



Patient and Family-Centered Collaborative Care: An Orthopaedic Model

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Abstract

Despite both longstanding and recent interest in patient-centered care, there are few models or methodologies for defining and implementing patient-centered care in the office and hospital setting thru a full cycle of care from the patient's perspective. We describe patient and family-centered collaborative care (PFCCC) as a low-technology, systems-based solution to many of the problems and challenges in today's healthcare arena and how to implement it in the hospital setting to provide safe, effective, timely and efficient health care. We hypothesized a patient and family-centered collaborative care model would provide a high quality of health care delivered, as well as a unique patient and family experience, within an orthopaedic setting. Prospective data was collected on six hundred eighteen consecutive patients undergoing total hip arthroplasty or total knee arthroplasty within a dedicated PFCCC orthopaedic program. Quality outcome measures showed a high level of patient satisfaction with overall satisfaction score of 91.4 using the national Press Ganey Survey. Infection and mortality rates were 0.3% and 0.1%, respectively. Average length of stay was 2.8 days for TKA and 2.7 days for THA with 91% of all patients (TKA and THA) being discharged directly home and 93% walking without handheld assistance at time of discharge. The PFCCC model is not just another clinical pathway, but a comprehensive systems-based approach that focuses on the full cycle of care while placing patients and their families as the top priority in order to provide a high quality of health care.

Introduction

Today's healthcare environment presents tremendous challenges to providing quality care to patients, including staffing shortages, ever-changing regulatory requirements, skyrocketing costs, and access issues. Although healthcare professionals consciously strive to provide quality outcomes and a satisfying patient experience, addressing these complex issues on a daily basis can easily command the majority of the attention of healthcare professionals, preventing even the most well-meaning from providing truly "patient-centered" care.

The Institute of Medicine (IOM) defines patient-centered care as "health care that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients' wants, needs and preferences and solicit patients' input on the education and support they need to make decisions and participate in their own care."⁹ In a subsequent report, the IOM defines a model of patient-centered health care which includes six criteria for improving the quality of health care in the United States. This IOM report states the aim of health care should be safe, effective, patient-centered, timely, efficient and equitable.¹⁰ The American Academy of Orthopaedic Surgeons (AAOS) has defined patient-centered care as "safe, effective and timely care achieved through cooperation among the orthopaedic surgeon, an informed and respected patient (and family), and a coordinated health-care team"¹⁵ In a 2001 article published in the *British Medical Journal*, Stewart described what patient-centered care is not: "it is not technology-centered, doctor centered, hospital centered, disease-centered."¹⁴

Taking these definitions of what patient-centered care is and is not, together with the day-to-day challenges with which healthcare professionals are faced, we are left with a healthcare system in which patient-centered care is an ideal that is rarely achieved. Instead, we have a healthcare environment typified, at best, by systems that require patients to “fit into” established routines that work for their caregivers and, at worst, poor quality care that is provided in a manner that is dissatisfying to patients and their families and in which patients are harmed rather than helped.⁹

A number of published articles call for the development of a patient-centered care model in the field of orthopaedic surgery.^{7,15} However, there are limited published reports in the literature highlighting patient-centered care programs, and how to develop and implement such programs as a tool to reach these stated health care goals. What then can those involved in the design and provision of health care today do to make a substantive improvement in the patient-centeredness and quality of the care they provide?

Furthermore, can providing patient-centered care maximize the quality of care provided within the orthopaedic setting? We describe patient and family-centered collaborative care (PFCCC) as a low-technology, systems-based solution to many of the problems and challenges in today’s healthcare arena and how to implement it in the hospital setting to provide safe, effective, timely and efficient health care. These quality measures in health care can be tracked by measuring outcomes, including; infection, mortality and dislocation rates, pain levels, patient satisfaction and physical function levels, length of hospital stay and discharge destination, and operating room efficiencies. The PFCCC

model of health care delivery is not just another clinical pathway, but a comprehensive systems approach thru the full cycle of care that uses the proper perspective of placing patients and their families at the center of focus.

The current state of health care delivery and in particular, total joint replacement surgery has become a commodity with little differentiation. Patients expect the best physicians, highest quality service, and newest/greatest technology available. Although these expectations are reasonable, the services provided often overshoot patients' needs or miss the boat entirely. Overuse, underuse, and misuse are pervasive quality problems in American medicine.⁴ An extensive literature review conducted the same year by the RAND Corporation substantiated each of these three quality concerns.⁶

PFCCC is a key area for hospitals and physicians looking to improve quality and differentiate themselves, resulting in a gain of patients and patient and family loyalty, but also resulting in significantly improved efficiencies and cost effectiveness. According to The Picker Institute, a nonprofit organization dedicated to improving healthcare quality through patient satisfaction, "The people who participated in the AHA focus groups...are deeply troubled about the changes they see taking place throughout the health care system. They are doubtful about the quality of the care they are getting and about the competence of their caregivers."¹³ Based on data collected by Picker from over 350,000 patients, what patients want falls into eight categories: (1) respecting a patient's values, preferences, and expressed needs; (2) access to care; (3) emotional support; (4)

information and education; (5) coordination of care; (6) physical comfort; (7) involvement of family and friends; and (8) continuity and transition.

Healthcare practitioners are, for the most part, compassionate, skilled, and caring. Yet, today's healthcare systems fail in providing a consistently satisfying, quality experience to those seeking healthcare services. This environment presents opportunities for low-end, in what Clayton Christiansen⁵ describes as “disruptive” processes to improve quality, satisfaction, and loyalty—processes that are not only systems-based, but disrupt the existent structure and routines of the healthcare delivery systems and are inexpensive and simple for both healthcare providers and patients.

The theoretical framework of health care delivery has been side-tracked by a lack of value-based competition. Porter and Teisberg, in their book, *Redefining Health Care: Creating Value-Based Competition on Results*,¹² provide a compelling explanation of the current, broken state of healthcare delivery and set forth a vision for refining healthcare systems that will result in improved quality care at lower cost based on value to the patient.

They submit the root cause of the current, failing state of healthcare delivery is the fact competition in health care operates at the wrong level. Rather than being focused on delivering value for patients, competition in the healthcare sector has become zero sum. Competition by healthcare providers to shift costs, increase bargaining power with health plans, capture patients and restrict choice, and reduce cost by restricting services erodes

the value of care to patients. Zero sum competition divides the pie rather than expanding it. Furthermore, competition takes place at the level of discrete interventions or services rather than addressing medical conditions over the full cycle of care, which includes prevention, diagnosis, treatment, rehabilitation, and ongoing management. This lack of value-based competition has supported a nonintegrated patient care environment in which patients receive piecemeal, fractured care across a variety of hospital departments, medical specialties, and physician practices in which each venue focuses only on a discrete intervention. Care providers rarely, if ever, meet, limiting the amount of shared information; outcomes and efficiencies suffer and errors are more likely to be made. Value can really only be measured over the medium or long-term, when true outcomes and full costs analysis can be measured. Measuring outcomes and cost during discrete interventions ignores the patient, who benefits from positive outcomes over the long term.

If competition were realigned to focus instead on a medical condition over the full cycle of care, true value would be delivered to patients and this level of healthy competition would “drive improvements in efficiencies and effectiveness, reduce errors, and spark innovation,” according to Porter and Teisberg. There are examples of competition at the right level where care is integrated across the full cycle and physicians attract patients based on results and price. In these instances, cost and quality improve. Specialty hospitals would be an example of competition at the right level. They exemplify an integrative model with dedicated teams, deep expertise, and facilities tailored specifically to patient needs. Specialty hospitals are designed with services and care providers

located within a single site focused on the entire cycle of care. Many are achieving good clinical and patient satisfaction outcomes and lowered costs in comparison with traditional hospitals.¹¹

We can also look outside the healthcare arena for a theoretical framework that, when applied to health care, can change the landscape of patient care delivery in ways that will bring substantive improvements to quality, outcomes, and patient satisfaction.

Christiansen, of the Harvard Business School, popularized the term “disruptive technology” to describe new products, services, and business models that initially target small customer segments but eventually evolve to take over the marketplace. In his 2003 book, *The Innovator’s Dilemma*,⁵ Christiansen uses the computer disk drive industry to illustrate how many companies and industries overshoot their customers’ needs even when applying sound business strategies such as conducting market studies. As opposed to innovations that make changes to the same basic products (sustaining technologies), disruptive technologies are cheaper versions of existing technologies that initially address a small market and eventually revolutionize the market because they have features that customers value. They are not “crammed” into existing procedures and processes but are separate, standalone ventures sometimes established as new businesses. Products based on these features are often less expensive, smaller, and easier to use.

Examples of disruptive technologies in the nonhealthcare arena would be automated teller machines, e-learning in place of classroom teaching, and i-Pods. These innovations each cut into the low end of their respective industries and eventually

evolved to displace high-end technologies. None came about as a result of continuing to apply sound management decisions in established markets. Rather, they applied disruptive innovations that over time became less expensive and pushed aside strong, established technologies, decisively changing the landscape.

The low-technology, systems-based approach to improving both quality and patient satisfaction in the healthcare setting, building on the theoretical frameworks discussed previously, can best be summed up as patient and family-centered collaborative care. PFCCC is not a new concept. Literature on patient-centered care dates back to at least 1969, when Balint and colleagues introduced the term “patient-centered medicine.”³

A number of organizations today have a focus on advancing the practice of patient and family-centered healthcare programs and systems. These range from organizations such as Planetree (www.planetree.org), an international leader in pioneering patient-centered care founded in 1978, to groups such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), the American Hospital Association (AHA), and the American Academy of Orthopaedic Surgeons (AAOS); which have all prioritized patient and family-centered care in their organizational agendas. JCAHO convened its first patient and family advisory committee in 2006. The NCQA is creating a patient and family-centered physician practice recognition program. IHI has made patient and family-centered care an area of innovation and research for 2006 and has embedded such care in all of its major programs, including the 100,000

Lives Campaign, Quality Allies, and Transforming Care at the Bedside (www.ihl.org). The AHA has collaborated, since 2004, with the Institute for Family-Centered Care to produce a tool kit on patient and family-centered care to provide to the chief executive officers of every hospital in the United States.² The AAOS has recently placed emphasis on the evolving healthcare paradigm of patient-centered care. In this paradigm, the patient is the source of control, knowledge is shared as information flows freely, decisions are evidence based, transparency is necessary and cooperation among physicians is a priority. The AAOS describes patient-centered care as “the cornerstone of the current quality movement in health care.”¹⁵

Despite the literature and both longstanding and recent interest in patient-centered care, there are few models or methodologies for defining and implementing patient and family-centered care in the office and hospital setting. The Total Joint Replacement (TJR) Program at the University of Pittsburgh Medical Center (UPMC) Magee-Women’s Hospital has developed a definition and model, implemented over the past 2 years, as part of a more comprehensive Bone and Joint Health Care Program. This model has generated strong outcomes in a variety of indicators, including patient and family satisfaction, clinical outcomes and organizational efficiencies.

PFCCC TJR, can be defined as the redesign of patient experiences so resources and personnel are organized around patients rather than around specialized departments and practitioners in a hospital and thru the full cycle of care. The focus is on processes, treatment, and the full cycle of care from the patient’s and family’s perspective. The

goals for PFCCC are: (1) 100% patient satisfaction and loyalty; (2) maximized improvement in patient outcomes; (3) reduced medical and surgical errors; (4) improved efficiencies and productivity; and (5) refocused existing resources (rather than acquiring new resources).

The PFCCC approach for TJR has, as its overriding philosophy and methodology, to provide the most effective and efficient care to patients in a friendly and user-friendly environment. The old care delivery processes are revamped so patients are placed at the top of the hospital's and physicians' agendas.

PFCCC, in this model, is a disruptive approach using Christiansen's framework in that the program is not "crammed" into existing hospital routines and systems. Rather, the PFCCC TJR program was designed from the ground up as a "hospital within a hospital," including location and facility design, staff recruitment and development, care delivery services and protocols, and scope of care (eg, prevention, diagnosis, treatment, post-hospital services, and ongoing management).

PFCCC is a process and methodology, as well as a mindset. The healthcare team, which includes not only the staff directly involved in the TJR program, but all ancillary service staff who connect with TJR patients and families at some point along the care path, are committed to the concept of PFCCC.

The PFCCC TJR program is built and organized around the patient's flow and care pathway, including pre- and post-surgical intervention and hospitalization. Patients choose to have a total joint replacement to regain a higher quality of life. For patients and families, however, the surgery is only one part of a much larger process. The PFCCC TJR program is designed to make the process easy, reduce pain, and limit anxiety as much as possible for patients and their families. There is conscious thought, among the entire care team, toward providing a positive experience and a successful outcome.

The entire team of physicians, nurses, therapists, and ancillary staff are part of the PFCCC focus, and are recruited and retained with an emphasis on attitude—being committed to meeting and exceeding the needs of patients and families.

The following specific priorities support the philosophical goals of the program: (1) patient and family education; (2) less invasive techniques; (3) multimodal anesthesia and pain management techniques; (4) rapid rehabilitation protocols; (5) rapid outcomes feedback (from the patients' and the providers' perspectives) resulting in efficient program changes; (6) creating a learning environment and culture; (7) developing a sense of community, competition, and team among patients and between patients and caregivers and staff; and (8) promoting a wellness (rather than sickness) approach to recovery.

The PFCCC process starts in the office. When the surgery date is selected by the patient, a preoperative visit is scheduled to the TJR program office. This initial visit, occurring

approximately 3 weeks before surgery, is organized as one-stop testing and education to set the stage for hospitalization. The streamlined visit allows patients to complete needed testing and education in approximately 2 hours. The visit also provides an opportunity to meet other patients and families who will be having surgery at the same time as well as staff. This lessens, considerably, delays that typically happen on the day of surgery. Pre-surgery discharge planning also takes place as patients meet with a social worker to discuss discharge to home and develop a home care plan. At the same time, a postoperative followup visit is scheduled with the physician, lessening anxiety about how and when the patient will receive followup. A coach is chosen at this time. The coach is a patient's family member or friend who will help the patient in the post-surgical recovery phase of his or her joint replacement and provides a single point of contact and communication among healthcare providers, patients, and other family members.

On the day of surgery, the physician, conscious of relating in a reassuring manner, meets with the patient and the patient's coach in the holding area. The physician marks the site of surgery at this time. Patients meet the anesthesiologist and learn more about special anesthesia techniques and postoperative pain management options. Anesthesia emphasis is on managing patient expectations; multimodal pain management protocols; integrating pre-, intra-, and postoperative care; the relation between pain and nausea treatment; and a commitment to low-cost pain management.

In the operating room, there is a dedicated staff for TJR, resulting in standardization, which reduces variability and improves quality, reduces down time, improves

productivity, reduces stress for the surgeon and operating room staff, and leads to reproducible results. Dedicated staff and reduction in variability necessarily mean enhanced skill development of the entire team. Speed is not synonymous with efficiency, but rather a byproduct of these combined results.

Rehabilitation begins the day of surgery as patients are encouraged to dress themselves in regular clothes once they return to their hospital room. The evening of surgery, physical and occupational therapists help patients get out of bed, and patients learn how to transfer from bed to chair and begin walking. Even after THA, patients are encouraged to put on their shoes and socks (by themselves), having no range-of-motion restrictions.

Patients receive physical and occupational therapy twice a day throughout their hospital stay, participating in group therapy in the on-unit gym and fitness area, which promotes an atmosphere of camaraderie, competition, and encouragement. Before going home, patients will be able to climb stairs and get in and out of a car safely. Hospital length of stay averages 2 days.

The sense of community and camaraderie continues as patients, families, and staff meet at the annual patient reunions, which are held in off-hospital sites such as a football stadium, a museum, or other such venue.

The full cycle of care also includes frequent community education initiatives provided by UPMC TJR physicians and staff regarding prevention, arthritis, and treatment options.

The inpatient unit for the TJR program at the UPMC was designed to provide comfort to patients and families and an “at-home” feeling. The patient rooms, the majority of which are private, were specially designed with the patient and family in mind. All of the rooms are equipped with Internet access. There is a state-of-the-art gym and fitness area on the unit as well as full 24-7 café-style room service for meals. There is a family room, designed as a kitchen and living room, which supports the sense of community among the patients and families moving through TJR together. This room provides a relaxing environment with rocking chairs, couches, big screen TV, and a fully stocked refrigerator. Patients enjoy time out of their rooms, like gathering with friends and family in the kitchen at home. There is even a massage therapist for patients and massage chairs for family members and staff.

A PFCCC TJR working group meets weekly with representation from all areas that influence patients’ experiences. This group includes physicians (surgeons and anesthesiologists), nurses, physical and occupational therapists, parking staff, office staff, dietary staff, pharmacists, social workers, home care staff, and others as relevant. The Chief Operating Officer of the hospital is part of the working group and attends the weekly meetings as does the hospital president periodically.

The focus of the working group is to look at the patient’s experience, along the care pathway, and continuously identify problems and areas for improvement. The meetings involve having each department or specialty representative, starting with office and

parking staff and ending with home care, discuss issues and/or areas of opportunity.

Each representative is charged with addressing areas within their control, whereas the group selects broader initiatives and innovations on which to focus. The participation of hospital administrative leadership lends import and credibility to the working group and serves as a mechanism to remove barriers that may be beyond the control of working group members.

The working group selects measurements and metrics to establish baseline and comparison data for future performance. A rapid-cycle quality improvement process is used in identifying and improving processes and care: evaluate, try, measure, evaluate, and try again. As problems are solved and improvements made, there is consistent focus toward revisiting previous resolutions to evaluate their ongoing effectiveness, moving on to the next problem, and moving to the next level: innovation. This “learning cycle” effects a culture of change in which participants become comfortable taking risks and addressing challenges creatively.

The first projects or areas of focused improvement of the working group were based on the findings of a patient and family shadowing program in which staff members partnered with patients and families to follow them through the care delivery pathway and report on their experiences. In this way, real-time feedback is obtained from patients and families, and staff awareness of the patient experience is heightened.

A sample of the ongoing projects that are under evaluation as a result of the PFCCC working group process includes: patient shadowing program, concierge/bellhop program, parking initiatives, timely administration of medications, video monitoring patient contacts, facility redesigns and signage programs, PFCCC day of surgery experience, medical resource management using safety lessons learned from the aviation industry using a model of focusing on the conditions under which mistakes were made not just the individual making the mistake, computer-based surgical simulator training, and “stealth” tracking technologies such as RFID or radio frequency identification, to support process improvement and efficiencies.

Materials and Methods

In order to measure this systems approach to health care delivery, data was collected on 618 consecutive patients undergoing total hip and total knee arthroplasties. The prospective data was collected from the implementation of the PFCCC program in February 2006 through December 2006 using patient reported forms and the hospital’s health management database. There were no exclusion criteria as this sequential and unselected series included all patients scheduled to undergo a total hip or knee arthroplasty during this timeframe.

Data collected included; length of stay and discharge destination, infection, mortality and dislocation rates, operating room efficiencies along with surgical care infection prevention compliance rates. Patient functional status was measured during standard

PT/OT sessions and patient satisfaction scores were collected using both the national Press Ganey Survey, as well as an internally developed patient survey.

Patient demographics showed of the 618 total joint arthroplasties, 415 were TKA and 203 THA. Patient demographics showed the TKA group consisted of 273 female and 142 male with an average age of 69.9 (sd=8.4, range 28-89). The THA group contained 102 female and 101 male with an average age of 64.7 (sd=11.3, range= 26-89).

Results

Safe health care was provided by the PFCCC model as the overall infection rate for all patients was 0.3%, 0% and 1.0% for the TKA and THA, respectively. The mortality rate for all patients was 0.1%, 0.2% for TKA and 0% for THA. There were no reported dislocations within the THA group. Compliance rates for the Surgical Care Infection Prevention (SCIP) Initiative within the TJR program between July 1, 2006 and December 31, 2006 (103 THA and 233 TKA) were 98% for both THA and TKA for antibiotics being given within 1 hour of surgery. Antibiotics being discontinued within 24hours from surgery were 93% and 94% for THA and TKA, respectively, while appropriate antibiotic selection was at 99% for THA and 98% for TKA.

The PFCCC system approach provided effective health care as ninety-one percent of TJR patients were discharged directly to home. The most recent national statistics for discharge destination indicate 29% and 23% of patients undergoing TKA and THA, respectively, are discharged home.¹ Ninety-nine percent of patients (426 of 428 recently

surveyed by the UPMC TJR program) reported pain had no influence on ability to perform post surgical physical therapy, including therapy started the same day as surgery. Forty-three percent of patients reported less than 5 on the Visual Analog Scale pain scale on Postoperative Day 1, 45% on Postoperative Day 2, and 74% on Postoperative Day 3.

Patient satisfaction results, using the national Press Ganey Survey, showed a mean overall satisfaction score of 91.4. While mean sub-category scores were 93.6 for admission, 89.1 for room, 86.9 for meals, 92.0 for nurses, 92.6 for tests and treatments, 94.3 for visitors and family, 93.4 for Physicians, 89.9 for discharge, 89.8 for personal issues and 93.1 for overall assessment. Patient satisfaction data using an internally developed survey from February through December 2006 (618 TKAs and THAs and 585 survey respondents, 94.7% capture rate) show the following: (1) 71.1% of patients reported no nausea after surgery; (2) 98.3% of patients reported their care to be excellent or good; and (3) 99.7% of patients indicated they would refer others to the UPMC TJR program.

The PFCCC model provided efficient health care as the average length of stay (ALOS) for TJR patients at the UPMC was 2.8 days and 2.7 days for TKA and THA, respectively. National ALOS outcomes for these two surgical interventions are 3.9 and 5.0 days, respectively, according to the US Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP).¹ Data collected internally between February and December 2006 indicate 93% of patients were walking without handheld assistance at discharge from the hospital.

Ninety-one percent of patients performed independent transfers (eg, bed to chair) without handheld assistance at discharge from the hospital. Between March 28, 2006, and May 31, 2006, the mean time for patient in room to next patient in room for TKAs (n = 84) was 116.4 minutes (range, 99-156 minutes). The mean time for patient in room to next patient room for THA (n = 58) was 113.6 minutes (range, 102-138 minutes).

Discussion

Improving the quality of healthcare, by providing safe, effective, timely, efficient, equitable and patient-centered care, should be the goal of every healthcare professional. Developing a PFCCC model can help achieve this goal. However, executive support for an effort of this type is key. Providing patient and family-focused care should not be controversial, but should be an undeniable priority for any healthcare executive. Yet, providing patient and family-focused care is a disruptive process given the current state of healthcare delivery. It requires restructuring and reorganizing resources to support the design or redesign of disease-specific care delivery rather than trying to fit it into already existing hospital routines. Changing the mind set and culture of healthcare professionals is made easier when hospital leadership is visible and puts its energies toward removing barriers and advancing the practices needed to reach care goals.

PFCCC cuts across departmental lines. Given the need to provide care across a full cycle of care, a substantial number of healthcare staff “touch” or influence a patient’s experience. Implementing a PFCCC program then needs to include representation from all relevant departments and specialties. Getting everyone onto the same page, with an

understanding of the programmatic philosophy and priorities, and developing a forum for ongoing, frequent interaction in this regard can be a daunting challenge, yet it is quite possible, particularly with the support and encouragement of hospital leadership. Weekly meetings, in which all relevant departments come together in a supportive environment where identification of opportunities to improve and/or innovate is rewarded, does create a cultural shift toward PFCCC and a sensitization to the needs and desires of patients.

The PFCCC TJR program benefits from being implemented in an environment that supports nontraditional approaches to patient care. UPMC leadership has welcomed the opportunity to apply a low-technology solution to the challenges of providing excellence in quality care and patient satisfaction.

Although initial outcomes for the PFCCC TJR initiative are strong, there is always opportunity for improvement and a need for vigilance in maintaining the focus on providing an easy and satisfying patient experience. The working group and TJR staff will continue to make observations and focus on areas that show less than optimal results.

Following the lead of other UPMC services that have begun to include former patients and families in efforts of this type, the PFCCC TJR program will look toward enhanced patient and family participation in the PFCCC initiative, perhaps by including former patients and families in the weekly working group.

Most importantly, it is critical to spread or export the PFCCC approach to other clinical programs within the hospital and to other hospitals. Exporting this methodology can be in the form of a hospital within a hospital (like in the TJR initiative), programmatic, or by individual project.

The export process has already begun with spread to other clinical programs at UPMC. In one such program, the physicians and administrative staff of the program attended several of the TJR workgroup meetings to get an initial understanding of the culture and operational processes of this group. They then put together their own workgroup, including hospital leadership. Initial positive outcomes after 90 days are impressive and include patient flow adjustments to increase patients per week and decrease patient wait times for appointments and in ancillary departments, increased efficiency in procedure room utilization, a patient dinner to solicit feedback and ideas to improve the PFCCC aspect of the program (with over 75 suggestions generated, now being prioritized and addressed), the reduction of a patient followup care plan from 16 pages to one page, a long-term patient followup schedule, and a multidisciplinary weekly case review conference.

It is the experience of the PFCCC TJR team that you cannot go wrong putting patients first. Every outcome that stems from putting patients first is a step toward closing the gap between the current state and the ideal state in patient care delivery. Addressing the lack of patient-focused care in today's healthcare environment need not mean complicated, expensive, or technologic innovations. Rather, focusing at the basic level of

easy, convenient processes can result in both satisfying patient experiences and improved quality of care.

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