Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

LESSONS LEARNED

Engaging Consumers to Improve Ambulatory Care

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Pioneering Patient Integration in Quality Improvement

Around the country, a handful of bold and innovative communities are making great strides in engaging patients and consumer advocates as advisers in the planning, implementation and evaluation of quality improvement initiatives in ambulatory care. By embedding the patient's voice and perspective across the continuum of quality improvement, these communities are transforming the future of ambulatory care.

Lessons from Aligning Forces

In July, 2011, ten communities from *Aligning Forces for Quality* gathered in Chicago to learn from each other's experiences about how to partner with patients, families and caregivers to improve ambulatory care. These projects place patients, families and advocates in positions of influence, from which they can advise and affect decision-making within their communities' health care systems. Shared here is the work of five of those communities.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

Inspiring Change: Consumer Engagement in Hospital Quality Improvement

Consumer engagement in improving the quality of ambulatory care is in its early stages. Yet a growing body of evidence from the hospital setting shows that in addition to transforming the culture of health care, putting patients in positions of genuine power and influence results in better-quality care. The following hospital-based consumer engagement programs demonstrate outcomes that include reduced length of stay, fewer fatal safety errors, better identification of "near misses," and improved population health through achieving higher rates of preventive care. Such evidence from hospitals helps support the need for consumer engagement efforts in the ambulatory care arena.

- **Georgia Health Sciences University** in Augusta, Georgia, has one of the largest patient adviser programs in the United States. More than 240 active patient and family advisers serve all hospitals and ambulatory care centers throughout the health system. They sit on councils and quality and safety teams, participate in training new employees about the concept of patient-centered care, and work on facility design. Patient Advisor Program data suggest that patient satisfaction increased by five points on a 100-point satisfaction tool over eight years; the average length of hospital stays for neurosurgery decreased by 50 percent over three years; staff vacancy rate decreased from 8 percent to 0 percent over three years; and malpractice expenses were reduced by 60 percent, from $2.5 million to $1.12 million.[i]

- **Dana-Farber Cancer Institute** (DFCI) in Boston, Massachusetts has over 400 advisers active at any one time. Spurred by a highly publicized patient death from an avoidable medical error, the organization has since involved patients and families in initiatives aimed at making care processes safer. Advisers at DFCI shape virtually every aspect of the organization, including safety and quality improvement teams, facility design, management, and strategic concerns. Their work has led to a profound culture shift, moving from skepticism about partnering with patients and families to full acceptance. DFCI has also had more than a decade free of fatal medication errors.[ii]
- In 2005, **Blanchfield Army Community Hospital**, a Military Treatment Facility (MTF) at Fort Campbell in Kentucky, established a Patient and Family-Centered Care Council. Advisers engage in many activities, including partnering with radiologists and other hospital staff to improve the mammography experience. Redesigning this process has led to increased patient, staff and physician satisfaction, and has helped Blanchfield achieve its prevention and screening goals. Blanchfield was the first military treatment facility to reach the HEDIS mammography screening performance measure.[iii]
- At **Emory Healthcare** in Atlanta, Georgia, nurse leaders worked closely with the health system's patient and family advisory council to standardize and simplify the bedside shift report process. Through personal stories of their own hospital experiences, advisers were instrumental in demonstrating the importance of this intervention and in convincing staff to implement it. Advisers played a major role in developing training curricula, and serve as faculty during education seminars for staff. Partnering with patients to transition to bedside shift reporting has led to improvements that include clinicians and patients catching "near misses" and errors, such as incorrect IV drip concentration, fall prevention issues, and situations that require rapid response teams. Patient experience ratings on nursing care have since climbed from 83.0 percent to 93.1 percent.[iv]

Humboldt County, California: A Swift and Sweeping Change in Culture

Community Health Alliance (CHA) of Humboldt-Del Norte, Inc.

www.communityhealthalliance.org

"At the first meeting, I thought, 'If this works, it's going to be a sea change, and I want to be a part of it,'" says Janina Shayne, a patient partner in rural Humboldt County, California. In January 2011, Shayne was one of 18 patients, each representing a primary care practice, who gathered to prepare for their first Primary Care Renewal (PCR) meeting. It was the first time most of the patients had been asked for their insights into ways the health care system could better meet their needs and those of families and caregivers.

The PCR Program supports practices making the transition to patient-centered medical homes. As part of the program, patient partners gather with providers and staff from the 18 practices every other month, in meetings attended by an average of 100 people. Topics range from coordination of referral tracking to health risk assessments and chronic disease self-management.

At-A-Glance

The Basics

- The Primary Care Renewal (PCR) Program supports practices making the transition to patient-centered medical homes.
- Eighteen patient partners each represent a primary care practice.

What Works

- Providers recruit patients, including some engaged in their own health management.
- A three-hour orientation for patient partners provides a "health care 101" overview.
- Patient partners attend pre-PCR meetings to discuss the following night's topic.
- Patients meet with providers and staff from the practices at formal PCR meetings.
- Patient partners help train newly recruited partners.

> *"I've seen changes in people who have no background in health, who were just patients. To see them empowered in their practice—it is a huge change."*
>
> — Janina Shayne, patient partner

Less than a year after the first PCR meeting, providers are regularly turning to patients for input on practice redesign and patient outreach and engagement strategies. The patient partners themselves are more informed, empowered and engaged than ever before. A project that began with just a few patients tasked with redesigning practices' brochures to make them more patient-friendly has led to a sweeping culture change, in which patient partners are a central part of efforts to improve health care delivery.

Some practices are setting up additional meetings with patient partners to plan for practice redesign and disease management. One practice consulted its patient partner about a decision to send a fecal occult blood test kit to every patient to screen for colorectal cancer, more prevalent in Humboldt County than in other parts of the state. Concerned that patients would be hesitant to use the kit at home, the practice took the patient partner's suggestion to add a sticker that read, "This could save your life."

As in other patient engagement efforts nationwide, practices are finding that providers are the most successful recruiters of patient partners. Patients asked by their providers feel honored and are more likely to accept. An orientation lays a common foundation, covering the patient-centered medical home concept, the role of patient partners, the basics of chronic disease, dynamics among providers and staff, and common medical terminology. Patient partners then convene separately before the formal PCR meetings. A retired nurse practitioner, who is also a consumer advocate and chronic disease patient, often co-leads patient partner meetings and helps the group see provider perspectives on discussion topics. Jessica Osborne-Stafsnes, the consumer engagement specialist at the Community Health Alliance, observes that these pre-meetings are critical to supporting patient partners, "Patients feel more empowered when they go back to their practice teams," she says. Shayne agrees that the initiative has "completely opened up the communication between the medical community and the patients."

"This program is redefining the patient-provider relationship," says Osborne-Stafsnes. "In the past, the doctor was the expert. But really, patients are the experts in their own lives and their own health. They're the only ones who can know about the many factors that affect their health." As Glen Twombly, a patient partner, said at a PCR meeting, "After 60 years, this is the first time someone has asked me my opinion as a patient."

Oregon: The Importance of Preparing for Change

Oregon Health Care Quality Corporation (Quality Corp)

www.q-corp.org

"There is a big fear that patient advisory councils are going to ask for things doctors can't provide," says Mary Minniti, project director for the Oregon Health Care Quality Corporation's Patients and Families as Leaders program. "In reality, patients are focused on what's important in the experience and come up with less costly alternatives."

At-A-Glance

The Basics

- Quality Corp's Patients and Families as Leaders initiative works with four medical groups and one health plan to help them collaborate with patient and family advisors to improve quality.

What Works

- A kick-off meeting raises awareness among medical groups and health plans, which are then invited to apply to participate in the program.
- Early assistance to medical groups and health plans includes training sessions on engaging patients in meaningful partnerships, assessment of practices, and help developing an action plan.
- Providers recruit patients to their advisory councils.
- Councils lead improvement projects rather than functioning only as focus groups.
- Council members use Flip cams for "walk-abouts" to interview patients at every touch point in the primary care setting (e.g., front desk, waiting room, after seeing their provider) and identify areas of improvement.
- One medical leader and one staff leader are required to attend meetings to ensure continuity of executive support/sponsorship.
- Meetings are designated as "acronym-free zones."

> *"We had expected that the Patient Advisory Council would help us identify ways to improve the care we provide to patients, but they also want to develop ways to help patients be better partners in their care."*
>
> — Scott Johnson, MD, Oregon Medical Group

The initiative began in the spring of 2010, and helps medical groups and health plans partner with patients and families to improve quality and patient safety. “We made sure to give a lot of technical assistance up front,” says Summer Boslaugh, Quality Corp program manager. Early assistance to the four medical groups and one health plan chosen for the initiative included a training session on engaging patients as partners, led by the Institute for Patient- and Family-Centered Care; help assessing the scope and depth of patient- and family-centered care in practices at the time; and working together on an action plan for engaging patients and families as advisors.

“A successful patient advisory program prepares an organization to understand the importance of consumer engagement,” says Minniti. “The Patient Advisory Council needs to be meaningful, not just tokenism.” Quality Corp staff helped the organizations collaborate with Patient Advisory Councils to come up with projects together, rather than simply ask for patient feedback. “Often, organizations make the mistake of treating advisory councils like focus groups,” says Minniti.

The four Patient Advisory Councils (PACs) and the health plan’s Member Advisory Council (MAC) consist of seven to 12 members each. Their projects include helping practices transition to a patient-centered medical home model, creating communication tools to explain the model to patients, and helping train providers in patient-centeredness. One advisory council suggested that a patient volunteer serve as a greeter in one clinic. Another council pointed out that a practice’s phone system required callers to wade through menu options before reaching a person. The practice was unaware of the problem and swiftly corrected it. Thanks in part to Quality Corp’s preparation of the practices, office staff now welcomes the involvement of patient advisers.

Quality Corp’s Patients and Families as Leaders initiative is changing the health care landscape in Oregon, one relationship at a time. “Doctors can feel anxious about this,” says Minniti, “but when doctors and staff get into meaningful partnerships with patients on redesigning care, the cynicism disappears. Patients and families bring energy and passion to health care.” According to Minniti, providers do not need grant funding to shift gears. “They can start tomorrow by asking patients or family members about their experiences in health care and what can be improved. Listening deeply, being open and providing opportunities for collaboration is a simple way to bring patients to the table.”

Minnesota: Paving the Way for Difficult Conversations

Institute for Clinical Systems Improvement

www.icsi.org

“In some ways, the timing could not have been worse,” says Janet Schuerman, project lead of the Institute for Clinical Systems Improvement (ICSI), a Minnesota nonprofit organization comprised of 61 medical practices. Just as ICSI launched a new patient engagement project focused on palliative care, national news media showcased so-called “death panels.” Yet in some ways, the timing could not have been better. Watching the coverage, Schuerman and her team gained insights into their project’s broader implications—and became even more determined to move it forward. ICSI has an impressive history of leading patient-centered health care transformation efforts, but its palliative care work is particularly innovative because it le-

At-A-Glance

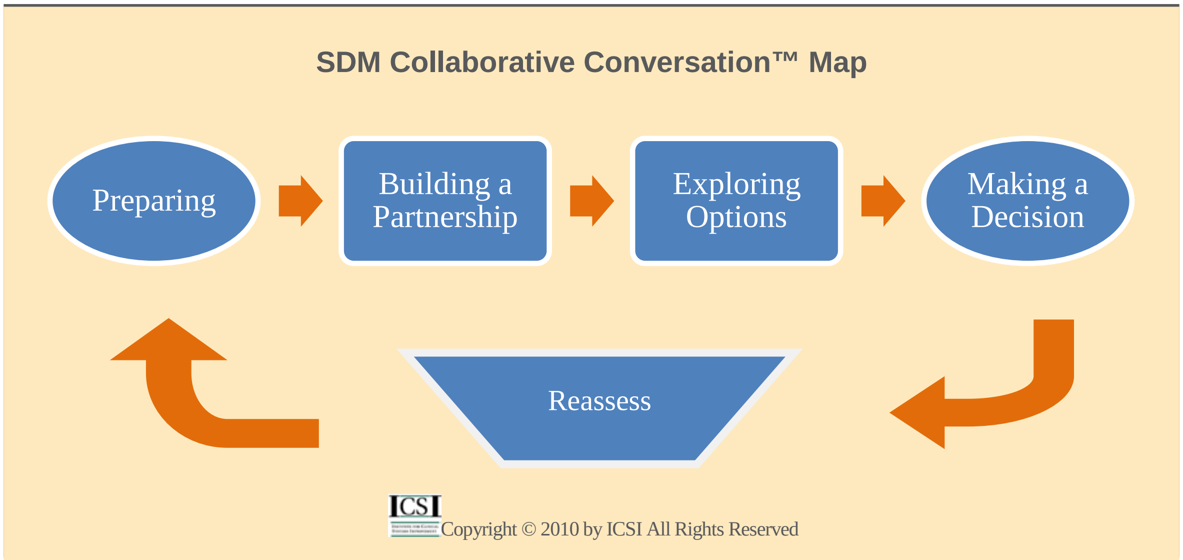
The Basics

- ICSI’s Patient Advisory Council consists of 15 patients from a variety of backgrounds.
- The Palliative Care Shared Decision-Making (SDM) Committee consists of about 20 stakeholders.
- The Palliative Care SDM Committee collaborates with the PAC on the SDM Collaborative Conversation Map.
- One staff member from ICSI serves as a central point of contact for the PAC.

What Works

- ICSI recruits patient advisers through word of mouth and recommendations from providers.
- Patients with interest in a particular topic can serve as interim members of the PAC.
- ICSI staff uses Flip cameras to record patient stories and share these videos at meetings to motivate and engage providers.
- Patients are involved in training, which is customized for each practice.
- Patients and patient representatives are interviewed to ensure they are matched with opportunities in their areas of interest.

verages the power of patient and physician partnerships and uses an existing Patient Advisory Committee (PAC) to spur transformation.


SDM Collaborative Conversation™ Map

ICSI brought together its PAC and its Shared Decision-Making (SDM) Palliative Care Committee, which had been established to help patients with life-limiting diseases receive the care they want. “We compared what palliative care looks like now and what the ideal could look like. What we found was a huge gap,” says Schuerman. The extent of that gap was evident at an early meeting, in which a cancer survivor and an oncologist were at the table together and the oncologist admitted he did not like bringing up the topic of palliative care because he feared it would make his patients think he had given up on them. The patient admitted he did not want to bring it up because he worried the provider would think he did not have faith in the provider’s ability. Both agreed that a failure to have the conversation happens all too often, denying patients and providers the opportunity to discuss important options.

In an effort to encourage these vital conversations, the two committees developed the SDM Collaborative Conversation™ Map—a tool that provides a tangible framework for patients, providers and families to engage in shared decision-making. ICSI has found using the Map changes the care process, and improves outcomes for both patients and providers.

The Map helps patients, families and providers prepare for conversations about treatment options, build partnerships with each other, explore options consistent with the patient’s and family’s values, make decisions, and reassess their choices as circumstances change. The Palliative Care Committee developed a first draft, which it brought to the PAC for review. The PAC was able to point out important opportunities for discussions that would otherwise have been missed. “We were seeing things in the Map that the providers on the SDM Palliative Care Committee weren’t. It’s like you’re wearing a different set of lenses,” says Barbara Degnan, a patient member of both the SDM Palliative Care Committee and the PAC. The PAC also suggested changes to the Map’s language and structure. “It was ugly—in a good way,” says Schuerman. “They looked at language like, ‘tailor interventions’ and said, ‘What does that mean? How about saying “exploring options” instead?’” Their suggestions led to the final, simple version of the Map, which used common language that worked for both patients and providers.

The Map is now being used by five pilot sites, including an inpatient palliative care site, oncology practices and a home health care program. All sites’ staffs receive ongoing training from ICSI in using the tool. Other pilot sites not affiliated with palliative care have begun to use the Map for shared decision-making. It is also being used in patient communication presentations, in patient review meetings, and has been adapted to one organization’s electronic medical record system to document patients’ values and preferences. Recently, patients have started serving as co-trainers with Schuerman during on-site clinic visits. “I hear from both sides—the providers and patients—that they’re getting heard,” says Schuerman. “They have confidence in the process and in their decision.”

All concerned agree that leveraging the experience and expertise of the PAC led to end results that are more patient-centered. The collaboration will not only have a lasting impact on how families experience end-of-life care, but also has the potential to change communication across the entire continuum of care in the region.

Maine: Making the System Whole, One Patient-Centered Medical Home at a Time

Maine Quality Counts

www.mainequalitycounts.org

In Maine, fragmented systems are being made whole by the Patient-Centered Medical Home (PCMH) Pilot (the Pilot). Led by a three-agency collaboration among the Maine Quality Forum, *Quality Counts* and the Maine Health Management Coalition, the Pilot includes 26 primary care practices, or 5 percent of all primary care practices in the state. The same year the Pilot started, staff convened the Patient and Family Leadership Team (PFLT), a consumer advisory group of 10 consumers, consumer representatives and quality improvement professionals to ensure each medical home benefits from patient and family voices at every stage of its development. In part, the Team accomplishes this by helping each practice recruit its own patient advisers to address that practice's specific needs.

Practices receive overall training and support as part of their participation in the Pilot. They can also request one-on-one technical assistance from the Team, which can then respond to needs ranging from planning to recruitment of patient advisers to ongoing support. Once patients agree to participate as advisers, practices give orientations that cover the PCMH concept and the role of patient advisers, using material from the Institute for Patient- and Family-Centered Care and other sources. Moving forward, the team plans to enlist Maine's Area Agencies on Aging to work with practices to recruit and engage more patient advisers.

At-A-Glance

The Basics

- The PCMH Pilot program involves 26 primary care practices.
- The Pilot convened the Patient and Family Leadership Team, which has 10 members, to assist practices in involving patient advisers in the transition to PCMHs.

What Works

- Providers recruited patients in person, through letters, and with a newspaper advertisement.
- Patient and family advisers are included in practice leadership meetings.
- The Patient and Family Leadership Team:
  - Interviews providers and leaders at the outset to assess practices' patient engagement initiatives;
  - Provides ongoing training and one-on-one technical assistance on request;
  - Provides technical assistance for recruitment of patient advisers upon request;
  - Provides an orientation for patients who participate, upon practices' request;
  - Encourages practices to engage as many providers and staff from the practice as possible;
  - Practices further along in the patient engagement process serve as mentors for other practices.

> *"Patients' feedback helps set priorities for the practice."*
>
> — Richard Engel, MD, Maine Medical Partners, Westbrook Internal Medicine

On average, the Pilot practices have recruited four to six patient advisers, who have already provided insights on practice signage and on triage, scheduling and referral systems. Some patient adviser groups found they could improve patients' experience simply by helping practices change their phone systems so callers can reach a person quickly and easily.

"Staff involvement is very important," says Kim Humphrey, consumer representative and coordinator of the PFLT. "The more doctors, nurses and staff are involved, the more patients feel they're being heard." Patients also feel listened to when their suggestions are implemented, or when they learn why they are not. For example, at one meeting, patients suggested a variety of simple practice changes (such as updating the magazines and raising the waiting room temperature) and by the next meeting, those changes had been made. Those simple improvements let the patient advisers know their suggestions had been heard. "It's very motivating for patients to share their experiences with providers and see that they truly care, but hadn't previously been aware of patients' perspective," says Humphrey.

Providers and practice staff have become more attuned to the patient experience, and have also ceased to fear an onslaught of patient criticism. “Patients are loyal to their practices. They want to help,” says Ted Rooney, project director of *Aligning Forces for Quality* in Maine. The collaboration between patients and practices is leading to better communications, which is leading to better care. Although the road ahead is long, the benefits of patient-centered medical homes in Maine are clear. While Rooney cautions that change does not happen overnight, the Pilot has given patients a glimpse into the future of ambulatory care in Maine.

South Central Pennsylvania: Giving Chronic Disease Patients a Voice in the Patient-Centered Medical Home

Aligning Forces for Quality in South Central Pennsylvania

www.aligning4healthpa.org

Kathy Hutcheson understands the needs of patients with chronic disease. “My mother wasn’t engaged at all in her care,” she says. Both of her parents had diabetes. So did all four of her grandparents. Only one of her father’s eight siblings escaped death from diabetes or heart disease. As a result, Hutcheson says, “When I look at a program for patient engagement, I ask, ‘Would this engage my mom?’”

As the Patient Partner Program coordinator of *Aligning Forces for Quality* in South Central Pennsylvania (SCPA), Hutcheson makes sure patients with chronic disease have a voice in local practices’ transition to patient-centered medical homes. The program is part of SCPA’s Planned Care Collaborative (PCC), a quality improvement initiative, which is helping seven primary care practices in the region with the transition and with using a chronic care model to strive for quality care for patients with preventable and chronic diseases. Patient partners are integrated into each practice’s team to ensure that the perspective of those receiving care is considered throughout the improvement process—and reflected in changes.

In 2011, PCC focused on improving diabetes care. With the help of Patient Partner Program staff, each practice worked to recruit at least two patients who either managed their own diabetes or cared for someone with the condition. With their deeply personal knowledge, these patient partners help practices understand the barriers patients and caregivers experience accessing the health care system and managing health challenges at home.

Although recruitment has been challenging, the program has brought on a wide range of patient partners, from managers and construction workers to retirees. They range in age from 25 to 74, and include more men than women. SCPA also makes sure patients and practices realize they are breaking new ground. “When I work with the patients to get them up to speed, I tell them ‘We’re blazing a trail here. We’re going to make mistakes and we’re going to move forward,’” says Hutcheson.

At-A-Glance

The Basics

- The Planned Care Collaborative (PCC) helps seven primary care practices transition to PCMHs.
- A chronic care model supports PCC’s efforts to provide quality care for patients with preventable and chronic diseases.
- The Patient Partner Program helps practices within the PCC engage patient partners to assist with their transition to PCMHs.

What Works

- Each practice recruits at least two patients who have diabetes or are caregivers to diabetes patients.
- The Alliance provides a list of effective patient-partner qualities and interview questions to support recruitment.
- Patient partners attend a four-hour training session and five dinner meetings with practice staff and providers.
- Patient partners participate in monthly conference calls led by the Alliance to share experiences and provide feedback.
- Each practice appoints a physician champion to serve as a liaison between patients and practices.
- Patient partners and practices chart and review the flow of interactions with patients with diabetes.
- The PCC measures care improvement from the outset of the program. For example, it measures number of diabetes patients who have their blood sugar level tested regularly.

Patient partners, along with leaders from the practices, plan to look at patient flow and study how well practices reach out to patients with diabetes by tracking the frequency of patient visits for A1C tests. A physician champion also serves as a liaison between patients and providers.

While still early in the program, excitement about its potential is spreading throughout the region. Other practices from the Planned Care Collaborative have already asked for assistance recruiting patient partners. The importance of involving chronic disease patients in quality improvement is clear: “Chronic disease is a different beast than other diseases. It involves a patient’s lifestyle,” says Hutcheson. “Physicians can’t reduce chronic disease without patient involvement.”

Lessons Learned

There is no one single model for how to embed patients in quality improvement initiatives. Communities differ, practices differ, and so do early lessons about integrating patients into quality improvement. However, there are some common themes across these efforts.

Address provider anxiety.

Although provider trepidation about involving patients in quality improvement activities is common, the *Aligning Forces* communities profiled here have been successful in quelling such fears. Provider anxiety about patient criticism is seldom realized. Instead, providers find patient involvement generally to be constructive and to have the power to inform and accelerate real change. Preparing providers to work with patients as partners can mitigate anxieties. Such preparation can include assessing current attitudes, talking openly about anticipated challenges, identifying ways to overcome these challenges, and listening to providers who have experience with these partnerships.

A Note on Cost

Costs for these programs vary by geography, number of staff, patient partners and practices. The Alliances have funded the efforts in a variety of ways, including Robert Wood Johnson Foundation Development Fund grants for programs focused specifically on patient-centered care, grants from other funders, and direct and in-kind contributions from health care provider organizations. To benefit consumer engagement efforts, resources are typically invested in staffing, patient stipends, and potential funds to participating practices.

Start small, but start somewhere.

Identifying needs and making concrete improvements can immediately make patients happier, patient advisers more engaged, and providers and staff aware of the potential of patients to enhance the practice for everyone. Even when it means making more basic improvements in things like phone systems, these early wins provide a key foundation of trust between advisers and providers that makes tackling more complex quality and safety issues easier.

Integrate patient engagement into current improvement efforts.

While it’s best to engage patient and family advisers at the inception of new initiatives, including project development and associated goals, partnering with patients does not require new projects. The key is to integrate patient and family advisers into the improvement work that practices are already doing, enhancing that work with the patient perspective rather than creating a separate patient-based approach that competes with a practice’s existing work.

Jump-start recruitment efforts by cultivating engaged patients.

Engaged patients want to help; take advantage of that. Patients who are engaged in their own health care often feel loyal to their providers and seek a more active role in improving the care they and their fellow patients receive. Providers can often identify these individuals, and inviting them to participate in quality improvement activities meets needs of the patients as well as the practice. Although it is important to ensure your improvement efforts meet the needs of the broader patient community (including patients who are less engaged), starting the recruitment process with provider input can build a strong collaborative foundation. Once that foundation is established, practices can expand their recruitment efforts to those who may better represent the gender, race, ethnicity, age, and level of engagement of the larger patient population.

Engage now, save later.

By identifying the right approach to engage patients early, *Aligning Forces* communities are saving practices untold sums in implementing systems and interventions that do not incorporate or respond to patient needs. What's more, when advisers and providers get experience working together, they are able to tackle more complex issues and make significant improvements to care delivery.

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[i] "Innovation Profile: Patient Advisers Participate in Hospital Councils, Committees, Staff Training, and Other Activities, Contributing to Improved Patient Satisfaction and Better Organizational Performance," AHRQ Health Care Innovations Exchange, submitted July 7, 2010, *http://innovations.ahrq.gov/content.aspx?id=2801* and Johnson B. "Hospitals and Communities Moving Forward with Patient- and Family-Centered Care: A Visual Tour." (Presentation at Hospitals and Communities Moving Forward with Patient- and Family-Centered Care, an Institute for Patient and Family Centered Care Intensive Training Seminar, St. Louis, May 2-5, 2011).

[ii] Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition)*. Cambridge, MA: Institute for Healthcare Improvement, 2008, *http://www.ihi.org/knowledge/Pages/IHIWhitePapers/SevenLeadershipLeveragePointsWhitePaper.aspx*

[iii] Johnson B, Abraham M, Conway J, et al. *Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: Recommendations and Promising Practices*. Bethesda, MD: Institute for Family-Centered Care, 2008, *http://www.ipfcc.org/pdf/PartneringwithPatientsandFamilies.pdf*

[iv] L. Murray summary based on 10/6/11 phone call with Michelle Gray, Nurse Unit Director, Emory University Hospital and Emory Healthcare, "Emory Healthcare Nursing Annual Report 2008," published online at *http://www.emoryhealthcare.org/employment/nursing-at-emory/nursing-2008-annual-report.pdf* [accessed December 2, 2011].

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