

COOLEY DICKINSON HOSPITAL

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September 29, 2009

Dear Patients, Families and Friends:

The Patient and Family Advisory Council of Cooley Dickinson Hospital is posting for your review our mandatory report submitted annually to the Massachusetts Department of Public Health describing the activities of the new council.

If you have questions or need additional information, please do not hesitate to call Jennifer Higgins, Ph.D., at (413) 582-4969.

Cooley Dickinson Hospital

2009 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.

The newly formed Patient and Family Advisory Council (PFAC) meets quarterly 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 8334 inpatients
- Handles 223, 856 million outpatient visits
- Records 37,220 emergency room visits
- Performs 5,038 operations
- Delivers 800 babies
- Translates medical information between English and Spanish languages

CDH also conducts clinical research and trials in age-related disease areas, such as cancer and heart failure. It participates in discoveries and breakthroughs in basic and clinical research, which translate into new and better treatments that transform medical practice and patient care.

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 Quality Improvement and Patient Care Services Departments, with the latter serving as the PFAC co-chair. The PFAC meets quarterly 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. Membership consists of thirty people, 70% of whom are patients and family members. Special attention was given to the recruitment of representatives of several specific hospital constituencies, including ethnically, culturally and religiously diverse patients and community members. Additional 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. 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 monthly 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. ADDITIONAL COUNCILS/COMMITTEES/MECHANISMS

In addition to its clinically-focused Microsystems involvement, CDH has formally incorporated patient, family and community member participation into the three aforementioned committees: HCCC, PCT, and CCC, all of which focus on the key mission-driven area of patient-focused care.

HAMPSHIRE COUNTY CONTINUING CARE CONSORTIUM

In September 2008, the case management department underwent an intense period of reform aimed at reducing readmissions specifically and inserting the patient voice into the discharge process. A significant outreach spearheaded by the hospital was the founding of the HCCCC, a body comprised of professionals and community members involved in long-term care. Changes also included the implementation of a SNF hand-off communication survey, which resulted in an immediate improvement in patient and post-acute provider relationships through the discharge process.

The composition of HCCCC is designed to be broad, comprehensive, representative of the community at large and empowered to take action. It consists of 25-30 community members, including patients, family members, long-term care providers, and religious, community, and business leaders. In addition, the membership includes the hospital's director of quality, patient safety and care management and executive director of the visiting nurses association.

Members are invited to serve for an indefinite period. The HCCCC meets quarterly and on an as needed basis. HIPAA training is not required as members provide overarching input and are not involved in direct patient care.

As the work of the consortium continues and CDH initiatives move forward, committee members continue to provide an invaluable perspective, raising critical issues, and looking to root causes of and solutions for problems and challenges. For example, CDH's select participation in the new Institute for Healthcare Improvement initiative to develop strategies for dramatically reducing readmissions affords the consortium an excellent opportunity to underscore patient and family discharge planning preferences.

PALLIATIVE CARE TEAM

In 2009, a growing group of CDH physicians, oncology and case management staffs, and local religious leaders, prepared and submitted a request for funding of a pain management project designed to demonstrate the effectiveness of an educational intervention for improving culture-specific pain management and self-control. Palliative care staffs are particularly interested in undertaking this project given recent revelations about the role of cultural and religious beliefs of Cooley Dickinson's Catholic patients in particular for impacting length of stay, hospital readmission rates, negotiation of advance directives and code status, and patient and family experiences. What is perhaps most striking is that a recent review of patient mortality data revealed that 50% of inpatient deaths were of Catholics and that these same patients had increased rates of readmission at the end of their lives, were less likely to present with a DNR upon admission, and had elongated periods of time prior to converting to palliative care or a DNR status.

CDH's primary goal is to identify enhanced methods for engaging patients of particular faiths and cultural groups in discussion about end-of-life care issues earlier in their hospital stay or, even better, in advance of admission altogether. Previous research indicates that education of non-oncology staffs, such as primary care physicians, social workers, case managers, and clergy, who are surprisingly likely to report reluctance introducing the issue of end-of-life care decision-making, is an especially effective way to encourage more timely discussions of highly sensitive end-of-life care issues in patients throughout the entire continuum of care. This same research suggests that education of non-oncology staffs can have considerable quality and cost benefits for patients and hospitals.

From the outset, the PFAC counsel has been regarded as an important vehicle for bringing together members of the PCT and cancer patients. Several PFAC members have been cancer patients at CDH. A few others have staffed the units where cancer patients are treated within the hospital. A new PFAC member has a longstanding career in pastoral care and counseling patients on end-of-life care issues. This same member has also been involved in end-of-life care initiatives on the state and local level.

Many of the changes the PCT has initiated throughout the past few years have greatly benefited patients and visitors. For instance, the participation of employees from

across the hospital, as well as the critical input from PFAC members with histories of cancer, have helped the hospital to increase awareness about the need for increased dialogue about and more effective interventions for end-of-life care as well as the need for greater distinction between palliation and end-of-life care.

CULTURAL COMPETENCY COMMITTEE

The broad initiative of the Cultural Competency Committee (established: 2009) focuses on identifying and implementing strategies for making care more culturally sensitive through enhanced governance, administration and management, service delivery, and on-going training and education for the hospital overall.

In May 2009, the CCC sponsored a Northampton health department-led community event where a segment of the film series *Unnatural Causes* was shown. The film demonstrates how policy and the conditions of the community affect health. This event also served as the public showing of a PhotoVoice project –a project where local people used cameras and journals to record their experience of how the built environment supports or is a barrier to physical activity.

In June 2009, the CCC received the results of data collection about the cultural needs of the CDH community. Through this report, the CCC has gained a much greater understanding of the hospital's role as a healthcare system in improving access. It has also gained a greater understanding of the challenges faced by providers who are limited by time, resources, and experience with the Latino community, in particular.

In September 2009, the CCC began an inpatient organizational project to investigate systems for collecting enhanced demographics of underserved populations, review diversity training and educational offerings for hospital staff, research best practices of other hospitals, and produce a written report on the future work of the committee.

Through participation by PFAC members on the CCC, PFAC will continue to use this committee to report on culturally-sensitive project updates, make recommendations for internal system improvements to enhance health access, and inform on effective ways of meeting the needs of an increasingly diverse patient population.

V. FUTURE PLANS

In November 2009, PFAC members will participate in an even more extensive training. A guest speaker from an area hospital with a longstanding and effective patient and family advisory council will conduct the training. Topics to be addressed include: achieving sweeping and lasting reform, elements of a successful council, and ways of maximizing learning as a council. A founding member of the guest speaker's council will also present about his/her personal experience as a council member.

On the heels of what is anticipated to be a successful event and drawing upon the hospital's solid history of working with patients and family members, CDH is in the process of developing targeted projects for involvement by PFAC members. It is expected that over the course of the coming year PFAC will identify several leading initiatives to undertake in addition to its continued work with the aforementioned councils/committees. The goal is to keep the initial momentum of the nascent PFAC

moving forward and, more broadly, to further the integration of the PFAC into all hospital-wide activities and on all levels of the organization.

An annual report of the hospital PFAC will be delivered to the hospital's Board of trustees by the vice president for patient care services, along with a designated patient/family member. This report and PFAC minutes will also be available for download via the hospital's website (www.cooley-dickinson.org).

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.

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