

PEOPLE CENTRED CARE

**How do Health Facilities Plan, Implement and Evaluate
the People Centred Care Concept?**

A Literature Review by Mandy Bellows

**In Partnership with Alberta Health Services: Capital Health and SEARCH
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ABSTRACT

Background

Alberta's health regions strive to provide high levels of quality care and patient safety. By developing partnerships, the facilitation of information sharing between healthcare recipients and healthcare providers, will increase health outcomes and overall satisfaction. Capital Health is in the process of developing a People Centred Care (PCC) strategy. To this end they want to inform the development of a PCC approach based on current best available evidence.

Purpose

To gather strategies identified within the literature which can assist health facilities to forward PCC momentum by incorporating the perspective of the healthcare recipient, healthcare provider and community.

Methodology

The author conducted a targeted review of the current state of knowledge and practices concerning PCC. The literature review involves critical appraisal of literature which met inclusion/exclusion criteria utilizing a qualitative VIA model approach for assessment of content quality and transferability, and inclusion of pertinent information for enhancing practice.

Results

While published peer reviewed literature did not meet all the critical appraisal criteria, it contained information which has relevance to PCC interventions. Grey literature included in the review provides the reader with additional general concepts and specific examples for use to forward PCC momentum within a health facility. Within the existing literature, two factors are consistently identified with successful applications of a PCC approach: 1) the importance and commitment of organizational leadership and 2) the feeling of ownership by the people.

Recommendations

PCC can be used to enhance a holistic approach to care and can contribute to increased quality and safety.

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EXECUTIVE SUMMARY

Background

People Centred Care is defined by the World Health Organization as “a balanced consideration of the values, needs, expectations, preferences, capacities and health and wellbeing of all the constituents and stakeholders of the health care system. (WHO, 2007). Health regions within Alberta strive to provide high levels of quality and patient safety, while existing within an environment of multidisciplinary health provider shortages. Practitioners, Managers and providers of care increasingly believe that by developing partnerships, the facilitation of information sharing between healthcare recipient and healthcare provider can improve health outcomes and increase satisfaction. Capital Health believes providing care that is respectful of the individual perspective will assist in achieving the best outcomes and maintain high levels of quality and safety. The Region is in the process of developing a PCC Strategy for building momentum to forward the people centred journey; to build on current PCC practices and to identify areas which could benefit from a PCC approach.

Objectives

This document will examine the evidence and resources available to health facilities to plan, implement and evaluate the People Centred Care concept. The goal of this project is to produce a working review of literature and web related resources. The information included may provide the Capital Health Region, and other health organizations with a tool for the promotion and enhancement of People Centred Care. The information is intended to be neither exhaustive nor definitive, rather to provide an initial review of the current state of the evidence retrievable and relevant to our Region’s desire to forward PCC.

Methodology

The Literature search was conducted using print and web related information from the following: the Cochrane Library, PubMed, Ebsco, Google Scholar, OVID, grey literature, published books and organizations who strive to improve the quality and safety of healthcare. The literature review involves critical appraisal of literature which met inclusion/exclusion criteria utilizing a qualitative VIA model (validity, importance and applicability) approach for assessment of content quality and transferability, and inclusion of pertinent information for enhancing practice. The Search was limited to English language, and human studies, and utilized key search terms and phrases: Patient and Family Centered Care, Client Centered Care, People Centred Care. The Canadian and American spellings of ‘Centred/Centered’ were used.

Results

While published peer reviewed literature did not meet all the critical appraisal criteria, it contained information which has relevance to PCC interventions. Grey literature included in the review provides the reader with additional general concepts and specific examples for use to forward PCC momentum within a health facility. Within the existing literature, two factors are consistently identified with successful applications of a PCC approach: 1) the importance and commitment of organizational leadership and 2) the feeling of ownership by the people.

Conclusion and Recommendations

People Centred Care is a challenging cultural movement designed to improve quality and patient safety through developing and supporting mutually beneficial partnerships. Through the use of current literature; experience of organizations specifically created to promote humanity in

healthcare and information provided on the internet, health facilities that are committed to planning, implementing and evaluating People Centred Care, can effectively and efficiently do so overtime. People Centredness is a way of being, an attitude that is reflected in behavior. Additional research and practice activities would advance health system goals to provide safe and high quality care which is appropriate and acceptable to patients, their families and the community.

A detailed report including the background, methodology, results, discussion of results and conclusions with recommendations can be obtained by contacting

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How do Health Facilities Plan, Implement and Evaluate the People Centred Care Concept?

INTRODUCTION

What does it take to create a “quality” health care system? And who should be involved? Quality, as described by William A. Foster, ‘is always the result of high intention, sincere effort, intelligent direction and skillful execution.’ Health experts describe a need to elevate the current state of health across the continuum. How can the system best work to achieve this goal? Health organizations and health facilities are exploring new and innovative ways to enhance quality and patient safety. In an interest to provide best care, health facilities are faced with blending current methods of providing healthcare with those which put the patient first and at the center of the health quality core. People Centred Care, also known as Patient and Family Centred Care and Client Centred Care, is a philosophy which supports partnerships and collaboration among those who receive healthcare and those who provide healthcare. The People Centred Care concept is a progression from provider based healthcare delivery to patient based healthcare delivery following four guiding principles as identified by the Institute for Family Centered Care (IFCC), ‘dignity and respect; information sharing; participation and collaboration.’ People centred care is a journey, where each and every individual is considered valuable. The World Health Organization supports a people centred approach to healthcare, one that equally incorporates and promotes technological advancement and its humanistic virtues.

Patient and Family Centred Care (PFCC); Client Centred Care (CCC); and People Centred Care (PCC) are all phrases being used within the literature to represent this current cultural movement within healthcare. A health environment that supports PCC, a gold standard for healthcare, will also promote and support its cultural counterparts, a just and trusting culture; disclosure and transparency. A PCC approach to increase quality of healthcare has been recognized by several health leaders and within widely distributed literature. This review addresses what is available in the current literature to assist health organizations to achieve and sustain a people centred approach to care. Provided in three parts, this document includes critical appraisal of three documents which meet preset inclusion/exclusion criteria; provides direction to answer the search question utilizing ten pieces of printed literature and four websites; and provides discussion and recommendations regarding the state of the evidence for use within the current healthcare environment. It is the researcher’s intent to provide Capital Health and other Alberta Regional Health Authorities with an overview of the literature on how to build understanding and capacity for how health facilities plan, implement and evaluate the PCC concept as applicable to today’s healthcare context. This review is neither definitive nor exhaustive, rather to provide an initial review of the current state evidence retrievable and relevant to our Region’s desire to forward PCC.

Conceptual Background

The initial concept of People Centred Care (PCC) (also described as Patient- and Family-Centred Care and Client-Centered Care) was introduced in the 1950's by Balint and Stewart et. al (de Haes, 2006). PCC is defined by the World Health Organization as “a balanced consideration of the values, needs, expectations, preferences, capacities and health and wellbeing of all the constituents and stakeholders of the health care system. (WHO, 2007).

Organizations within the United States, namely the Picker Institute and Institute for Family-Centered Care (IFCC) are devoted to research and its application to forward a PCC approach to healthcare (Conway, 2006). IFCC developed core concepts or guiding principles of PCC:

- Dignity and Respect;
- Information Sharing;
- Participation; and
- Collaboration

The core concepts provide a framework for health stakeholders to guide decision making and develop mutually beneficial partnerships.

In 2001, the US based Institute of Medicine included patient-centered care as one of six aims for reinventing healthcare of improved quality. The Canadian Adverse Events Study (2004), supports efforts to make patient care safer through the requirement of ‘leadership....[and] judicious application of new technologies and improved communication and coordination among caregivers’. Health Canada acknowledges the importance of public involvement in health decision making and has created a Policy Toolkit as a means to improve and maintain the health of Canadians.

Health regions within Alberta strive to provide high levels of quality and patient safety, while existing within an environment of multidisciplinary health provider shortage. Practitioners, Managers and providers of care increasingly believe that by developing partnerships, the facilitation of information sharing between healthcare recipient and healthcare provider can improve health outcomes and increase satisfaction.

Local Context

Capital Health Region is invested in providing PCC. Included within Capital Health's mission and values, PCC is located within the core of the quality matrix. Providing care to patients, families, the health team and the community, that is respectful of the individual perspective will assist in achieving the best outcomes and maintain high levels of quality and safety. The Region is in the process of developing a PCC Strategy for building momentum to forward the people centred journey; to build on current PCC practices and to identify areas which could benefit from a PCC approach. The author of the literature review has been requested to assist the region in developing a framework; a plan, to support this movement. A PCC Committee, including members from across the continuum of care, will support the region to, ‘bring the perspective of patients, families, the health team and [community] directly into the planning, delivery and evaluation of healthcare’ (IFCC, n.d.).

Question Development

In April 2007 the search question was developed in consultation with Capital Health Executive. When presenting the idea for question during the first SEARCH Canada Learning module, it was suggested that the question be modified due to its broad nature. As a result the reviewer contacted the appropriate stakeholders to determine if question revision was a viable option given the area of interest. As the process of planning and evaluation are intrinsically linked, the originators of the question felt it responsible to attain as much knowledge as possible within the given time period. The following search question was agreed:

How to health facilities plan, implement and evaluate the People Centred Care concept?

To answer the search question the author conducted a targeted resource review by critically appraising literature which fit preset inclusion and exclusion criteria and by utilizing a variety of information sources. The critical appraisal process, its results and a set of next step recommendations comprise the remainder of this report.

PART ONE: CRITICAL APPRAISAL OF THE LITERATURE

Search Question

How to health facilities plan, implement and evaluate the PCC concept?

Methodology

The literature review was conducted systematically by the author in consultation with SEARCH Canada Faculty, Librarians from the Centred for Health Evidence, Librarians from the Capital Health Region and with colleagues from Capital Health's Regional Quality Office. To ensure a systematic approach the methods section of the review is divided into three parts, literature identification, literature selection and literature assessment. The key phrases: Patient and Family Centred Care, People Centred Care and Client Centred Care will be used interchangeably within the body of the review document.

Literature Identification

The literature search was conducted with the assistance from Capital Health Library Services Department and SEARCH Canada's Research Librarians initially in May 2007 with the latest update in November 2007. The publication date of the literature search was limited to 1990 onward. The initial concept of People Centred Care was introduced in the late 1950's (de Haes, 2006), however the 1990 date was selected as it was felt the context of time would be more specific to today's practices and settings. The search was limited to English language, and human studies

Literature was identified using keywords and key phrases, sources and limiters based on a question developed in consultation with Capital Health Region Executive and SEARCH Canada Faculty. Individual key words and key phrases were used in combination to provide specific direction. The American and Canadian spellings of "centered/centred" were used to gather appropriate literature. The review was conducted by one primary reviewer.

A MeSH Terms search was trialed for the words "People" and "Patients". The following results (associated words) were identified: Client, People, Consumer, Patients (Inpatient and Outpatient), Visitors of patients, Resident, Persons. When searching for literature however, only specific words were used to conduct the search, as identified in the Key words and Key Phrases table (please see Appendix A, Table 1). Suggested MeSH terms identified (i.e. Consumer and Resident) were not utilized to conduct the literature search as they are not consistently used within the literature and by People Centred Care experts.

A selection of Electronic Databases, Web search engines and Websites were utilized to conduct the search for literature (please see Appendix A, Table 2).

Full Text versions of the literature found meeting the appropriate inclusion and exclusion criteria as outlined in the Literature Selection section were reviewed.

Part one of the Literature Review Document will critically appraise pieces of literature which met the inclusion and exclusion criteria (three documents). Part two of the literature review document includes information from ten pieces of literature and four websites to answer the search question: How do Health Facilities plan, implement and evaluate the People Centred Care concept?

Literature Selection

Full text versions of the literature retrieved were reviewed by the author to determine if they met the preset inclusion and exclusion criteria.

To meet inclusion criteria set by the author the literature had to:

1. Involve discussion of People (the patients, their families and healthcare providers);
2. Include discussion on planning, and/or implementation and/or evaluation of People Centred Care practices/concepts; and
3. Involve discussion related to People Centred Care and Health Facilities (which could include: clinics, hospitals, continuing care facilities or long-term care facilities).

Due to the character of the search question exclusion criteria were not strictly set as all stories and experiences are applicable in nature to the people centred concept and practice (i.e. documents written by a patient, their family, concept expert, or by a healthcare provider could all be included). For purposes of question relatedness, literature which included mention of all three components (plan, implement and evaluate), that involve the “People” and “Health facilities” were selected for analysis (please see Appendix B -- Documents which met all criteria are highlighted in grey and were assessed for quality, as discussed within the Literature Assessment section of the Review).

Literature Assessment

The literature was assessed using a qualitative approach to determine validity (V), importance (I) and applicability (A). Literature which met the inclusion/exclusion criteria within the literature selection section was assessed using VIA.

Validity was assessed from a qualitative perspective (i.e. evaluating the trustworthiness of the literature). Trustworthiness utilizes credibility, dependability, confirmability and transferability as measurements of validity. When assessing validity of the information collected the following specific areas of the components of trustworthiness were used:

- Credibility
 - referring to the confidence in truth of the data (Polit, D.F., Beck, C. T., & Hungler, B. P, 2001); and
 - for the purposes of the review the reviewer chose to use researcher/author credibility; and Triangulation (data source and theory triangulation) as an evaluation of overall credibility of the source.
- Dependability
 - referring to the stability of the data overtime and over conditions (Polit, et al., 2001); and
 - for the purposes of the review the reviewer chose to use inquiry audit to scrutinize the references supporting each piece of literature to assess dependability.
- Confirmability
 - referring to the objectivity or neutrality of the data (Polit, et al., 2001); and
 - for the purposes of the review the reviewer chose to compare and contrast how many times a “component” or “concept” or “idea” is mentioned (i.e. finding trends within the literature). This would provide confirmation of the “practice” or “idea” as suggested within the literature.

- Transferability (generalizability)
 - referring to the extent to which the findings can be transferred to other settings or groups (Polit, et al., 2001); and
 - for the purposes of the review the reviewer chose to assess how generalizable the information within the selected documents is.

Importance was assessed by determining whether the piece of literature makes reference to how important the PCC concept is and if the document provides rationale for why the concept should be employed. What does the literature say about how important People Centred Care concept is?

Applicability (feasibility) was determined by assessing how the results can be applied to the Capital Health; Alberta; and Canadian context. Is the information provided useable by healthcare models theoretically different from the US based system (publicly vs. privately funded)? And how well does the information provided answer the search question?

Description and Synthesis of the Literature

Of the articles found during the “acquiring” phase of the literature review, three pieces of literature fit the inclusion and exclusion criteria as discussed in the Literature Selection section. The three documents were found while searching web search engines and websites. The Institute for Healthcare Improvement, Institute for Family Centered Care and The Commonwealth Fund are the originators of the three pieces of literature. The three documents (grey literature) met all of the criteria set; where as published literature found did not meet the criteria. The published literature pertaining to the search question was specialized; dealt with specific interventions or concepts of People Centred Care, or discussed/included limited information directly related to the search question and therefore has not been included in this section of the review. Respectively, documents are a self described report, background paper and ‘how to guide’, Patient centered care: What does it take? (Shaller, D., n.d.), Partnering with patients and families to design a patient- and family- centered health care system: A roadmap for the future (Conway, J., Johnson, B., Edgman-Levitan, S., Schlucter, J., Sodomka, P., & Simmons, L., June 2006), and Advancing the practice of patient- and family-centered care: How to get started (Institute for Family Centered Care, n.d.). They include overviews of patient and family centered work currently underway within healthcare institutions in the United States. All documents include an introduction to the concept of Patient and Family Centered Care, and lead the reader to strategies for building PCC momentum. Each of the documents includes examples of Health Facilities and Organizations within the United States who have been identified as a leader in people centredness. Each document addresses the concept of change at individual; organizational and system levels.

Assessing for Validity

Validity was judged across four dimensions: credibility of the authors and sources including data source triangulation and theory triangulation; dependability of information provided; confirmability, and; transferability.

Credibility

One document does not list principle or supporting authors, but provides the organization name. The organization, the Institute for Family Centred Care is well known nationally and internationally, for developing and furthering patient and family centred practices. Another document is written by one primary author Dale Shaller, in consultation with others in his company, Shaller Consulting. Shaller is a Masters graduate of the Humphrey Institute of Public Affairs at the University of Minnesota. With 22 years of experience in applied healthcare, policy analysis and related management consulting, Shaller works as an independent consultant and serves as managing director of the National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Benchmarking Database as described on the NRC+Picker website. For seven years he was the President of Policy Studies at the Centre for Policy Studies in 1988. Shaller has 13 articles listed within the electronic database PubMed, which have been published by academic journals including American Journal of Medical Quality; Pediatrics; Health Affairs; and Journal of the American Medical Association, between 1979 and 2007. The third document is co-authored by seven individuals. All seven authors have an extensive repertoire of experience in the healthcare field, jointly over 100 years. The authors hold varying roles as advocates of patient and family centeredness; they are President and CEOs; Consultants; Patient and Family Representatives and Institute for Family Centered Care and Institute for Healthcare Improvement Advisors. Please see Appendix C for a description of all authors included within the credibility section of the review document.

Data Source Triangulation

Each document uses a variety of data sources to provide information on the topic, utilizing key informants; web related resources; and written documents. Shaller's document includes interviews from six 'leaders of organizations demonstrating excellence in Patient Centered Care' and 11 interviews of 'Experts in design and implementation of Patient Centered Strategies'. All documents include organizational examples of forwarding patient and family centeredness in a variety of healthcare settings (acute care, continuing care, and facilities designed to accommodate a specific sector or disease process).

Theory Triangulation

The utilization of multiple perspectives within the three documents is well documented within each reference section. Shaller's document includes 43 references; IFCC document includes 25 references and Conway's document includes 32 references, in attempt to provide a cohesive understanding of how to design and advance People Centred Care.

Dependability

One of the three documents does not contain a reference list; however it does contain a Resource List for readers to search. The other two documents include reference lists which contain between 32 and 43 references (print and web related). Please see Appendix D for a table containing all references included within the three documents. The table provided in Appendix D, compares the references of all documents (and identifies if a reference has been used by more than one of the three appraised documents). Conway's document is referenced by the other two

documents which met the inclusion/exclusion criteria for critical appraisal. Six references (print and web related) were included within two of the critically appraised documents.

The theory or concept of PCC is young in relation to the paternalistic approach to medicine as mentioned by de Haes. What seems to be apparent is a move away from the traditional care approach towards PCC, one that facilitates sharing of information and partnership between the healthcare recipient and healthcare provider. Each of the three documents features and celebrates organizations and leaders who have made great strides to forward change.

Confirmability

Each document provides the reader with an introduction to the concept of PCC; description of PCC's place within the current healthcare environment as perceived by the writer through supporting documentation; description of environments (individual, organization and system) which foster/nurture PCC; indicate as to how one might forward PCC momentum within their own organization; and inclusion of related resources and references. Of 13 listed organizations, MCG Health System, is used by all three documents and Cincinnati Children's Hospital Medical Center is used within two documents. The majority of examples are included within the Shaller report. Health Leaders/Experts are identified within the Shaller document. IFCC and Conway, et al. do not use personal interviews to support the written literature, and do not name specific individuals.

The ideas and concepts (i.e. required support from organizational leadership and suggested areas to initiate the transformation process) were mentioned within all three critically appraised resources. Shaller's document, synthesizes the key principles of PCC as developed and identified by influential models of PCC within the US. Comparing PCC key attributes of the Picker/Commonwealth Organization, The IFCC, and Planetree, six attributes or principles are similar in their focus. Please see Appendix E for Confirmability Table and Appendix F for Tables containing PCC strategies for planning, implementing and evaluation as identified within the literature.

Transferability

Conway, et. al. include that the background paper was created to 'facilitate the development of an action plan to ensure that sustained, meaningful partnerships with patients and families are in place in hospitals and health systems; in community clinics and other ambulatory settings; in schools educating the next generation of health care professionals; in national associations; in federal, state and community agencies; in foundations and advocacy organizations; and among payers. The IFCC document indicates the steps a 'hospital' can take to develop partnerships, and provides readers with an 'initial hospital assessment' to determine its current stance on patient centredness. Shaller uses the term "organization", which can be attributed to any health facility, as the definition of organization is not provided and is left for interpretation by the reader. In all cases the information can be applied to any and all health facilities. Of the three documents, none list specific areas for the application of PCC principles. However, the contexts and the cultures within which PCC is being introduced may well impact the success or at least the ease and speed of introducing PCC in a sustained way.

Importance

The importance of the PCC concept is evident. Shaller discusses the increased prominence of PCC within the U.S. Health system, 'growing recognition of the importance of patient-centered care, as well as evidence of its effectiveness in contributing to other system goals such as efficacy and effectiveness.....' (Shaller, D., n.d.). The IFCC document indicates that, 'studies

increasingly show that when healthcare administrators, providers, and patients and families work in partnership, the quality and safety of healthcare rise, costs decrease, and provider and patient satisfaction increase (IFCC, n.d.). Conway, et. al., includes reference to the Institute of Medicine's (IOM) 2001 report titled, Crossing the quality chasm: A new health system for the 21st century. Within the overview, the PCC concept is described as the 'framework and [strategy] to enhance the quality and safety of health care'.

All three documents immediately indicate the importance of the concept. Conway, et.al., discusses terms associated with quality and patient safety, where 'none may be as critical as Patient- and family- centered care'. Both Shaller and the IFCC utilize the word "importance" when suggesting that the perspective of the patient and family have long since been missing from healthcare.

Applicability

The information presented by the three documents appear to be applicable to both privately and publicly funded health care systems. Each piece of literature was created utilizing U.S based source examples, however can be applied to varying contexts as illustrated by insitu examples. Two of the three documents (IFCC and Conway, et.al.) include the specific words 'plan', 'implement' or 'delivery', and 'evaluate'. The IFCC suggests, 'bringing the perspectives of patients and families directly into the planning, delivery and evaluation of healthcare, and thereby improving its quality and safety, is what patient- and family- centered care is all about' (IFCC, n.d.). The desire to improve patient safety and quality is not unique to the American healthcare system. The Canadian Adverse Events Study by Baker and Norton include recommendations which support enhanced communication and coordination in healthcare.

PART TWO: ANSWERING THE SEARCH QUESTION

Utilizing ten pieces of printed literature and four websites the reviewer will provide an overview of resource content to assist in answering the search question. Three pieces of literature which met criteria for critical appraisal and seven which did not, are included here to provide a wider perspective of PCC.

Planning and the People Centred Care Concept

Implementation of quality or patient safety initiatives requires patience, commitment, determination and a plan. The desire to ‘revise’ one’s organizational culture is a challenging task that can be achieved overtime. A cultural revolution has begun within healthcare organizations and systems to ‘change’; to become conscious of the ‘knowledge and experience that each person brings to the care situation’ (McCormack, 2003). As Health facilities further their people centred practices the challenge of knowing what changes to make; whom should the changes effect; and how to make the changes can immobilize and overwhelm those tasked with moving the organization from provider focused to people focused. Planning, defined as “a process to determine goals and objectives and to devise the means by which they can be accomplished” (Standing Committee on Evaluation and Accountability, 2001), is the first step towards becoming people centred.

The Institute for Family Centred Care, founded in 1992, is designed to be cognizant of the health of individuals and families across the continuum of care, and to ensure the concepts of patient and family centred care are reflected within the care provided (Shaller, p. 3). Provided within the IFCC’s document titled, *Advancing the Practice of Patient and Family Centred Care: How to get started....*, is a list of eight steps which can help set a hospital or health system on its journey toward patient and family centered care.

1. Implement a process for all senior leaders to learn about patient- and family-centered care. Include patients, families, and staff from all disciplines in this process.
2. Appoint a patient- and family- centered steering committee comprised of patients and families and formal and informal leaders of the organization.
3. Assess the extent to which the concepts and principles of patient- and family-centered care are currently implemented within your hospital or health system.
4. On the basis of the assessment, set priorities and develop an action plan for establishing patient- and family- centered care at your institution.
5. Using the action plan as a guide, begin to incorporate patient- and family-centered concepts and strategies into the hospital’s strategic priorities. Make sure that these concepts are integrated into your organization’s mission, philosophy of care, and definition of quality.
6. Invite patients and families to serve as advisors in a variety of ways. Appoint some of these individuals to key committees and task forces.
7. Provide education and support to patients, families and staff on patient- and family- centered care and how to collaborate effectively in quality improvement and health care redesign
8. Monitor changes made, evaluate processes, measure the impact, continue to advance practice, and celebrate and recognize success. (IFCC, n.d.).

To provide the health facility with an understanding of their current state of PCC, the IFCC suggests the use of an assessment tool. The assessment tool included within IFCC's Advancing the Practice of Patient- and Family-Centered Care document, is to be completed by members of the facility administration, middle managers, frontline staff and patients and families, and provides the facility with a 'snapshot' of how well the facility already incorporates the concepts of people centred care and acts as a mechanism for identifying areas to improve.

The IFCC Website provides visitors with free resources to promote change towards people centred practices. Displayed on the IFCC home page, is a description of the services the Institute provides, "national leadership in patient- and family-centered care and serves as a resource for policy makers, administrators, program planners, direct service providers, educators, design professionals, patients, and family members." Resources include, tools for change (self assessment surveys, documents fostering people centredness, environmental design support), conference notification, and resources specific to whom may be utilizing them, patients and families, advisory councils, organizational leaders, health care clinicians, health professional educators, researchers and hospital facility architects and designers. To assist health facilities plan their change, the IFCC will:

- [Assist] hospitals in the preliminary exploration of what patient- and family-centered care is and what it can mean to an organization.
- [Facilitate] the process or provides guidance for launching collaborative endeavors with patients and families.
- [Provide] customized training for staff at all levels of an organization and for patients and families on patient- and family-centered care and effective collaboration.
- [Conduct] assessments on where a hospital is along the continuum of implementing patient- and family-centered care, makes recommendations for improvement, and assists in further processes of change and improvement.
- [Assist] with facility design planning to ensure that renovation and new construction projects support the practice of patient- and family-centered care and incorporate current innovations and best practices in design.

The website provides the visitor with easy to find contact information, profiles of United States Health facilities sharing their committed journey towards becoming people centred and identify organizations who utilize the services of the IFCC.

Shaller identifies seven factors which contribute to an organization achieving people centredness, "leadership; a strategic vision clearly and constantly communicated; involvement of patients and families; care for the caregivers through a supportive work environment; systematic measurement and feedback; quality of the built environment and supportive technology." (Shaller, p.vi). The document reflects on how the seven consistent PCC factors were fulfilled over time within two health facilities in the United States, the MCG Health System in Augusta, Georgia and the Bronson Methodist Hospital in Michigan. Both facilities initiated the transformation process in the mid 1990's, and continue to identify areas for improvement.

Commitment of Leadership, identified within the discussion paper as the most influential factor in moving an organization forward, Shaller provides readers with strategies to overcome barriers at organizational and system levels.

Prepared in 2006, is a collection of PCC insights titled, *Partnering with Patients and Families To Design a Patient- and Family- Centered Health Care System: A Roadmap for the Future*, and was originally developed as a background paper for a meeting held in June 2006 hosted by the IHI and IFCC. The paper provides the reader with a basis for what PCC is, defines the concept in relation to its guiding principles and provides organizational examples of facilitating PCC across the continuum of health. Specific attention is afforded to the concept of ‘building momentum’ for PCC. Several examples from health institutions within the United States, offer the reader a wide variety of contextual representations of what was done to encourage the adoption of PCC within their setting. Ambulatory care facilities, acute care hospitals specific to disease(s), quality improvement organizations and areas of professional education speak to initiatives that were implemented, what worked/didn’t work and next steps. A page within the background paper subtitled as ‘Barriers to Collaboration’, focuses on attitudinal, educational, and organizational barriers which may be identified during the planning and implementation stages (Conway, 2006).

Planetree, a non-for profit US based organization, created in 1978 by a patient, is available for consultation to health organizations of all sizes and specialties, who would like to create and build on healing partnerships between the health care recipient and healthcare provider. The Planetree website contains information on its organizational mission and values and discloses which health organizations hold ‘planetree memberships’. It does not contain readily available resources, requesting website visitors request information and resources as needed through email.

Attempting to alter a hospitals culture can be met with resistance. Many will suggest that the facilities practices are people centred. The application of an assessment tool to determine a hospital’s current culture or readiness to change can provide valuable insight and serve as a starting point. As illustrated above there is a variety of resources available to forward momentum within the planning construct of people centred care. Please see Appendix F for planning strategies from organizational examples within the chosen literature.

Implementing and the People Centred Care Concept

Implementation, defined as, “carrying out the action plan” (Du Gas, 1999), or “the carrying out or physical realization of something” (www.answers.com), is possible when dedicated resources are made available, and therefore enabling the act of planning to come to fruition. Within the literature, trends regarding implementation; the delivery of change and its subsequent sustainability was evident. The National Health System (NHS) developed a sustainability model, which can be utilized as ‘a diagnostic tool....to predict the likelihood of sustainability for an improvement project.’ Most resources include mention of sustained patient and family involvement in all aspects of policy and procedure development to promote responsive delivery of care.

Determining if a change is required and actually making and sustaining a change are very different. Gillespie, Florin, and Gillam (2004) explored the theoretical concept of PCC and how it transforms into practical application. They suggest that, “implementing a policy such as

patient-centred care requires patients and professionals to feel ownership of the concept” (Gillespie, 2004). Gillespie, et.al. describe that a lack of clarity surrounding the definition of PCC, and lack of perspective from ‘managerial, lay and non medical clinical’ staff can be a crucial barrier successful PCC implementation.

Shaller and Conway, et al. use examples from leading PCC institutions to provide health organizations with helpful suggestions to further PCC implementation. Recognized US PCC organizations suggest revising all documentation and printed resources materials, employment descriptions and visiting hours and to include the patient and family in daily multidisciplinary rounds.

Wilkins, Pollock, Rochon and Law (2001), state that the most effective way to implement change is through participatory action, to involve patients, families and health providers of all disciplines in the delivery of change. Included within their document Wilkins, et al., mentions the occasional disparity between the philosophical context of PCC and the perceived need to develop tangible ‘items’ for concept incorporation into practice, “service providers [feel] a need to develop practical strategies for implementation” (Wilkins, et al., 2001). Due to staff shortages and limited resources, some health staff may perceive PCC as too labor intensive to deliver, ‘time constraints were identified by all participants as a significant challenge to implementing client centred practice” (Wilkins, et al., 2001), as health staff attend to the requests of patients and families and ‘typical’ daily treatment requirements.

The literature includes examples of implemented strategies but does not provide the process by which the intervention was applied. The MCG Health System began its PCC journey in the early 1990’s, and as such, it could be implied that the implementation of PCC strategies were operationalized in small tests of change over a period of time.

Please see Appendix F for implementation strategies from organizational examples within the chosen literature.

Evaluation and the People Centred Care Concept

Program evaluation, described by Patton is “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming” (Canadian Evaluation Society, 2008). When reviewing the resources for evaluation methods for People Centred Care, two ways of interpreting evaluation became apparent. The literature selected for evaluation content approached evaluation in two ways, one, to provide insight to the methods of evaluation upon the implementation and delivery of People Centred Care and the tools used to do so, and two, the evaluation of the People Centred Care concept or philosophy. Both ways of interpreting evaluation will be discussed as both are relevant to the question, How do Health Facilities plan, implement and evaluate the People Centred Care concept.

The How to Get Started guide created by the IFCC, suggests that an organization should “monitor changes made, evaluate processes and measure the impact, [to] continue to advance the practice” (IFCC, p. 3) of people centred care. Identified within the literature is the use of tools to gather information specific to People Centred Care. When attempting to evaluate the family centeredness of services provided, King et al., utilized the Measure of Processes of Care (MPOC), to “measure parents’ perception of healthcare providers’ behavior”. The MPOC, a newly developed tool, measuring components of patient and family centred care focuses on five areas: “enabling and partnership; providing general information; providing specific information

about the child; coordinated and comprehensive care for child and family; and respectful and supportive care.” (King, 1997). The tool was applied to families separated into three groups, recruited using convenience sampling, which access children rehabilitative services in Ontario. Applying MPOC to families with varying socioeconomic status, it is identified as being a “potential instrument to evaluate the impact of change in response to this [family centred approach] major shift in the style and content of service delivery” (King, 1997).

Patient satisfaction surveys are used by organizations as a mechanism for evaluation of PCC practices. NRC+Picker, “a leader in developing surveys designed to measure patients’ experience with their care” (Shaller, p.1), provide survey related services to health facilities including, development of surveys based on context, delivery of survey to clients and analysis of survey content. Attributable to ambulatory care and acute inpatient care settings surveys are being used to affirm people centred implementation. However, as discussed within Shaller’s discussion paper, “after all this investment in measurement, a clear need remains to determine how such information can be used to actually make and sustain improvements in the patients experience with care.” (Shaller, p.1).

The Bronson Methodist Hospital of Kalamazoo, Michigan utilize the following data, “employee turnover, outcomes, length of stay, cost per unit of service, waiting times, patient satisfaction levels, nosocomial infection rates and organizational behaviors” (Shaller, p. 16), as an indication of a shift towards patient and family centred practices, and philosophy. To determine if a shift in practice actually exists, the Bronson Health Group compares their new facility, the Bronson Methodist Hospital, to that of other facilities within the health group using the factors previously described.

The application of administrative data and patient and employee satisfaction surveys to evaluate the gains towards becoming a people centred facility is the tendency as illustrated within the literature reviewed. Price has suggested that “there have been difficulties in translating the concept into practice and developing measures that demonstrate [this] approach in action” (Price, 2006).

Shields et al. (2006), discuss the difficulty in measuring the implementation of People Centred Care. Within the systematic review of qualitative studies, Shields suggests that “Cochrane systematic reviews, are much easier to conduct if the intervention under examination is discrete and readily measurable and the difficulty of doing this for a sometimes nebulous intervention such as [PCC]” (Shields, 2006). As well, Jones says, “Understanding patients as individuals, helping them to relate to their situation, lifestyle and needs, represents an important but ultimately immeasurable activity” (Price, 2006).

As facilities move forward to transform themselves from provider focused to patient/family/employee focused, several organizations are available to provide insight and guidance. Much of the literature centers on People Centeredness as the gold standard of care, and therefore something that every health care organization should strive for. Contained within Haes article titled, *Dilemmas in patient centeredness and shared decision making: A case for vulnerability*, is a stand for PCC concept limitation. Haes describes the concepts and ideology of People Centred Care, its evolution through time and its place within context. A main theme within the text is ‘Non supportive Findings’ including subheadings titled ‘Patient centeredness may not always be preferred; Patient Centeredness may not necessarily be effective; and Patient

Centeredness may not be effective under certain conditions or for certain patients” (Haes, 2006). When comparing approaches to communication, a component of information sharing and guiding principle of PCC, Haes suggests that not all patients prefer a patient centred approach. Utilizing a randomized experimental study by Swenson et al., to support this subcategory, approximately 40% of patients preferred a medical approach to communication, of which it is suggested are those who are elderly or less educated.

To determine the effectiveness of PCC Haes reviewed 13 studies from the Cochrane Library using satisfaction, healthcare behavior, and health as reported outcomes. Not all outcomes were supportive of the People Centred Care Philosophy, and therefore was suggestive, “that the effectiveness of patient centeredness is not necessarily evident” (Haes, 2006).

Using context to describe situations when PCC may not be optimal, Haes suggests that in an acute care setting where a patient is requiring immediate life saving measures, a medical approach to care would deem more successful. And where as in a clinic setting, a partnered approach (collaboration for care between patient and physician or healthcare practitioner) could be seen as more favorable (de Haes, 2006). Haes reviewed a study by Graugaard and Finset, where type of communication (medical approach or patient centered approach) and patient anxiety level were compared and found “persons with a low trait anxiety level were found to report higher satisfaction after a patient-centered consultation....and patients with a high anxiety level at baseline were less anxious after a doctor-centered consultation” (de Haes, 2006).

As evidenced by de Haes’ (2006) review of studies suggesting that a People Centred Care approach is not necessarily preferred based on patient and situational context, requires a return to a review of the meaning of people centeredness. Understanding the patient as an individual and referencing the patient’s context will contribute to ensuring consumer appropriate care at all times and within every situation. Please see Appendix F for Evaluation strategies from organizational examples within the chosen literature

PART THREE: DISCUSSION AND RECOMMENDATIONS

This section includes discussion of Part One: the critical appraisal of the literature meeting the preset inclusion/exclusion criteria, Part Two: Answering the search question and how PCC applies to the context of health in Alberta. Recommendations are provided to enhance understanding of the PCC concept.

Critical Appraisal of the literature

When assessing the literature for validity (trustworthiness), the three pieces of literature are written by or are supported by concept experts. As evidenced by the credibility, dependability, confirmability and transferability sections, the information is supported by health institution examples which overtime have transformed their internal practices and culture. Those who authored the three documents can be considered experts in the field of Health Promotion and Patient and Family Centered Care. All documents are prepared by content experts who have a long history (greater than 20 years) of academic or applied research in the health system, are currently all employed by organizations which support and promote information sharing and partnerships among patients, families, health practitioners, and health systems. These individuals and organizations are repeatedly recommended as health facilities to ‘go to’ for assistance when wanting to create momentum towards achieving people centredness. The appraised literature identifies a variety of resources to support the PCC approach to care and how to forward its practice.

As indicated within Appendix D, a majority of the references were not utilized more than once. One can ascertain that this is an indicator of the breadth and depth of information available in the PCC area of qualitative and quantitative research. As the PCC approach to healthcare, is perceived as ‘newer’ within the healthcare context, there is an incredible opportunity to study its effects on healthcare outcomes. The ability to utilize current practice settings where PCC is not an actively measured can provide a ‘baseline’ from which change can be described and measured. To understand what change is required (i.e. what are we trying to accomplish?), it is useful to have accurate unbiased, unaltered data to support the change (i.e. how will we know a change is an improvement?) and to provide insight as to which aspects of practice; of culture; of behavior require change (i.e. What changes can we make that will result in improvement?). The suggested newness of the PCC approach to care can be considered an asset, a fantastic opportunity to partner and collaborate nationally and internationally with people, health organizations and systems.

Shaller (n.d., p 6-8) discusses the empirical evidence collected using the CAHPS Database/survey system to “gather information from millions of patients in hospitals and physician practices in the US, Canada, UK, Germany and other European Countries.” The Picker Institute was described within the document as an early leader in developing such surveys, which model and frame surveys used by CAHPS. National Research Corporation (NRC)+Picker provide services to health organizations to assist in the development/conduction/analysis of surveys to assess healthcare consumers satisfaction in care received. As Shaller is currently employed by the Picker Institute as the Managing Director of the National CAHPS Benchmarking Database (NRC+Picker), his document could be considered as a well informed advertisement for the Picker Institute; a mechanism for creating potential future business/ financial opportunities. The Shaller document is transparent and discloses early on, that the Picker Institute commissioned the paper creation; however it does not disclose

Shaller's employment status. This could be considered a conflict of interest. However, as indicated by their vision, NRC+Picker "[are] dedicated to measuring and improving the most important aspects of the patient experience". The organization appears to be invested in promoting information gathering and sharing approach to health care (a guiding principle of PCC). Within health facilities and organizations, data collection, analysis and application is supported, and in turn financial resources are allocated from internal yearly budgets to this area. CAHPS described by NRC+Picker as a mechanism, "designed to support benchmarking and research related to consumer assessments of care (www.nrcpicker.com), provides these same organizations with the ability to outsource benchmarking assessments. Subscribing to companies which provide the data collection services described above could enable health facilities and organizations to reallocate financial resources to the operational aspects of quality and patient safety.

The examples used within the literature to forward momentum towards a PCC environment were consistent within all documents. The ideas and concepts (i.e. the required support from organizational leadership, the executive and administration; and suggested areas to initiate the transformation process) were mentioned within all three critically appraised resources. Shaller's document, synthesizes the key principles of PCC as developed and identified by influential models of PCC within the US. Comparing PCC key attributes of the Picker/Commonwealth Organization, The IFCC, and Planetree, six points are represented multiple times. The literature suggests that the PCC concept lacks definition clarity however the convergence on similar aspects of PCC Models provides indication that there is a relative shared understanding of PCC characteristics. When implementing (delivery) PCC at the operational level, similar interventions (i.e. 24/7 visiting hours, incorporation of PCC into documentation, etc), are repeatedly recognized within PCC literature. This supports the confirmability and successful function of models of care and the tangible constructs for implementation. As the philosophy and operational application of PCC become wider spread, the knowledge of change examples will mature and grow.

As the three documents meeting the quality criteria were based within the US healthcare context, it is reasonable to ask whether the application of PCC may be different when applied to a Canadian context. Conway et.al (2006), suggests, in the interest of creating and sustaining mutually beneficial partnerships all involved, health care recipients and health care providers and 'payers' should commit to the enormous task which is PCC. Usage of the term 'payer' is the only occurrence within the literature where the reviewer was able to identify specific US application. As compared to Canada's Healthcare system which provides universal health coverage based on the need for service rather than the ability to pay for the service (Health Canada, 2008), there is no obvious indication that the critically appraised literature was applicable only to the American context of health. The vocabulary used to describe contextual setting is: health system, hospital, clinic, health organization, and medical centre, which can apply to publicly or privately funded health environments. The organizational examples used to describe clinical settings and PCC characteristic infusion into practice is left open for interpretation. One is not constrained by the origination of the literature for its content and theory application. The transferability and generalize-ability of literature content may be more universal in function. Further enhancement of PCC in Canadian healthcare system environments will help determine the level of transferability of concepts and practices.

Answering the Search Question

When reviewing the literature for answering the search question: How do health facilities plan, implement and evaluate the PCC concept? similar streams of information were repeated. The literature represented main concepts of each component of the search question consistently. When planning a PCC movement, the phrase “commitment of leadership” continually surfaced; when implementing (or delivering/incorporating) PCC practices into the daily healthcare setting, ensuring sustained participation of all involved is crucial; and when evaluating PCC infusion, is difficult to measure as the definition of PCC is unclear and ambiguous.

Some say PCC is basic customer service. Others suggest PCC is reflective of the ethic of reciprocity (or the ‘Golden Rule’), ‘treat others as you would like to be treated’, (www.wikipedia.org). The concept described above is rooted in respect, compassion and selflessness. PCC is a reflection of attitude in behavior. Planning requires involvement from patients, families, health providers, and organizational leadership, where the feeling of ownership is integral to the success of PCC. The infusion of the PCC philosophy into practice does not necessarily require tangible, resource filled interventions. PCC can easily exist as a campaign for ‘free hugs’ or a ‘smile’ button worn by health practitioners. The desire to change and the commitment to try is what differentiates those who launch the journey towards PCC and those who are left behind.

Evaluation of PCC is suggested as being an immeasurable task. Some of the literature included in the Evaluation section, has suggested that the PCC approach is not the preferred approach to care in certain situations. De Haes (2006), utilizes examples from Cochrane reviews to support this finding. The article entitled, *Dilemmas in patient centeredness and shared decision making: A case for vulnerability*, mentions frequently the limitations of PCC. The author does not include the concept of informed consent, or reinforce the process of ‘shared decision making’ between patient/client and caregiver within his argument. PCC, guided by: information sharing, respect and dignity, participation and collaboration, requires and incorporates consideration of the person and contextual situation. It seems that de Haes, has formulated a construct around PCC, ignoring the philosophy’s integral basis, where the patient/client is free to choose the degree to which they feel comfortable participating in their own care. Informed consent is paramount in facilitation of communication between the health recipient, regardless of socioeconomic status, and the health provider. It is the responsibility of both parties to effectively participate in health promotion; to generate an environment of ‘openness’ for free flow of information and rapport.

PCC in the Context of Health in Alberta

As Alberta’s population continues to grows, health regions strive to provide high levels of quality and patient safety in an environment of multidisciplinary health provider shortage. Alberta’s Health regions have identified that ‘something’ needs to change. The World Health Organization acknowledges, the “people centred approach meets broader challenges....[It] involves a balanced consideration of the rights and needs as well as the responsibilities and capacities of all the constituents and stakeholders of the health care system” (WHO, 2007). This statement is suggestive of the importance of empowering and enabling the promotion and protection of health, by governments, health authorities and their associated health facilities, and the People (leaders, patients, families, health providers and communities). The literature suggests that the adoption of PCC into health environments can improve health outcomes at individual, organizational and system levels. Partnering to achieve high levels of health through

collaboration can facilitate effective and efficient ways to meet the needs of our current health state.

Alberta's health and political environment is seemingly supportive of the concept of PCC, in such that the development of Primary Care Networks (PCN) and Community Health Councils (CHC) has elevated the capacity for collaboration between health providers, health recipients and the community. The creation and maintenance of health networks which rely on partnership is paramount to promotion of health and prevention of disease. PCN's and CHC's, when used to their full and intended capacity, are an effective way to begin to incorporate the perspective of the community and the people into the primary prevention dimension of health. The Health Quality Council of Alberta (HQCA), key health stakeholders and Alberta's nine Health Regions endorse the application of the Alberta Quality Matrix for Health. PCC can be applied to all six dimensions of health and four areas of need within the Alberta Quality Matrix for Health, and as such, proponents believe PCC improves health outcomes at individual, organizational and system levels.

To counteract the multidiscipline health provider shortage within Alberta, health regions are engaging in national and international recruitment strategies to bring skilled, professional health laborers to Alberta. The US based Dana Farber Cancer Institute, a recognized PCC Facility, was awarded with "Magnet" designation from the American Nurses Credentialing Center (www.danafarber.org). Magnet recognition is given to health organizations which show excellence in nursing service and practice (successfully attract and retain nurses), and is evidenced through lower mortality rates, fewer staff injuries, and higher work satisfaction. An attempt was made to compare nursing vacancy rates of Dana Farber, Capital Health Region and Calgary Health Region, however the data definition for nursing 'vacancy rate' is not consistent among Alberta's large urban health regions and therefore no conclusion can be drawn (www.calgaryhealthregion.ca, 2005). The comparison of nursing vacancy rates could provide insight as to the importance of a PCC environment. The ability to attract and retain skilled, professional health providers enables resources which may have been allocated to staff recruitment and retention to be focused on other areas of the care continuum or the enhancement of care provided.

Recommendations

- 1) Conduct additional literature review on evidence based PCC indicators for purposes of evaluation upon specific intervention delivery;
- 2) Conduct additional literature review on PCC effects on recruitment and retention of healthcare providers;
- 3) Gain additional understanding of how PCC, Disclosure and Just Culture co-exist (symbiotic relationship). As no mention/connection of PCC, Disclosure and Just Culture within the literature reviewed;
- 4) Utilize community PCC structures/networks already in place to fullest capacity (PCNs, CHCs, etc);

- 5) Form an Alberta PCC Committee (with involvement from the AHS, Health Regions, HQCA and all other key stakeholders) to share PCC lessons learned and act as an intra-Alberta mechanism for networking and collaboration;
- 6) Undertake further research and evaluation of the search question: How do health facilities plan, implement and evaluate the PCC concept?;
- 7) Develop additional empirical and theoretical insight in to the benefits and cost of PCC; and
- 8) Conduct additional literature review on “People Centred Care” to increase the understanding of what people centred care is.

Conclusion

Through this critical appraisal the reviewer has provided an overview of the current state of literature for how health facilities can plan, implement and evaluate the people centred care concept. Literature reviewed, is authored by content experts in a new area of qualitative research which some say requires additional content and philosophical or theoretical clarity. Infusion of PCC into Alberta's healthcare context may help to alleviate multidiscipline health provider shortages while sustaining quality and safety and improving health outcomes overall. PCC is a philosophy of care which supports a shift from a paternalistic or provider focused approach to healthcare to one of collaboration and partnership between the health provider and health recipient. PCC is a health care cultural movement which evolves and develops overtime. 'Becoming [people-centred] requires more than a declaration from administration. It must be a genuine part of the values held by everyone within the organization" (Wilkins, et al., 2001).

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Appendix A:

Table 1

Key Words	Key Phrases
People	People Centred (and Centered) Care
Client	People Centred (and Centered) Care Planning
Patient	People Centred (and Centered) Care Implementation
Family	People Centred (and Centered) Care Evaluation
Staff	Patient and Family Centred (and Centered) Care
Physicians	Patient and Family Centred (and Centered) Care Planning
Health	Patient and Family Centred (and Centered) Care Implementation
Centred	Patient and Family Centred (and Centered) Care Evaluation
Centered	Client Centred (and Centered) Care
Evaluation	Client Centred (and Centered) Care Planning
Planning	Client Centred (and Centered) Care Implementation
Implementation	Client Centred (and Centered) Care Evaluation
Hospitals	
Health facilities	

Table 2

Electronic Databases	Web Search Engines	Websites
The Cochrane Library	Google	The Institute for Healthcare Improvement
PubMed	Google Scholar	Commonwealth Fund
OVID (all)		Institute for Family Centered Care
Ebsco (all)		American Hospital Association
		Planetree
		NHS
		NRC+Picker
		The World Health Organization

Appendix B:

Literature Selection Table

Legend	Symbol
Document discusses component	√
People	∞
Planning	P
Implementation	I
Evaluation	E
Health Facility	HF

Documents which met all criteria are highlighted in grey and will be assessed for quality, as discussed within the Literature Assessment section of the Review.

Author	Title	Source	∞	P	I	E	HF
Conway, J., et al. (June, 2006).	Partnering with patient and families to design a patient and family centered health care system: A roadmap for the future	Institute for Healthcare Improvement	√	√	√	√	√
de Haes, H. (June, 2006).	Dilemmas in patient centredness and shared decision making: A case for vulnerability	Patient Education and Counselling (62), Elsevier	√			√	√
Gillespie, R., Florin, D., & Gillam, S. (2004)	How is patient-centred care understood by the clinical managerial and lay stakeholders responsible for promoting this agenda?	Health Expectations (7)	√	√	√		
Institute for Family Centered Care, (no date).	Advancing the practice of patient and family centred care: How to get started.....	Institute for Family Centered Care Website	√	√	√	√	√
King, G. A., Rosenbaum, P. L., & King, S. M. (1996).	Evaluating family-centred service using a measure of parents perceptions	Blackwell	√			√	√
Maher, L., Gustafson, D., & Evans, M. (2007).	Sustainability: Model and guide	NHS: Institute for Innovation and		√		√	

		Improvement					
Price, B. (2006).	Exploring person-centred care	Nursing Standard	√			√	√
Shaller, D. (no date).	Patient centered care: What will it take?	The Commonwealth Fund	√	√	√	√	√
Shields, L., Pratt, J., & Hunter, J. (2005).	Family centred care: A review of qualitative studies	Children and Families	√			√	√
Wilkins, S., Pollock, N., Rochon, S., & Law, M. (April, 2001).	Implementing client centred practice: Why is it so difficult to do?	Canadian Journal of Occupational Therapy	√	√	√		

Appendix C:

<u>Author Name</u> (alphabetically)	<u>Education</u>	<u>Work Experience / History</u>	<u>Number of Articles Published</u> (PubMed)	<u>Name of Journals author has been published in</u>
Conway, J.	<ul style="list-style-type: none"> Master Degree in Science 	<ul style="list-style-type: none"> 27 year career at Boston Children’s Hospital; Senior Vice President at the IHI; and Executive Vice President and Chief Operating Officer at Dana Farber Cancer Institute (1995-2005). 	31	<ol style="list-style-type: none"> Journal of Environmental Health Frontiers of Health Services Management Psychiatric Services Journal of Nursing Administration Healthcare Executive Trustee Hospital and Health Networks Radiology Management Journal of Public Health Management and Practice Canadian Journal of Anesthesia Undersea Biomedical Research American Journal of Preventative Medicine Educacion Medica y Salud American Family Physician Hospitals Journal of Consulting and Clinical Psychology
Edgman-Levitan, S.	<ul style="list-style-type: none"> Graduate Physician Assistant program at the University of Michigan and Duke University, (magna cum laude) 	<ul style="list-style-type: none"> Executive Director, John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital IHI Fellow for Patient and Family Centered Care 		None found. However Edgman-Levitan co-authored the following book titled: <i>Through the patient’s eyes.</i>

		<ul style="list-style-type: none"> • Assistant Professor at Duke University Medical School Board Member of the following: <ul style="list-style-type: none"> • Planetree • National Patient Safety Foundation • Foundation for Informed Medical Decision-making • American Academy of Physician and Patient • Serves as a Commissioner for the Center for Information Therapy 		
Ford, D.	Information not found	<ul style="list-style-type: none"> • Family Member and has provided several patient safety presentations • CAPS Member • WHO Champion • Vice President with Furst Group • Joint Commission Patient and Family Advisory Group 	1	1. World Hospitals and Health Services
Johnson, B.	Information not found	<ul style="list-style-type: none"> • President and CEO of the Institute for Family Centered Care • 25 years of experience in leading non-profit organizations 		None found
Schlucter, J.	<ul style="list-style-type: none"> • Bachelors Degree in Psychology at the Villanova University 	<ul style="list-style-type: none"> • Member of the Institute for Family Centered Care Advisory Board • Past Board Member of the Association for the Care of Children's Health • Founder and CEO of BridgeKeeper • nationally recognized speaker, consultant and patient advocate in the field of family-centered care 	1	1. Pediatric Nursing

Shaller, D.	<ul style="list-style-type: none"> • Masters Degree in Public Affairs (attained from the Humphrey Institute of Public Affairs at the University of Minnesota) 	<ul style="list-style-type: none"> • Owns independent consulting firm • 22 years of experience in applied healthcare policy analysis and related management consulting • President for Policy Studies at the Center for Policy Studies for seven years (1988) • Serves as Managing Director of the National CAHPS Benchmarking Database (NRC+Picker) 	13	<ol style="list-style-type: none"> 1. Journal of Experimental Medicine 2. Annals of the Rheumatic Diseases 3. Health Affairs (Project Hope) 4. Business and Health 5. Journal of Occupational Medicine 6. Mayo Clinic Proceedings 7. American Journal of Medical Quality 8. Journal of the American Medical Association 9. Pediatrics
Simmons, L.	<ul style="list-style-type: none"> • Master of Science in Health Policy Management 	<ul style="list-style-type: none"> • IHI Project Director and Grants Director • Deputy Director of New Health Partnerships 		None found
Sodomka, P.	<ul style="list-style-type: none"> • Master's in Hospital and Health Services Administration at Ohio State University 	<ul style="list-style-type: none"> • Senior Vice President of Patient- and Family-Centered Care at MCG Health, Inc. and Director of the Center for Patient- and Family-Centered Care at the Medical College of Georgia • More than 27 years' experience in health care management. • Featured on IFCC Website as an Organizational Leader 	2	<ol style="list-style-type: none"> 1. Frontiers of Health Services Management 2. Journal of Healthcare Management

Appendix D:

Legend for Table	Symbol Meaning
Indicates inclusion	∂
Indicates appraised document inclusion in other reference list	Δ
References from Conway, J., et al.	\$
References from IFCC	%
References from Shaller, D.	#

Reference List			Appraised Document (by Author Name)		
Reference Symbol	Resource Title/Name	Publication date	Conway, J., et al.	IFCC	Shaller, D.
#	Crossing the quality Chasm: A new health system for the 21 st century	2001	∂		∂
#	Envisioning the national health care quality report	2001			∂
#	National healthcare quality report	2005			∂
#	Primary care and health system performance: Adults' experiences in five countries	2004			∂
#	Partnering with patients and families to design a patient and family-centered health care system	June 2006	$\Delta\partial$	∂	$\Delta\partial$
#	Through the patient's eyes	1993	∂		∂
#	www.familycenteredcare.org				∂
#	www.planetree.org				∂
#	Patient-centered care: An overview of definition and concepts	2004			∂
#	2006 CAHPS health plan survey chartbook	2006			∂
#	Why not the best? Results from a national scorecard on U.S. health system performance	2006			∂
#	Primary care	2004			∂

#	Why not the best?	2006			∂
#	CAHPS hospital survey chartbook	2006			∂
#	An empirical assessment of high performing medical groups: Results from a national survey	2005			∂
#	Organizational culture and leadership	1992			∂
#	Leading physicians through change: How to achieve and sustain results	2000			∂
#	Healing partnerships: The importance of including family and friends	2003			∂
#	Radical systems change: Innovative strategies to improve patient satisfaction	2003			∂
#	Radical loving care: Building the healing hospital in America	2003			∂
#	The CAHPS improvement guide: Practical strategies for improving the patient care experience	2003			∂
#	Healing environments: Architecture and design conducive to health	2003			∂
#	www.healthdesign.org/research/pebble				∂
#	Partnering with patients	2006			∂
#	www.ifcc.org			∂	∂
#	www.mcghhealth.org/News/e-news/partnering_patients.html				∂
#	http://baldrige.nist.gov/PDF_files/Bromson_Profile.pdf				∂
#	Harvard business school case study	2006			∂
#	www.henryford.com				∂
#	www.healthdesign.org/research/pebble/				∂
#	Personal communication with Heather Kopecky, Heidrick & Struggles	2006			∂
#	www.pickereurope.org			∂	∂
#	Patient-focused interventions: A review of the evidence	2006			∂
#	Americans and their health care	2004			∂
#	Decision aids for people facing health treatment or screening decisions	2004			∂
#	www.cahps.ahrq.gov				∂
#	Hospital performance reports: Impact on quality, market share, and reputation	2005			∂
#	Consumers in health care: Creating decision support tools that work	2006			∂
#	www.ncqa.org				∂

%	Changing the concept of families as visitors: Supporting family presence and participation	2003		∂	
%	AHA Mckesson quest for quality prize criteria	2008		∂	
%	Strategies for leadership—Patient and family centered care toolkit	2004	∂	∂	
%	Advancing the practice of patient and family centered geriatric care	2002		∂	
%	Creating patient and family faculty programs	no date		∂	
%	Remaking American medicine: Healthcare for the 21 st century	2006		∂	
%	Effectiveness of strategies for informing, educating and involving patients	2007		∂	
%	Partnering with patients and families to design a patient- and family centered health care system: Recommendations and promising practices	2007		∂	
%	Patients as partners: How to involve patients and families in their own care	2006	∂	∂	
%	Patients as partners: Toolkit for implementing national patient safety goal 13	2007		∂	
%	Engaging patients and families: A high leverage tool for health care leaders	2006		∂	
%	Developing family-centered vision, mission and philosophy of care statements	2007		∂	
%	Developing and sustaining a patient and family advisory council	2000		∂	
%	www.culturechangenow.com			∂	
%	www.aha.org			∂	
%	www.cgsupport.nhs.uk/Programmes/Patients_Accelerating_Change_Programme.asp			∂	
%	www.patientsafety.org			∂	
%	www.cqi-mass.org			∂	
%	www.familycenteredcare.org			∂	
%	www.ihl.org/IHI/Topics/PatientCenteredCare			∂	
%	www.npsf.org			∂	
%	www.newhealthpartnerships.org			∂	
%	www.voice4patients.com			∂	
\$	Training medical students in patient-centered medicine	1969	∂		
\$	Family centered care: Four decades of progress	2000	∂		
\$	Family centered care for children with special health care needs	1987	∂		

\$	Family centered care for children needing specialized health and developmental services	1994	∂		
\$	Putting patients first: Designing and practicing patient-centered care	2003	∂		
\$	The future of patient-centered care: scenarios, visions and audacious goals	2004	∂		
\$	Challenging restricted visiting policies in critical care	1999	∂		
\$	Understanding social factors and inequalities in health: 20 th century progress and 21 st century prospects	2002	∂		
\$	Social isolation and health, with an emphasis on underlying mechanisms	2003	∂		
\$	Family centered care and the pediatrician's role	2003	∂		
\$	Implementing community-based systems of services for children and youths with special health care needs: How well are we doing?	2004	∂		
\$	Family-centered care: Putting it into action	2003	∂		
\$	The online health care revolution: How the web helps Americans take better care of themselves	2006	∂		
\$	Healing by design	1995	∂		
\$	Improving healthcare with better building design	2006	∂		
\$	The role of the physical environment in the hospital of the 21 st century: A once-in-a-lifetime opportunity	2004	∂		
\$	Patient-centered care for underserved populations: Definitions and best practices	2006	∂		
\$	Reflections of patient and family voices	2005	∂		
\$	A case study: Building a patient- and family-centered model of care in an academic medical center	2006	∂		
\$	Tearing down the walls	2005	∂		
\$	System innovation: Concord hospital	2002	∂		
\$	Center for medical home improvement: Report of the medical director	2006	∂		
\$	Parent and nursing partnership model for teaching therapeutic relationships	2004	∂		
\$	Improving partnerships with children and families: A model from the children's hospital in Philadelphia	2005	∂		
\$	Learning from the dying	2005	∂		

\$	Family re-union: Back to the future: Accomplishments and Next steps	2001	∂		
\$	Consumer involvement in health technology assessment	2005	∂		

Appendix E:

Confirmability Table

Legend for Table	Symbol of meaning
Included within appraised document	√
Not included within appraised document	∩

List of identified concepts, ideas, and examples	Appraised Document (by Author Name)		
	Conway, J., et al.	IFCC	Shaller, D.
Introduction of PCC concept	√	√	√
Current role in healthcare	√	√	√
Description of environments which foster PCC	√	√	√
Examples (of organizations and/or by leaders)	√	√	√
Resources for reference	√	√	√
Named organizations used as examples (promoting PCC)			
MCG Health System	√	√	√
Cincinnati Children's Hospital Medical Center	√		√
Concord Hospital	√		
Maine Medical Center	√		
Dana Farber Cancer Institute	√		
University of Washington Medical Center	√		
Birth Center at United Hospital (Minnesota)	√		
Boston Medical Center	√		
Massachusetts General Hospital	√		
Bronson Methodist Hospital			√
Virginia Mason Medical Center			√
Henry Ford Health System			√
Weill Cornell Medical College (New York)			√

Named Experts/Leaders (alphabetically)			
Cama, Rosalyn	Individuals are not named within the body of the document	Individuals are not named within the body of the document	√
Chapman, Erie			√
Coughlan, Peter			√
Edgman-Levitan, Susan			√
Frampton, Susan			√
Goonan, Kathleen			√
Johnson, Beverly			√
Kaplan, Gary			√
Kopecky, Heather			√
Leebov, Wendy			√
Luther, Katharine			√
Morath, Julie			√
Sardone, Frank			√
Schlichting, Nancy			√
Sinioris, Marie			√
Sodomka, Patricia			√
Warden, Gail	√		

Appendix F: Strategies

The tables below include planning, implementation and evaluation strategies health facilities may draw upon to forward PCC momentum. Strategies contained in ‘grayed’ boxes have been identified by at least 2 of the 3 critically appraised documents identified in the Literature Assessment section.

PCC Planning Strategies

Attain commitment of Leadership / Executive	Align mission, values, and vision with PCC philosophy and operational priorities	Commit to abolish organizational barriers to PCC
Engage senior leaders to learn about PCC	View ‘people’ as allies	Attain commitment from all levels of the organization
Assess degree to which PCC is currently incorporated into organization	Incorporate PCC into the core business model	Include ethical considerations
Set priorities and goals to develop action plan	Focus on the person not the illness	

PCC Implementation Strategies

Revise documentation and templates to reflect PCC	Patient-centered Steering Committee	Designate staff as PCC Liaison
Job descriptions to reflect PCC	Consolidation of Patient and Family Education materials	PCC Orientation and Education for all “People”
Units open to visitors 24/7	Patient and Family led university courses for multidiscipline health practitioners	Celebrate accomplishments
Patients and families participate in multidisciplinary rounds	Shared Care Plan	Compensation for patients and families on PCC Advisory Councils
Human Resources Department to ensure new employees possess PCC attitudes and skills	Walkrounds™ (by Executive) on health facility wards/units	Internal rewards and incentives
Widespread organizational training in quality improvement	Empower and enable all levels of management to support change and PCC	Develop Policy and Procedures supporting PCC
Training for multidisciplines to succeed as team (not individuals)	Invest resources in PCC	Develop practical strategies
Provide time to staff to reflect on practice	Training for staff to develop negotiation skills	

PCC Evaluation Strategies

Patient Care Satisfaction Survey Scores	Staff Vacancy Rate	Health outcomes
Employee Care Satisfaction Survey Scores	Wait times (Emergency Room)	Length of stay
Adverse Event rate	Use of patient-centred health information technology applications	Nosocomial infection rates
Discharge Volume Rate	Employee turnover (retention)	Organizational behaviors in new versus old health facilities
Public Reporting	Accreditation (CCHSA ROPs)	