

Cooley Dickinson Hospital

2010 REPORT ON PATIENT AND FAMILY ADVISORY COUNCIL

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I. INTRODUCTION

At Cooley Dickinson, patient-centered care is a philosophy of providing care that encourages partnerships between patients, families and health care providers. It also recognizes the importance of patient participation in the delivery of care at all levels of the organization, and this model emphasizes the strengths, priorities and preferences that are unique to each patient.

At this point in time, the Patient and Family Advisory Council (PFAC) meets ten months of the year to help advance the goals of patient-centered care and effect change for patients and families at Cooley Dickinson Hospital.

II. COOLEY DICKINSON HOSPITAL — A SNAPSHOT

Cooley Dickinson Hospital (CDH) is a 142 bed community hospital, located in the City of Northampton, in rural Western Massachusetts. CDH offers advanced diagnostic and therapeutic care in many specialty and subspecialty areas of medicine and surgery. In addition, the hospital provides care and services in multiple health centers located within neighboring communities such as Easthampton, Holyoke, and Amherst.

- Each year Cooley Dickinson:
- Admits 8374 inpatients
- Handles 268,908 million outpatient visits
- Records 38,051 emergency room visits
- Performs 5,222 operations
- Delivers 804 babies
- Translates medical information between English and Spanish languages

In addition, CDH offers teaching and internship opportunities to high-quality students. CDH is committed to training and mentoring the next generation of area leaders in science and medicine, providing a wealth of opportunities for physicians, nurses, and other health professionals. These clinicians, in turn, provide fresh and innovative perspectives on care and treatment of patients.

III. PFAC AT COOLEY DICKINSON HOSPITAL

OVERVIEW

At CDH, the patient and family advisory council is grounded in the belief that health care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations and their lifestyles. Patient-centered care makes the patient and their loved ones an integral part of the care team who collaborate with health care professions in making clinical decisions.

COOLEY DICKINSON PFAC BACKGROUND

The first PFAC was formed at Cooley Dickinson Hospital in 2009. In May 2009, a twenty-member PFAC Task Force was established to develop policies and procedures for the permanent council. Meeting four times from May through August of 2009, the Task Force developed a draft charter and mission statement, membership application and selection criteria, and confidentiality agreement. Supplemental members of the permanent council, which was established in September 2009, were then recruited through the use of direct referral, word-of-mouth, and open applications.

There is considerable overlap between the members of the PFAC and participants in several service-based and hospital-wide committees, including the Hampshire County Continuing Care Consortium (HCCC) (established: 2008) and the Palliative Care Project Team (PCT) (established: 2009), which provide opportunities for regular case review and extemporaneous discussion. The frontline participation made possible through this committee work results in a hospital-wide impact.

As stated within the hospital's mission, CDH is committed to improving the health and wellbeing of the diverse communities it serves. In an effort to better inform this critical work, CDH also operates a Cultural Competency Committee (CCC) (established: 2009), comprised of staff, patients and families, and representatives from the community at large, which also includes PFAC members.

PFAC STRUCTURE

The PFAC is supported by CDH staff of the Patient Care Services Division, including the Vice President of Patient Care Services/CNO serving as a co-chair with a community council member. The PFAC currently meets ten months of the year and has a defined charge, mission statement, charter and agenda of priority initiatives. While the PFAC is largely self-determining in terms of setting priorities and driving agendas, it has specific structures and guidelines designed to facilitate governance and support its members.

PFAC COMPOSITION

The PFAC is comprised of representatives of the following groups: CDH volunteers and staffs, patients, and family members. At the conclusion of this year, the membership consists of twenty-five people, 58% of whom are patients and family members. At the conclusion of this fiscal year, the community co-chair stepped down from the council and a new community co-chair will be elected. Special attention has been given to the recruitment of representatives of several specific hospital constituencies, including ethnically, culturally and religiously diverse patients and community members. Members were recruited to offer enhanced representation of underrepresented groups such as older and younger adults, cognitively impaired patients, families with young children, non-users, and regional and clinical variations.

New council members undergo training and orientation to the hospital and its policies upon becoming a member. The orientation ensures that each member understands the

PFAC purpose, goals and policies. All members sign annually a hospital confidentiality statement.

The PFAC operations are guided by a formal charter and documents outlining its mission, purpose, membership committee, membership, membership terms, membership responsibilities, co-chair responsibilities. In addition, members of the council are integrated into a variety of key clinical microsystem units and serve as liaisons to hospital leadership.

Outside of the council's meetings, the group continues to connect via electronic mail and face-to-face meetings that help ensure accurate, timely and inclusive communication. Council members use these exchanges to engage in important dialogue, review draft materials, access video and other project-related communications, store meeting minutes (for at least five years), locate key reference materials, etc.

Priorities and Outcomes:

To help guide its work, the PFAC has identified several top priority areas of focus, including:

- Facilitation of communication and collaboration among patients, families, caregivers, providers, staff, administration and the board;
- Promotion of patient and family advocacy and involvement;
- Participation in promotion and development of programs, services, and policies for a model community hospital.

IV. FISCAL YEAR 2010 ACCOMPLISHMENTS

In November 2009, PFAC members participated in an extensive training. Massachusetts General Hospital (MGH), provided Jacqueline Summer and founding member of their respective PFAC, were guest speakers. MGH has a longstanding and effective patient and family advisory council and conducted a successful training to CDH PFAC. Topics addressed included: achieving sweeping and lasting reform, elements of a successful council, and ways of maximizing learning as a council. The guest founding member also presented a personal experience as a council member.

PFAC reviewed and identified several leading initiatives. The committee worked with CDH Microsystem teams and undertook the following three initiatives: Emergency Department Care, Palliative Care, Intensive Care. An information sheet was prepared to provide background and objective to patients and families who may be surveyed. Subgroups were formed which meet with clinical partners at CDH whereby collaboration was developed and the following is reported:

Emergency Department Care: After meeting with people working in the Emergency Department (ED), reviewing Press Ganey patient satisfaction information and other information gathering, the group decided to focus on issues of communication and patient satisfaction. Cooley Dickinson ED had been in the process of recruiting new leadership, for this reason, some group efforts got a late start. We made field trips to local

competitors. In addition, we made trips to the Emergency Departments, including travel to Middlesex Hospital in Connecticut, who had achieved Press Ganey Summit status ranking in the 95th percentile or above for a minimum of three years. A visit to Southwestern Vermont Medical Center had to be postponed. CDH Administrative Director of ED, and two staff members joined us for this all-day visit. We got a welcome reception and departed with many good ideas for CDH ED.

Palliative Care: Opening another Pod (Pod C for palliative care) was discussed and eventually delayed pending staff reorganization. Collaboration with CDH staff brought forward the following information:

- a. Palliative care is routinely (and necessarily) administered in the ICU when a patient's death is imminent (hours or days).
- b. There is a need to make ICU and palliative care rooms more comfortable by changing the atmosphere (music, couches, lighting, closing off medical equipment behind screens, etc.)
- c. There is a need for funds to provide needed atmosphere and décor changes
 - procedures and mechanisms needed to encourage families of deceased palliative care patients to donate for these changes;
 - a request to the Development Office will be made, especially as CDH has lost the services of J. Higgins, grant writer.

The Palliative Care subgroup will continue to explore ways to be a vehicle for post-mortem discussions with patients' families to determine quality of palliative care and suggested changes for improvement.

- d. Review and revise the current palliative care information booklet.
- e. Explore avenues for community education about palliative care.
- f. M. O'Brien will act as a liaison to Smith College for purposes of enlisting a student intern to aide the PCSG.
- g. Invite additional CDH partners to attend and become a permanent sub-group member.

Intensive Care: Group activities have included: subgroup planning meetings; a tour of the ICU; communication with a ICU nurse about added points to incorporate in the current ICU brochure in use; sub-group meetings with the Administrative Director, Critical Care Services and Telemetry nurse staff; trips to the volunteer and chaplains' offices to assess pamphlets currently available in the hospital; review and refinement of a draft brochure to be further discussed in the Intensive Care Unity break room at an ICU Microsystems Team Meeting.

Additional Work: PFAC members participated in critical strategic planning meetings for Cooley Dickinson Hospital led by the President/CEO. The PFAC is recognized as pivotal in representation of the community and their feedback has great value to the CDH administration.

V. FUTURE PLANS

The current subgroups will continue to their work in the upcoming year. The PFAC will also continue to review initiatives and create subgroups as needed. Currently, a subgroup is being formed to work in Women's Care at CDH.

The PFAC subgroups will provide a progress report at the council meetings as a means of tracking their progress throughout the year.

VI. SUMMARY

Moving forward, CDH will continue to cultivate the participation of patients and family members, incorporating their vision and voice into the work and various hospital initiatives. The PFAC will serve as the primary vehicle for doing so.

CDH has long been committed to creating a patient- and family-centered environment of care — the cornerstone of our mission. And this cultural value comes to life every day through the actions of our broad and distinct staffs. But it is the perspective — the voices and the vision — of our patients and families that provides our moral and operational compass.

The annual reports of the hospital PFAC are delivered to the hospital's Board of trustees by the vice president for patient care services, along with a designated patient/family member. The PFAC annual reports are available for download via the hospital's website (www.cooley-dickinson.org).

Thank you for this opportunity to share a brief overview of our PFAC and for future opportunities to report on its important work.

PATIENT AND FAMILY ADVISORY COUNCIL

Member Application Form – Patient or Caregiver

Date: ____/____/____

Name:

Mailing Address:

—

City: _____ State: _____ Zip

Code: _____

Telephone: ____ -- ____ -- ____ E-mail Address:

Date of Birth: ____/____/____

1. What is your preferred way of receiving communication about the council? (Please choose one)

Email Regular Mail

2. From which of the following sources did you learn about this opportunity? (Please choose one)

Newspaper Radio Internet Health care practitioner Word-of-mouth Other

(specify): _____

3. Have you or a family member had a recent health care experience? (i.e., within the past 2-3 years)

Yes No

➤ If yes, at which facility?

4. What do you want to achieve as a council member?

Please complete this form fully and return it by mail or e-mail to:

Leesa-Lee Keith
Cooley Dickinson Hospital
30 Locust Street
Northampton, MA 01061