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The Leading Edge

A case for integrating the Patient and Family Centered Care Methodology and Practice in Lean healthcare organizations

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ABSTRACT

Many healthcare organizations using Lean are becoming interested in the Patient and Family Centered Care Methodology and Practice (PFCC M/P). We suggest that integrating the two approaches can accelerate the pace of improvement and provide a powerful mechanism to keep the patient and family as the primary focus of improvement activities. We describe the two approaches and note the ways in which they are complementary. We then discuss the ways in which integrating the PFCC M/P adds value to patients, families, providers, and organizations and accelerates transformation. Finally, we suggest ways to implement PFCC M/P within Lean healthcare organizations.

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1. Introduction

Many healthcare organizations that have invested time and money in Lean process improvement have expressed interest in the Patient and Family Centered Care Methodology and Practice (PFCC M/P). The two main reasons are to address the challenge of keeping the patient (and family) as the primary focus of improvement activities and to add 'patient *experience*' as an equal focus with eliminating waste. While conceptually "patient first" is the process driver in Lean in healthcare organizations,[1] some healthcare organizations find this to be a challenge in conventional, real-world Lean implementation.[2,3] We suggest that integrating the two approaches – adding PFCC M/P to Lean – can address these needs, build on Lean efforts, and accelerate the pace of improvement. For organizations not yet using Lean, the PFCC M/P can be a catalyst for pursuing Lean process improvement. Organizations already using Lean who want to pursue the PFCC M/P as well can adopt the PFCC M/P quickly and at minimal (to no) incremental cost.

To understand how the PFCC M/P augments Lean in healthcare organizations, we first describe the central ideas in Lean (briefly because of the already-widespread use and understanding of Lean in healthcare) and then in more detail the steps and principles of the PFCC M/P. We note the ways in which the two approaches are complementary, followed by a discussion of the differences and how integrating the PFCC M/P increases value to patients, families, providers, and organizations. Finally, we suggest ways to implement PFCC M/P within Lean healthcare organizations.

2. Basic principles of Lean in healthcare organizations

The Toyota Production System (TPS) was developed more than 50 years ago to streamline manufacturing processes, primarily through the elimination of waste in work processes.[4] The term "Lean" was coined in the 1990s and Lean concepts that evolved from TPS began to make their way into healthcare.[4] The central idea in Lean in healthcare is to improve the quality of care for patients, the ultimate customer, by eliminating waste and inefficiencies (with a zero defect goal) using these core principles[4]:

1. Identification of customer value;
2. Management of "value stream";
3. Developing capabilities of flow production;
4. Use of "pull" mechanisms to support flow of materials at constrained operations; and
5. Pursuit of perfection through reducing to zero all forms of "waste".

This is typically accomplished by small teams of staff trained in Lean techniques, working to optimize the flow of products and

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services horizontally through value streams. In the best case scenario, Lean implementations in healthcare include strategy deployment so that horizontal, vertical and longitudinal integration of improvement throughout divisions of the organization can occur.

Table 1
PFCC Working Groups at [blinded for peer review version]: 2006–2014.

Hospital or Facility	Care Experience Working Group
Charles Morris Skilled Nursing and Rehabilitation Center	Day of Admission
Children's Hospital of Pittsburgh of UPMC	PFCC Champion Working Group
	PFCC Ambulatory Super Group
	Ear, Nose & Throat
	Pediatric Outpatient Surgery
	Dental Services
	Surgical Care
	Inpatient Medical Care
	Emergency Room Registration
	Radiology
	Pediatric Intensive Care
Magee-Womens Hospital of UPMC	PFCC Network and Shadowing Exchange
	HCAHPS – Cleanliness and Noiselessness
	HCAHPS – Discharge/Portal
	HCAHPS – Care Giver Communication
	Antepartum Care
	Bariatric Care
	Breast Surgery
	End-of-Life Care
	Geriatrics
	Hand-Hygiene
	ICU Care
	Life After Weight Loss
	Lobby/Wayfinding
	Neonatal Intensive Care
	Perinatal Loss
	Secure Environment
	The Bone and Joint Center
	Women's Cancer Services
UPMC Mercy	Emergency Services
	Surgical Care
Mon-Yough Community Services	Adult Outpatient Care
	Dual Eligible Care
	Mon Yough Child and Family Care
UPMC/Jefferson Regional Home Health	Home Health Rehabilitation
	Inclusion
	Take My Call
UPMC Passavant	Orthopaedics Specialists
UPMC Presbyterian	PFCC Super Working Group/Network
	Bedside Shift Report
	Ambulatory-Outpatient Care
	Communication
	Center for Liver Disease
	Endocrine
	Cardiothoracic Care
	Imaging Patient Access
	Dining
	Environment of Healing
	Medication Reconciliation and Discharge Medications
	Mobility Care
	PFCC Hospital Team
	Portal Experience
	Surgical Care
	Pre-Transplant Care
	Transplant Care
	Trauma Care
UPMC St. Margaret	Employee Inclusion
	First Impressions
	Surgical Care
UPMC System	Lactation Network

3. Basic principles of the PFCC M/P

The PFCC M/P was developed in 2006 at a large integrated academic health system. The PFCC M/P's 6-step approach views all care experiences through the eyes of patients and families and then closes the gap between the current and ideal state. Over the past 8 years, the PFCC M/P has been adopted in over 65 different clinical areas (Table 1) at the health system where it was developed and is increasingly being adopted by healthcare organizations nationally and internationally.[5,6,7,8,9,10,11,12]

The PFCC M/P creates value by improving healthcare experiences over the full cycle of care, concurrently improving outcomes and decreasing cost – the PFCC Trifecta.[5,6,7,8,9,10,11,12] While eliminating waste and inefficiency is one outcome of the PFCC M/P, a broad array of opportunities to improve care delivery are identified through this approach, with its unique, laser-focus on the perspective of patients and families who are engaged as full partners in redesigning care delivery. Priorities for action are identified by what is most important to patients and families. Teams of staff (or care givers in the language of the PFCC M/P), from each and *every* touchpoint that impacts the experience of care, collaborate with patients and families to identify the current state and the ideal state. With the ideal state in mind, they work to close the gap between them. The broad cross-functionality and sustainability of these teams (called PFCC Working Groups) creates the culture change starting at a grass-roots level and growing out and up throughout the organization.

While simple to understand and to implement (users can literally learn about it one day and begin to apply it the next), the PFCC M/P is based on a wealth of theoretical underpinnings (Table 2), belying its simplicity. There are 3 fundamental keys to the success of the PFCC M/P:

***Key #1*: Viewing all care as experiences exclusively through the eyes of patients and familie**s. Through the six steps of the PFCC M/P, care delivery is redesigned around patients and families rather than requiring patients and families to fit into the existing organizational structure.

***Key #2*: Engaging patients and families as full partners in co-designing care**. This is important for assuring that care redesign truly meets the needs and desires of patients and families. After-the-fact data found in surveys and focus group feedback is useful but hard to act upon in a truly meaningful way. PFCC M/P tools provide real-time understanding of patients' and families' experiences, from their points of view, in a way that can be acted upon quickly and effectively.

***Key #3*: Providing *simple* methods within complex systems to overcome hurdles and break down barriers to providing ideal care delivery**. The PFCC M/P creates broad teams of care givers from every function and level of the organization who *work together* to close the gap between current and ideal care experiences. These cross-functional teams break down the existing silos pervasive in healthcare settings to create high performance care teams focused on transformational change.

The Patient and Family Centered Care M/P

Step 1: Select a 'care experience' (e.g., total joint replacement, bariatrics, home care, trauma services, etc.) for improvement and define the beginning and end points of the care experience on which to focus

Step 2: Establish a 3–4 person PFCC Guiding Council (Administrative and Clinical Champions and a Coordinator)

Step 3: Identify the current state through Shadowing and Care Experience Flow Mapping

Step 4: Establish a cross-functional and cross-hierarchical PFCC Care Experience Working Group

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