient flow	The clinic is set up in a way that allows the patient to flow from one area to the next, according to the care plan. For example, if the patient needs lab work, the patient will go first to the lab and then to the exam room. The lab results are shared with the Primary Care Provider in real time using Sea Mar's electronic medical record. When the Primary Care Provider arrives in the room, all of the information the provider needs is in the medical record. The Medical Assistant attends the appointment, so that the PCP can focus on the patient, while the Medical Assistant documents in the medical record.
Care coordinators	Patients also have access to care coordinators, who educate patients about their conditions (for example, diabetes), and help coordinate access to services. Highly complex patients have a care manager who provides assistance with not only medical needs, but also helps to address social determinants of health. Finally, patients with behavioural health needs have access to a Behavioural Health Integration Specialist who works with the patient to address behavioural health needs in the primary care setting.

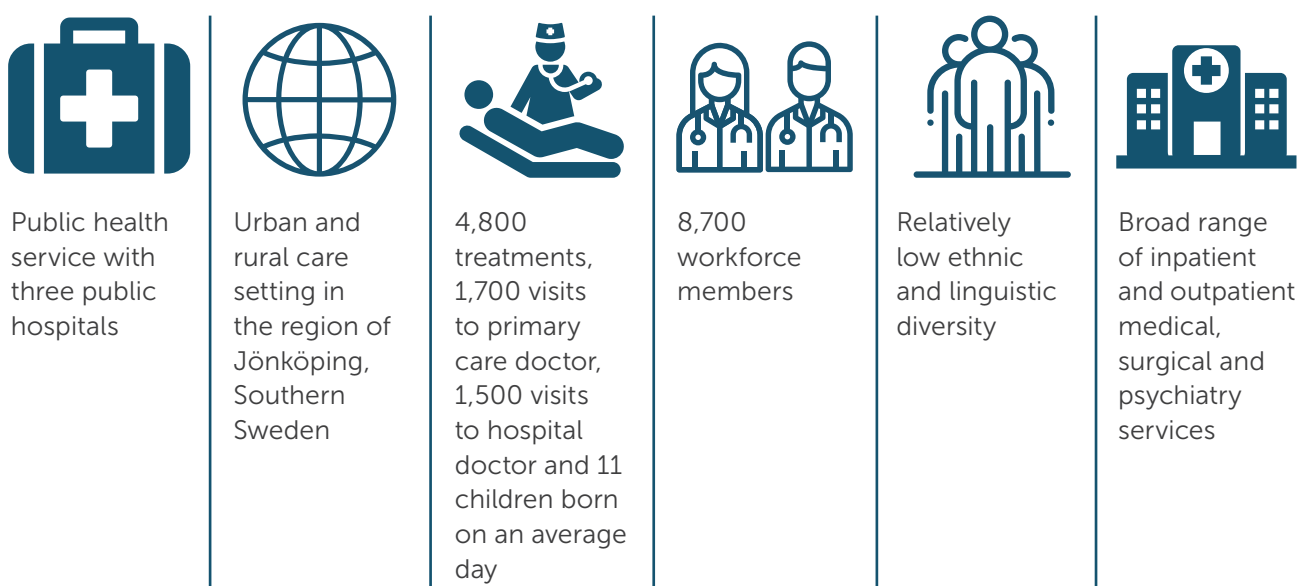
Jönköping Healthcare Service, Region Jönköping County, Sweden

Overview of the organisation

The Healthcare Service is part of the Region Jönköping County – an elected regional health authority serving around 340,000 people in southern Sweden. Services are organised in four health care processes: surgery, medicine and rehabilitation, psychiatry and primary care. The system also consists of three hospitals, each with an emergency room.

Region Jönköping County is best known for its work on quality improvement and developing integrated health and care services – particularly in aged care.

Figure 14: About Jönköping Healthcare Service



Person-centred care at Jönköping Healthcare Service

Jönköping's journey towards person-centred care started over 20 years ago – with the decision of the County Council to pursue a population-based vision for its citizens of 'a good life in an attractive region'. This vision encompasses a commitment to continuous quality improvement as a key business strategy in the delivery of health and social care.

Qulturum is a centre for innovation and development of improvement knowledge in healthcare. It was established in the late 1990s as the meeting place for innovation, creative collaboration, method development and skills development, and it has maintained an important strategic role in driving system level improvement and change. Qulturum initiates and leads large-scale changes on all levels, learning programs, break-through series, sessions, conferences, and consultative support in developing methods for improvement, evaluation and research.

Implementation of person-centred care at Jönköping is still an ongoing journey. The service has worked hard to both maintain enthusiasm and momentum in long-running programs, but also to evolve with leading and innovative practice.

Key features of person-centred care

Jönköping has many attributes across the health service that support the delivery of high-quality, person-centred care. This case study is not intended to be comprehensive account of all these attributes. Rather, it seeks to highlight some key examples that other health services to learn from.

Person-centred care is articulated and understood across the system

One of the most powerful and distinctive features of the Jönköping Healthcare Service is the extent to which person-centred care can be articulated and understood at a system level. This has been enabled through the long-standing Esther model (the model began in the late 1900s), which created a fictional persona for an elderly patient with complex needs that involve multiple providers. The central idea was that care should be guided by the following questions:

- What does Esther need?
- What does she want?
- What is important to her when she is not well?
- What does she need when she leaves the hospital?
- Which providers must cooperate to meet Esther's needs?

Over time, the Esther persona and program has become common language in the health service to articulate delivery of person-centred care. Providers across the system refer to Esther. 'Esther coaches' (clinical and administrative staff) to drive improvement projects on the ground. Patients see themselves as an 'Esther.' Quarterly events to involve communities in improvement and redesign take place in 'Esther cafes.' The term is also known and used in political discussion.

Recently, the service has been making a gradual shift from first asking 'What is best for Esther?' to focusing first on 'What matters to Esther?' This reflects a move from seeing the patient in the centre, to seeing the patient as part of the team.

Engaged and committed leaders foster a culture of improvement

Jönköping recognises that to create a culture that is dedicated to person-centredness and improvement, there needs to be a personal, active and visible commitment from executive and senior leadership. Jönköping Healthcare Service is fortunate that improvement, person-centred care and customer focus has had consistent senior leadership focus and support for a long time (this focus on improvement has been country-wide and not just in Jönköping).

The service invests in leadership development to drive change, and delivery of this training is an important function of Qulturum. The ongoing support of Qulturum and the involvement of the Executive Director of Qulturum in regional executive groups is a visible symbol of this commitment. On the ground, leaders demonstrate engagement and commitment to person-centred care by opening



each senior leadership meeting with patient stories, continuing support for growing the Esther Coach program (through which individuals receive eight days training in improvement and then commit to implementing an improvement initiative with their manager), and informally ‘asking the question’ when they speak with members of the workforce during rounds and fika (Swedish time for coffee and pastries).


Patients play a prominent role in disseminating patient-centred care and design of new services

Four individuals are employed as patient supporters within the health service. This is a funded role for patients inside the organisation that is complementary to the rest of the health system. This role recognises that everyone is expert in different ways, and that past patients with lived experience can have a particularly strong impact on peer experience of care. The role is not to act as the ‘patient’ in every meeting, rather to actively drive change in practice and co-design of new services.



“Strong patients are the influencers and innovators. We have to be humble enough to shift our behaviour. We are just a part of development in the whole society”
 Staff member

Figure 15: Role of patient supporters in design



Role of patient supporters in the design and operation of the Jönköping self-dialysis unit

A patient supporter was instrumental in the design and development of the Jönköping self dialysis unit, and has now been employed at the unit since 2012. When getting started, patients typically come in during the day and are coached by patient supporters, who have been through the unit themselves before. Patients feel that ‘an experienced patient can explain in a different way than someone who does not have the experience,’ ‘a patient supporter knows what it means to be sick.’ (Poster in self dialysis unit)

Broader patients and communities are also actively involved in sharing patient stories and co-design of service delivery. One way in which this occurs is through quarterly Esther Cafes, which are open to everyone in health and care services who want to improve life and care for Esther. The cafes feature a story or case study told by Esther, relaying their experience of recent health and social care services, followed by a discussion on what could be done better and sharing best practice. Each café event ends with an actionable list of improvements to be implemented. This involvement builds engagement in and ownership over the health service.

The service understands and responds to the needs of the local population

Region Jönköping County uses population level data and public health trend analysis to better understand the needs of the population overall and track health outcomes. This analysis allows plan to be systematically person-centred, not just at the individual level, and supports more effective use and distribution of resources. It also leads to targeted interventions for particular cohorts, with current focus on:

- Children and young people
- People with mental health conditions
- People living with drug and alcohol addiction
- Older people.

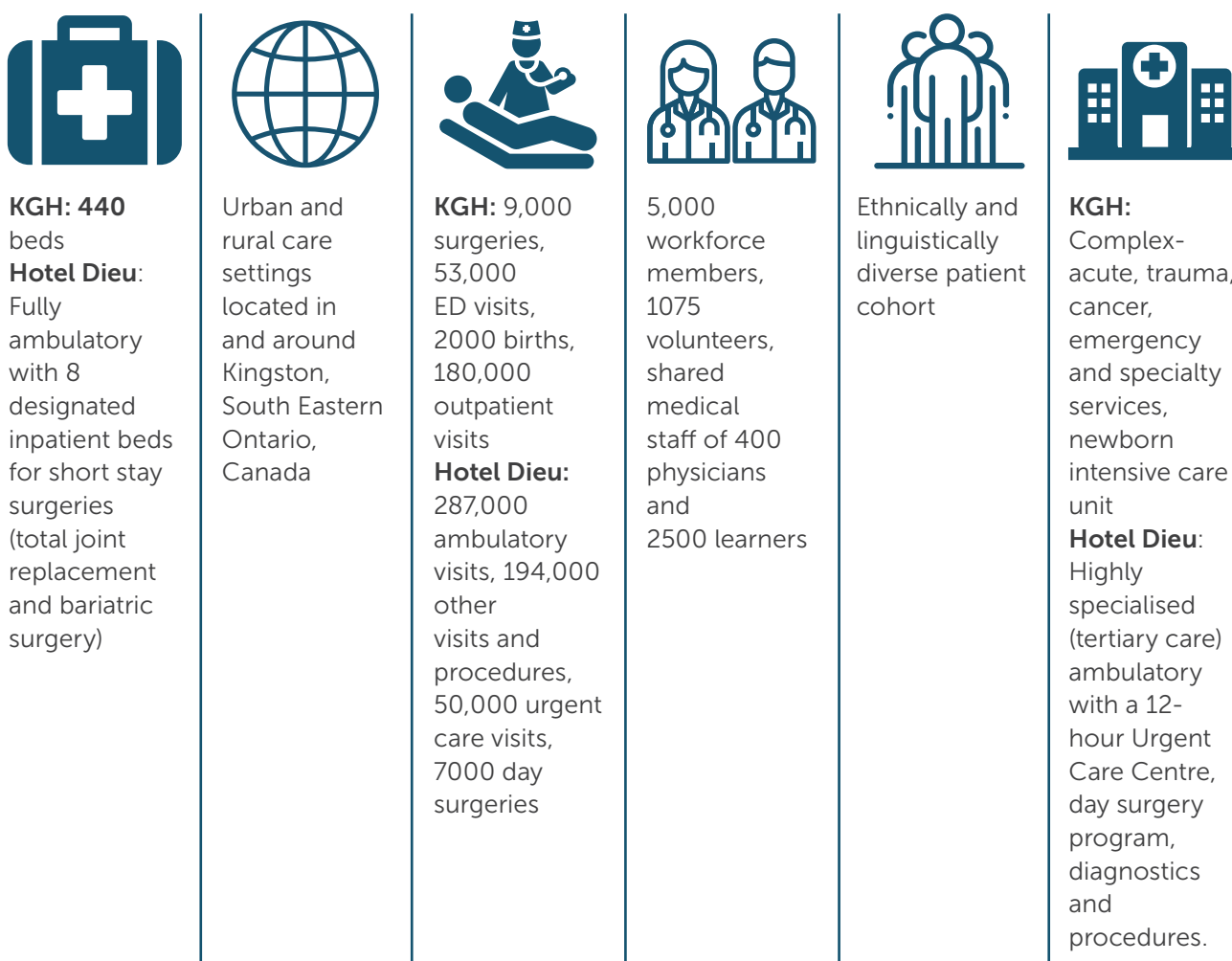


Kingston Health Sciences Centre, Ontario, Canada

Overview of the organisation

Kingston Health Sciences Centre was formed in April 2017 through the integration of two hospitals that have been part of the community for about 175 years – Kingston General Hospital (KGH) and Hotel Dieu Hospital (Hotel Dieu). KGH provides complex-acute, specialty care, emergency care, and trauma services and is home to the Cancer Centre of South Eastern Ontario. Hotel Dieu is a Catholic hospital originally founded by the Religious Hospitallers of Saint Joseph and now sponsored by Catholic Health International. Hotel Dieu is an ambulatory care hospital with specialized programs in paediatrics, medicine, ophthalmology, cardiology, urology, surgery, mental health, oncology and urgent care. Both hospitals are affiliated with Queen’s University and are teaching and research hospitals. Both hospitals are accredited with exemplary standing by Accreditation Canada.

Figure 16: About Jönköping Healthcare Service



Person-centred care at Kingston Health Sciences Centre

KGH began its person-centred care journey in 2007 and Hotel Dieu began a few years later in 2010. Because the hospitals have always worked collaboratively, Hotel Dieu looked to KGH for lessons learned, best practices, and advice when developing its patient and family centred care model. When KGH began its journey, it too sought mentorship, and partnered with Georgia Regents Medical Center in the United States. The hospitals have been very successful in creating a patient and family centred care environment, from direct patient care to involvement in hospital policies and program design. However, as is typical with significant systemic change, there have been challenges. These challenges include:

- Use of technologies that could facilitate person-centred care, such as a patient portal or electronic health record; however, the significant expense of these systems and provincial guidelines about regional requirements for IT investment
- Early identification of an executive level physician to serve as a champion for patient and family centred care, though physician champions have emerged
- Sufficient financial resources to carry out all programs and changes identified by patients and families that will improve the overall experience.

KGH and Hotel Dieu have not viewed these challenges as barriers to success, but instead as opportunities to put in place key change management strategies. All change takes time, but that is not a barrier, instead KGH and Hotel Dieu view the time it takes as a demonstration of good design and intentionality.

Key features of person-centred care

Kingston Health Sciences Centre has many attributes that support the delivery of high-quality, person-centred care. This case study is not intended to be a comprehensive account of all these attributes. Rather, it seeks to highlight some key examples that other health organisations can learn from.

“Don’t wait until you have your ducks in a row. Just get started.”

Lead Patient and Family Centred Care

Person-centred care is a core component of the organisations’ strategy and a priority of leadership

Kingston General Hospital (KGH) began its person-centred care journey in 2007 at a time when the hospital was in crisis. KGH had lost the confidence of the community and the health ministry and it was in serious financial trouble. The leadership of the hospital knew that significant changes had to be made. In response, the hospital went through a strategic planning process that intentionally focused on creating an environment of patient and family centred care. This process occurred simultaneously with a financial recovery and Ministry of Health imposed administrative and governance change. Despite considerable limitations of financial resources, the hospital leadership, starting with a new Chief Executive Officer, committed to becoming a high-performing patient and family centred care organisation.



Using the information gained through comprehensive stakeholder engagement, KGH identified four strategic objectives. The first was to transform the patient experience through a relentless focus on quality, safety and service by providing care that is consistently safe, excellent and truly patient-centred.⁴⁹ KGH also developed a strategy measurement process whereby the progress toward achieving the objectives is measured and reported publicly on a quarterly basis.⁵⁰ This sends a clear signal to the workforce that patient and family centred care is not optional.

In 2010, Hotel Dieu Hospital released a five-year strategic plan in which ‘Excellent Experience, Excellent Care’ was identified as a key strategic objective.⁵¹ Hotel Dieu used the principles of patient and family-centred care as the foundation to achieve this strategic objective.⁵² Hotel Dieu also implemented a process of measuring progress toward achieving the strategic objectives, including reporting to all leaders every 120 days and to the Board of Directors using a scorecard that tracked progress on key deliverables. Patient and family-centred care remains a key element of Hotel Dieu’s 2016–17 Strategic Plan.⁵³ In this Strategic Plan, Hotel Dieu is focusing on important enablers of patient- and family-centred care, such as investing in information technology and systems and enhancing performance, accountability and quality.

Through the integration process, Kingston Health Sciences Centre is the entity that now formally brings together the two sites. Kingston Health Sciences Centre has developed its first Integrated Annual Corporate Plan for 2017–18.⁵⁴ This corporate plan includes a focus on improving patient experience through compassion and excellence, and includes specific Quality Improvement Projects designed to do so. Later this year, the two hospitals intend to engage in joint strategic planning. They have a fully integrated leadership team responsible for continuing to provide high-quality patient and family centred care across Kingston Health Sciences Centre. This includes the Vice President, Missions, Strategy, and Communications and the Lead for Patient and Family Centred Care.

Patient Experience Advisors assure the patient perspective is meaningfully incorporated in decisions

The leadership and workforce at KGH and Hotel Dieu understood that patient engagement is vital not only at the point of care, but in decisions about the hospitals’ operations, program design, and continuous quality improvement. As a result, each hospital established Patient and Family Advisory Councils and the Patient Experience Advisor role. Each is described in **Table 23**.

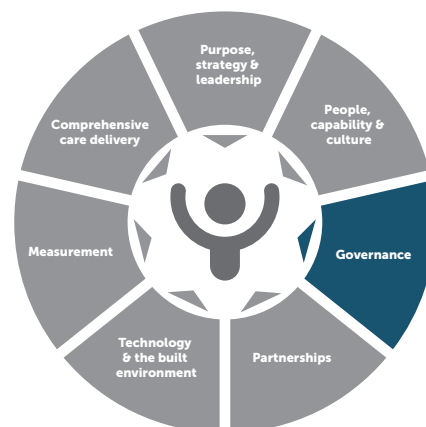


Table 23: Patient and Family Advisory Councils and Patient Experience Advisors

<p>Patient and Family Advisory Council</p>	<p>The Patient and Family Advisory Council is responsible for assuring that the hospital’s patient and family centred care strategic objective is being met, including, among other things, analysing data from surveys and other performance metrics and submitting a report to the Board of Directors on this progress. The KGH Patient and Family Advisory Council is co-chaired by a Patient Experience Advisor and by the Lead for Patient and Family Centred Care. The Hotel Dieu Patient and Family Advisory Council is chaired by a Patient Experience Advisor, but the Vice President, Missions, Strategy, and Communications serves as a non-voting member and supports the Patient and Family Advisory Council and its committees.</p>
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Patient Experience Advisor

A Patient Experience Advisor is someone who has had a recent experience at the hospital either as a patient or a family member. Identifying the right people to serve as Patient Experience Advisors is key. It is important to identify people who can partner with the workforce and leadership and look at the big picture. Someone who is an advocate for a particular issue is not likely to be a good fit as a Patient Experience Advisor, as this person may not be able to partner and seek to improve the patient and family experience broadly. The Patient Experience Advisors at both hospitals have participated in many endeavours, including serving as members of service-based and corporate committees, participating in job interviews, serving as members of program review and improvement teams, creating and giving new members of the workforce and residents orientation, and developing policies and procedures.

Through the process of integrating the two hospitals, the Patient and Family Advisory Councils and Patient Experience Advisors at both hospitals will evaluate whether the two separate councils should integrate and, if so, how and when that would be best done. This will be a decision made by the councils and not determined by the hospital’s leadership.

Workforce education and engagement is key to creating an environment of patient and family centred care

Both hospitals understood, from the outset, that everyone who interacts with a patient and family must receive education on patient- and family-centred care and that education must be continuous. Education is an important part of creating a culture of patient- and family-centred care. Through education, the hospitals empowered the workforce to be patient- and family-centred and distinguish between ‘good care’ and patient partnership.



To accomplish this, both hospitals have developed patient- and family-centred care education modules for new and current workforce members, and experts are brought in to provide training in the hospitals, as well as outside of the hospitals, such as those provided by the Institute for Patient and Family Centred Care. For example, Hotel Dieu developed a four-hour training module on the principles of patient- and family-centred care for all nursing staff and allied health professionals, and a condensed (two-hour) module for all others. Once the majority of the current workforce was trained, the module was introduced into the new workforce orientation. This was fundamental to orienting people to the language, concept and actions of patient- and family-centred care and to identify ways to partner with patients.

At KGH, the Patient Experience Advisors developed training for the workforce and residents, and Advisors also deliver this training. Additionally, KGH has brought in speakers to provide physicians and the workforce with training, such as Cleveland Clinics Communicate with H.E.A.R.T. program.⁵⁵

Between the two hospitals, more than 3,000 staff, residents, and physicians have been educated in the principles of patient- and family-centred care and receive ongoing education. Importantly, as teaching hospitals, both hospitals are effectively training new physicians and other healthcare professionals in the delivery of patient- and family-centred care. This has an important downstream effect, as residents and healthcare professionals complete their training, then move on to other care settings, bringing this training and practices to new sites and new patients.

An Interprofessional Collaborative Practice Model of Care supports patient and family centred care at KGH

KGH's strategic plan included an objective to bring to life new models of interprofessional care and education. KGH leadership understood the connection between interprofessional models of care and delivery of patient and family centred care. In response, 54 staff and physicians across different disciplines and services came together to develop KGH's Interprofessional Collaborative Practice Model. In 2010, Patient Experience Advisors were incorporated into the design and implementation process in order to assure that the model was truly patient- and family-centred. The KGH Interprofessional Collaborative Practice Model of Care consists of four interacting levers, supported by four enabling levers, outlined in **Table 24**.⁵⁶

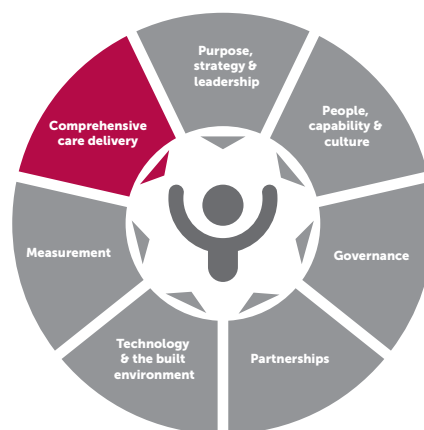


Table 24: Levers of the Interprofessional Collaborative Practice Model of Care

Interacting Levers	Enabling Levers
People working in a collaborative, interprofessional team with clear, consistent, appropriate roles	Collaboration and coordination across the continuum
Enabled by accessible technology	Effective communication
Accessing timely, accurate information to support decision-making	Ongoing education
Leveraging efficient, effective processes	Committed, supportive leadership

The Interprofessional Collaborative Practice Model of Care was implemented over a three-year period on 18 inpatient units and 33 ambulatory clinics. Evaluation of the model pre- and post-implementation was done on four of the inpatient units and has found improved patient satisfaction and quality of care, but has also found improved workforce and physician collaboration and job satisfaction. In addition, there is a greater sense of equality among patients and families as they are involved in decisions that previously have been limited to healthcare providers. There has also been improvement in role clarity among the care team.

The development and implementation of the Interprofessional Collaborative Practice Model of Care coincided with the hospitals work to redesign many of its processes and patient flows, which were also developed with Patient Experience Advisor input. Collectively this has resulted in significant improvement in patient care at KGH. The focus now has shifted from implementation to sustainability and continuous improvement. As the two hospitals continue integration, there is an opportunity to bring KGH's Interprofessional Collaborative Practice Model of Care model to Hotel Dieu or to redesign the model in a way that best meets the needs of the patients across the integrated system.

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