Lessons Learned From Two Decades of Patient- and Family-Centered Care in Radiology, Part 1: Getting Started

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Abstract

Patient- and family-centered care has a long history, but the application of these principles to radiology is limited by infrequent direct patient contact for many radiologists; scarce peer-reviewed data in the radiology literature; and sparse access to implementation strategies, tools, and best practices. In a series of two articles, the authors share two decades of lessons learned from implementing patient- and family-centered care in a radiology department.

Key Words: Patient- and family-centered care, patient-centered design, patient experience, patient satisfaction, radiology, Imaging 3.0

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INTRODUCTION

Patient- and family-centered care (PFCC) is a model of delivering care in which patients are partners in the design of their care [1] (see Table 1). Principles of patient engagement and PFCC are entering all aspects of health care, from shared decision making to reimbursement. The changes are due in part to the linkage of patient experience to reimbursement for hospitals through the Medicare Value-Based Purchasing Program and physicians through alternative payment programs and the Merit-Based Incentive Payment System. PFCC is particularly criticized for the limited availability of data showing quantifiable results of this approach to care. Some results have been published in the peer-reviewed literature [2]. Other data are often not published in peer-reviewed journals commonly read by physicians or may not even be found in the peer-reviewed literature [3-6]. The lack of a common nomenclature or formal taxonomy further limits the successful dissemination and identification of effective strategies and tactics to transform care. For hospitals and physicians who are just starting to explore this space, it is helpful to look at lessons learned and best practices from organizations that have already begun this journey and achieved demonstrable success.

Radiology has unique challenges because not every encounter includes a direct interaction between a patient or family and a radiologist. Although radiologists seldom experience PFCC in current imaging workflows, when interaction with patients does occur, it can have measurable impact. In our experience at our own and at other institutions, limited direct interaction between radiologists and patients does not diminish the impact radiologists can have on other aspects of the radiology experience, such as ensuring that appropriate imaging occurs and delivering a high-quality, actionable report that informs care. We contend that PFCC can occur in all aspects of the imaging value chain, regardless of whether patient and radiologist interaction actually occurs [7].

In a two-part series, we review two decades of experiences with implementing PFCC principles in a radiology department at an academic medical center. We highlight factors that are enablers and accelerators as well as potential barriers and obstacles encountered. We present a

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Table 1. Patient- and family-centered care principles

Dignity and respect
Information sharing
Participation
Collaboration

Source: Johnson [1].

series of real-world projects that engaged patients and families, along with the trade-offs, lessons learned, and actual outcomes. Because the hospitals in our health system changed names over the past two decades, we refer to the institution as "our institution." In this first article, we focus on the beginnings of PFCC at our institution through two case studies. We study the design of a new children's hospital (including the creation of a pediatric radiology department) and the renovation of a mammography suite. In the second article, we will study a series of smaller renovations in a radiology department and the lessons learned from each project. We believe that this approach will demonstrate that it is possible to implement PFCC in radiology. It will also encourage additional experimentation and the development of a larger body of evidence to propel PFCC adoption forward in radiology.

BUILDING A HOSPITAL WITH CHILDREN AND PARENTS

It is important to understand the time period when our institution began its PFCC journey. Angelica Thieriot formed Planetree in 1978, after a series of traumatic personal health experiences [8]. Planetree was named for the tree under which Socrates taught medicine to his students and was focused on a holistic and patient-centered view of medicine. Every aspect of health care was to be reevaluated from the patient perspective. In the 1990s, the pediatric community was exploring ways to include families in the care of chronically ill children [9-11]. It was in this environment that planning for a new children's hospital began. The process was led by the medical center's executive director, Patricia Sodomka [12], and was unprecedented. Sodomka was a hospital administrator but had a clinical background as a physical therapist. In 1993, the Family-Centered Care Steering Committee was formed at our institution [5]. Several parents of young children with chronic conditions were identified by nursing staff members to participate. As a first step, both staff members and families were trained to learn how to collaborate effectively. Three critical planning elements were identified; the first element was defining core values (Table 2). In the first year, hospital leaders convened a retreat at which administrators, clinical staff members, families, and both community and faculty physicians developed a philosophy and value statement for the new hospital. A second critical element was the expanded involvement of families. After the retreat, family members were appointed to all design committees for the new hospital. The Family-Centered Care Committee was appointed and charged with exploring ways to integrate family-centered care into all aspects of the new hospital.

Through these progressive interactions and collaborations, the hospital planners recognized the opportunity to move beyond naming patients to committees; by

Table 2. Statement of values

The Children's Medical Center honors each child and family as unique and respects their values, needs, environments, cultures, resources, and strengths. We recognize them as integral members of the health care team. Therefore, we believe:

- In empowering all employees to be family-centered, in an environment where education and employee development is valued;
- In providing a healing environment:
  - that offers access to friendly, natural environments appropriate to the development needs of children,
  - where the daily needs of families are met in a comfortable and nurturing way,
  - where procedures are performed with respect for the dignity of children and families as well as the privacy and psychological well-being of individuals, and
  - that promotes family-to-family support and networking;
- In education and research programs for students and professionals that incorporate family-centered values;
- In the participation of community-based physicians, health care professionals, community service providers, families, and other members of local communities in carrying out the mission of the Children's Medical Center;
- That the exchange of information with families and across disciplines in the hospital and community is essential to promote the health and well-being of children;
- That policies based on family-centered care concepts promote efficiency, cost effectiveness, quality care, and flexibility.