HEALTH CARE FOR ALL

Patients and Families Improving Care

Patient and Family Advisory Councils

A Review of 2011 PFAC Reports

by the
Consumer Health Quality Council
Health Care For All, Massachusetts

2012

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Patient Family Advisory Councils
A Review of 2011 Activity Reports

I. Overview of PFAC Law

In 2008, Massachusetts enacted a law that requires all hospitals to create and maintain Patient and Family Advisory Councils (PFACs). PFACs are groups of current and former patients and family members who collaborate with hospital staff to improve the care experience. Many hospitals, including some in Massachusetts, have had PFACs in place for a number of years.

The Massachusetts 2008 law states:
"The department (of public health) shall promulgate regulations for the establishment of a patient and family advisory council at each hospital in the commonwealth. The council shall advise the hospital on matters including, but not limited to, patient and provider relationships, institutional review boards, quality improvement initiatives and patient education on safety and quality matters. Members of a council may act as reviewers of publicly reported quality information, members of task forces, members of awards committees for patient safety activities, members of advisory boards, participants on search committees and in the hiring of new staff, and may act as co-trainers for clinical and nonclinical staff, in-service programs, and health professional trainees or as participants in reward and recognition programs."

In 2009, the Department of Public Health (DPH) issued regulations regarding the establishment of PFACs. The regulations state:

- Hospitals must establish PFACs by October 2010. By September 30, 2009, they must develop a plan for establishing PFACs.
- It is recommended that the PFAC have a chair or co-chair who is a patient/family member.
- At least 50% of the PFAC must be current or former patients and/or family members. The membership must reflect the community served by the hospital.
- Hospitals must write an annual report on the work of the PFAC starting October 2010. The September 2009 plan and every annual report must be available upon request to the public and DPH.

II. Health Care For All and Consumer Health Quality Council

Health Care For All (HCFA) is a statewide consumer health advocacy organization. (Learn more at www.hcfama.org.) HCFA started the Consumer Health Quality Council

(Consumer Council) in 2006. The mission statement of the Consumer Council is as follows: "*The Consumer Health Quality Council empowers those impacted by health care quality issues to have a voice in our health care system, to engage fellow consumers to be active partners in their health care, and to advocate for high quality, safe, and accessible health care for all Massachusetts residents*."

Consumer Council members worked throughout the 2007-2008 legislative session to advocate for an omnibus health care quality improvement bill. A number of provisions of the bill became law, including the hospital PFAC requirement. Council members decided that it was important to continue their involvement as hospitals began to establish PFACs. Council members gathered the initial PFAC plans and the subsequent PFAC annual reports from Massachusetts hospitals and posted the reports on-line, so that consumers and providers could read them. The Consumer Council and HCFA created a PFAC webpage with general information about PFACs and a link to a page listing all Massachusetts hospitals with links to their annual PFAC reports. Council members analyzed the available PFAC annual reports in 2010 and in 2011 and reported on their findings. This current report summarizes Consumer Council impressions and findings from the 2011 PFAC annual reports.

III. Method of Review

Consumer Council members searched Massachusetts hospital websites for 2011 PFAC reports. Where a report was not readily accessible from searching a hospital's website, a Council member contacted hospital staff and requested the report. Links to each of the hospital reports are provided on HCFA's PFAC page.

Council members created an on-line review instrument to evaluate reports. (See Appendix A for the review tool.) This review covered the following areas: organization, leadership, training and orientation of members, the impact of a PFAC with regard to specific quality improvement initiatives, and the extent to which the quality improvement initiatives in which PFAC members participated relate to national or state health care system reform priorities.

As of late June 2012, when the report analyses were completed, Council members had sought out or been sent reports from 74 hospitals and were able to review 62 PFAC reports pertaining to 59 hospitals (one hospital operates and created separate reports for its 3 PFACs). While only those received by late June are included in this report, by October 2012, the Consumer Council had received reports from all but three hospitals (see Appendix D for list of hospitals that sent reports). Council members actively reached out to all acute care hospitals. A number of rehabilitation hospitals also sent

reports. Next year, Council members will reach out to all rehabilitation and acute care hospitals.

IV. Findings

A. Year Established

Almost half of reporting PFACs became active in 2010 (44.6%, n=26), although 14 (24%) were active in 2009 or earlier (inaugurating between 1998 and 2007). In 26% of reports (n=15) reviewers could not determine the year in which the PFAC became active.

B. Meeting Frequency

During 2011, PFACs met regularly, with 81% (n=47) reporting that they met 4 or more times a year. 31% of PFACs reported meeting 6 times a year (n=8). Less than 2% met fewer than 4 times per year.

Reviewers were unable to determine the frequency of meetings in 17.2% (n=10) of reports.

C. Membership

PFACs have a wide range in the number of members, from 6 to 28, with an average membership of 14. In future reports, reviewers will look for any relationship between the size of the hospital and the size of the PFAC.

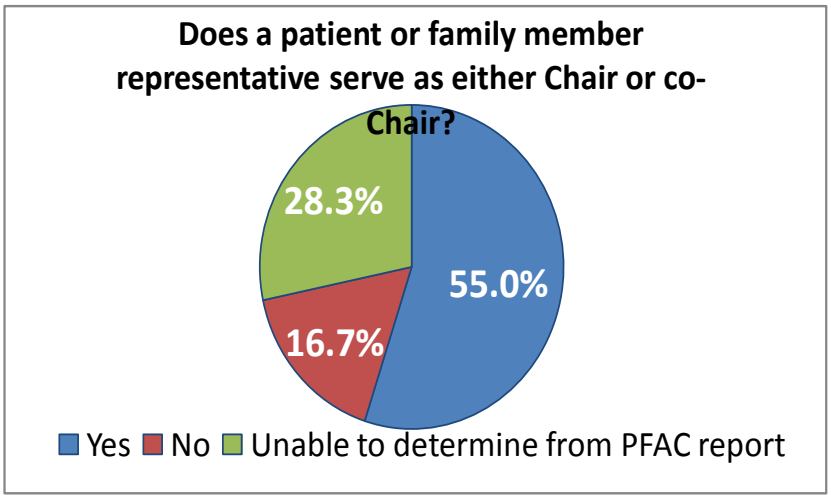
Reviewers were unable to determine the number of PFAC members in 22% (n=15) of reports.

D. PFAC Chair/Co-Chair

DPH regulations recommend that the PFACs have a chair or co-chair who /is a patient/family member. A large cohort of PFAC co-chairs consist of at least one patient or family member representative (55%, n=33). In 16.7% (n=10) of PFAC reports, a patient or family representative clearly did not serve as either Chair or co-Chair. In 28.3% (n=17)of reports, reviewers could not determine the membership affiliation of the PFAC Chair or co-Chair.

Chart B below illustrates the extent to which patient or family representatives serve either as Chair or as co-Chair of the PFAC.

Chart B. Patient or Family Representative Serves Either as Chair or Co-Chair

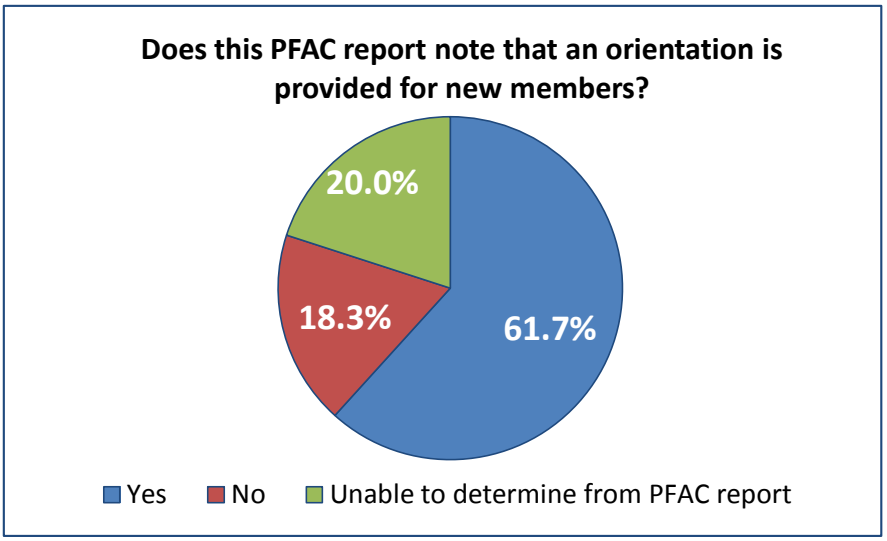


E. New PFAC Member Orientation

The majority of PFAC reports indicate that there is an orientation for new members (61.7%, n=37). In some cases the areas covered by orientation were included in PFAC bylaws. In 20% (n=12) of PFAC reports, reviewers were unable to determine if an orientation is provided to new members.

Chart C below shows the PFAC reports that convey an orientation is held for new PFAC members.

Chart C. Orientation for New PFAC Members



For reports with orientation descriptions, reviewers provided an opinion as to whether the orientation appeared sufficient for patient and family member representatives. (See Appendix B for examples of orientations deemed sufficient and insufficient.)

F. PFAC Impact: 2011 Quality Improvement Initiatives

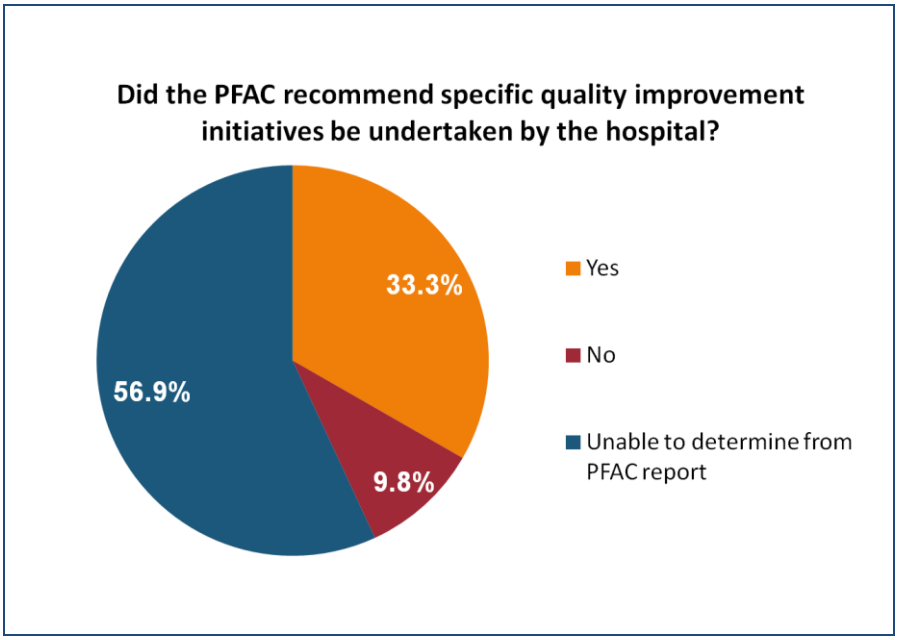
The Consumer Council is interested in the extent to which PFACs are making a difference to improve quality of care and service in hospital settings. For 2011, reviewers examined PFAC reports for descriptions of quality improvement initiatives and where noted, whether improvement activities were identified as initiated by the PFAC (i.e. PFAC-generated) or were activities for which the PFAC was consulted (i.e. PFAC-involved). Consumer Council reviewers also looked for PFAC quality improvement activities that were associated with well-publicized state and national quality improvement initiatives for hospital-based care to determine the extent to which Massachusetts PFACs were engaged in well-established quality of care initiatives.

In the majority of reports, reviewers were unable to make a determination of PFAC activity or influence related to quality improvement (56.9%, n= 29). Often this was because there was no indication as to what steps the hospital took in response to PFAC suggestions or feedback or because it was unclear from the annual report whether or not the PFAC actually made suggestions when presented with quality of care information.

In 33% (n=17) of PFAC reports, specific quality improvement initiatives were noted, while no mention of quality improvement activity was found in 9.8% (n=5) of reports. This modest finding of PFAC-generated quality improvement activity may be due in part to a focus during 2011 on organizing and establishing operating protocols. Or, it may be that PFAC members and/or PFAC leadership are not aware of the scope of the law and regulations that suggest areas for PFAC consultation.

Chart D below illustrates PFAC engagement in any type of quality improvement activity noted in 2011 PFAC reports.

Chart D. PFAC Quality Improvement Activity Noted in 2011 Reports



Hospital quality improvement activities that can be attributed to PFACs seemed principally focused on improving information provided to patients and families. Improving information made up 87% (n=20) of PFAC-generated impact and 59.4% of PFAC-involved impact. Typical is this example of improving information, "*PFAC members worked to improve patient and family information about their rights. A team worked with hospital registration staff and the hospital foundation to create consistent and uniform packets for patients and families."* Another example is, ""*The council is working with nursing and other caregivers to develop written material entitled "When You Make Medical Decisions for Another."*

Council reviewers also examined the extent to which identified PFAC quality improvement initiatives align with state and/or national health care improvement initiatives. We looked at this activity two ways – activity directly initiated by the PFAC or activity in which the PFAC played a consulting role by providing input or feedback on an initiative advanced by another party.

In both scenarios we found little activity related to well-known state or national quality of care concerns. (State and national hospital quality of care concerns are listed below in Tables A and B, from questions 13 and 14 in the review instrument in Attachment A.)

Public reporting of performance, fall prevention, hand-washing, and healthcare acquired infections received some notice. Again, the preponderance of activity focused on improving information for patients and families.

Table A below shows PFAC-initiated quality improvement activity as relates to state and national health care improvement priorities.

Table A: PFAC-initiated Activity Tied to State and National Quality of Care Priorities

State and National Health Care Quality Improvement Priorities	Response Percent	Response Count
Healthcare acquired infections	4.3%	1
Public reporting of hospital performance	13.0%	3
Rapid response teams	4.3%	1
Handwashing initiatives	4.3%	1
Checklists for surgical procedures	0.0%	0
Checklist for non-surgical procedures	0.0%	0
Apology and disclosure of harm	0.0%	0
Fall prevention	4.3%	1
Informed decision making/informed consent	13.0%	3
Improving information for patients and families	87.0%	20
Health care proxies	4.3%	1
End of life planning (e.g., hospice, palliative, advanced directives)	0.0%	0
Care transitions (e.g., discharge planning, passports, care coordination, medication & follow up between care settings)	21.7%	5
	Total	**23**

When we examined the extent to which PFACs were consulted and provided input or feedback on quality improvement initiatives proposed by other entities within the hospital, we found a slight difference in those related to state or national quality concerns. Again the largest number of improvement initiatives (59.4%, n=19) related to improving information for patients and families.

To distinguish from PFAC-generated initiatives, example of consultation by the PFAC to another group within the hospital on improving communication to patients and families is
"A year-end financial presentation was made and recommendations for new whiteboards for patient rooms were discussed."

Along with improving information to patients and families, care transitions were the next most frequent area addressed by PFACs. About 50% of PFACs provided consultation to other entities in the hospital working on discharge and care transitions. An example of an this kind of initiative is, "*PFAC discussed issues with various subject matter experts such as the hospital's case manager and made suggestions for what they felt was a smoother process. Coordination of home services and follow up PCP visits are*

key. They felt that the process of medication reconciliation was also important. Current process was reviewed and suggestions offered that were sent to the NUR committee and improvements were made to Meditech system."

Table B below illustrates the extent to which PFACs were consulted on areas relating to state or national quality improvement priorities.

Table B: PFAC-influenced Activity Tied to State and National Quality of Care Priorities

State and National Health Care Quality Improvement Priorities	Response Percent	Response Count
Healthcare acquired infections	12.5%	4
Public reporting of hospital performance	15.6%	5
Rapid response teams	12.5%	4
Handwashing initiatives	9.4%	3
Checklists for surgical procedures	0.0%	0
Checklist for non-surgical procedures	0.0%	0
Apology and disclosure of harm	0.0%	0
Fall prevention	3.1%	1
Informed decision making/informed consent	0.0%	0
Improving information for patients and families	59.4%	19
Health care proxies	0.0%	0
End of life planning (e.g., hospice, palliative, advanced directives)	3.1%	1
Care transitions (e.g., discharge planning, passports, medication, care coordination & follow up between care settings)	50.0%	16
	Total	**32**

G. Noteworthy PFAC Activity and Impact

The Consumer Council wants to commend PFACs on the strides they have made and are making. We were pleased to learn that so many hospitals have implemented PFACs, that PFAC membership predominantly consists of patients and family representatives, and that PFACs are likely to be co-chaired by a patient or family member. This helps level the power differential between the hospital staff and the patient/family PFAC members.

We were also pleased to learn how often these volunteers are meeting, many every month, to contribute in a serious manner to care improvement. PFAC members are not only meeting as their own committee but in many cases, members are also serving on other hospital committees. We are enthusiastic about this trend and believe it imperative that the impact of PFAC involvement in each hospital be recorded in some measurable and transparent way.

While 2011 was, for a significant number of PFACs, an organizing year of approving bylaws for their function and electing leadership, other PFACs were actively consulting and generating quality of care improvement projects. We hope to see more PFACs describing a move in that direction in their October 2012 reports.

The Consumer Council hopes that PFAC members are clearly informed about their role as envisioned by the Legislature, codified in law and further described in DPH regulations. We undertook this report to determine the extent to which PFACs are in place and making a difference; we hope to communicate the importance of the PFAC function in the overall quality improvement efforts of Massachusetts hospitals.

We anticipate that this report will serve to share good ideas and inspire future quality of care improvement initiatives. Also, we hope all hospital staff is informed about their hospital's PFAC, its availability for consultation on the view and experience of patients and families, and the difference that collaboration with patients and family members can make.

Below are some examples of noteworthy initiatives, culled from 2011 PFAC reports:

- Establish system of emeritus membership for those who have been on the PFAC for a number of years;
- Integrate PFAC members into other hospital committees and initiatives;
- Utilize PFAC members as secret shoppers;
- Create a a better discharge packet with instructions from various members of the patient's multidisciplinary care team and describing specific signs and symptoms warranting a patient call to their physician;
- Experience being a patient admitted to and then discharged from the ER and admitted to ER and then as an inpatient). Visit E.R.s in other hospitals to compare and evaluate;
- Establish a Care Partner for each patient;
- Create educational information for staff about "Perfect Patient Experience:"
- Create a brochure to explain the role of the hospitalist;
- Conduct a needs assessment among PFAC members to identify processes, initiatives or education on which the PFAC could have an impact;
- Work with E.R. staff to develop an E.R. ambassador program with volunteers who assist patients;
- Work with hospital staff on reducing noise;

- Work on ways to enable better communication for patients on ventilators ;Develop subcommittees of the PFAC to do focused work on certain areas;
- Collaborate with hospital to improve the quality of some of the patient hygiene items (eg. toothbrushes, drinking cups, etc.).

We appreciate the time and expertise PFAC members offer to improve care in our hospitals and look forward to learning and sharing more exemplary quality improvement initiatives across the state.

H. Recommendations and Next Steps for the Consumer Council

a. Create/distribute a standard report template that covers relevant organizational features, procedures and impact of PFACs, so that the influence of PFACs is tracked and trended over time. (See Appendix C.)

b. Deliver this Consumer Council evaluation report to the legislature, to DPH, and to hospital contacts, with a request that this report be shared with PFAC membership.

c. Request feedback on this report from PFAC members and other stakeholders to inform future reports and ensure that they are useful.

d. Create an annual statewide webinar and every other year an in-person conference on PFAC impact. These forums would facilitate the sharing of successful quality improvement initiatives and enable an opportunity to provide context of national and state performance on areas of health care improvement to inform local PFAC activity. The Massachusetts Department of Public Health could advise PFACs on data available for their use to identify quality improvement projects and track progress on interventions aimed at improving performance.

Appendix A

Consumer Health Quality Council Review Instrument for 2011 Reports

1. Hospital name: _____
2. In what year did this PFAC become operational? (If hospital has more than one PFAC, use hospital-wide PFAC to answer all questions.)
   - Prior to 2009 (If prior to 2009, please enter year PFAC operational: _____.)
   - 2009
   - 2010
   - 2011
   - Unable to determine from PFAC report
3. For the year covered by this PFAC report, how many PFAC meetings took place? (Do not include committee or workgroup meetings, e.g., meetings that occur between regularly scheduled PFAC meetings.)
   - Less than 4
   - 4
   - 5
   - 6
   - More than 6
   - Unable to determine from PFAC report
4. How many members does this PFAC have? _____
5. How many of those members are dedicated as patient or family member representatives? ____
6. What type of member serves as the Chair of the PFAC?
   - Hospital administrator
   - Doctor or nurse on hospital staff (direct patient care role)
   - Patient or family representative
   - Other type of hospital staff
   - Unable to tell from PFAC report
7. Does a patient or family member representative serve as either Chair or Co-Chair?
8. Does this PFAC report note that an orientation is provided for new members?
9. Please note all information regarding new member orientation noted in the PFAC report in the text box below.
10. In your opinion, is the new member orientation sufficient for patient and family member representatives?
    - Yes appears sufficient
    - No does not appear sufficient (If insufficient, note why in comment box below.)
    - Mentioned in PFAC report but I can't form an opinion with information provided.
    - Not mentioned in PFAC report so unable to give an opinion
    - If insufficient, what additional information or topics should be covered in orientation?
11. Did the PFAC recommend specific quality improvement initiatives be undertaken by the hospital?
12. List all quality improvement projects recommended by the PFAC and adopted by hospital. (Note: Initiatives may have been recommended in a previous year but still active as a quality improvement initiatives. Please note if an activity was initiated in a prior year and is continuing and what is new during the year reported.)

13. Which, if any, quality improvement activities directly proposed or recommended by the PFAC relate to national and state priorities? Check only those that are PFAC generated quality improvement initiatives. (Check all that apply.) Question 14 will cover initiatives or recommendations generated by other entities but in which the PFAC participated in some manner, perhaps offering input or feedback.

- Healthcare acquired infections
- Public reporting of hospital performance
- Rapid response teams
- Hand-washing initiatives
- Checklists for surgical procedures
- Checklist for nonsurgical procedures
- Apology and disclosure of harm
- Fall prevention
- Informed decision making/informed consent
- Improving information for patients and families
- Health care proxies/substituted decision making
- End of life planning (e.g., hospice, palliative, advanced directives)
- Care transitions (e.g., discharge planning, passports, care coordination & follow up between care settings)

14. This question addresses quality improvement recommendations or suggestions initiated by another entity (non-PFAC), but to which the PFAC provided input or feedback. Check below if any of this PFAC's quality improvement activities, initiated by other entities, relate to national and state priorities. (Check all that apply.) For example, if the Emergency Dept. planned to institute a new hand washing protocol and asked the PFAC to comment on the procedures, the reviewer would check off "hand-washing initiative" under this question but not under question 13 above.

- Healthcare acquired infections
- Public reporting of hospital performance
- Rapid response teams
- Hand-washing initiatives
- Checklists for surgical procedures
- Checklist for nonsurgical procedures
- Apology and disclosure of harm
- Fall prevention
- Informed decision making/informed consent
- Improving information for patients and families
- Health care proxies/substituted decision making
- End of life planning (e.g., hospice, palliative, advanced directives)
- Care transitions (e.g., discharge planning, passports, care coordination & follow up between care settings)

15. What is this PFAC doing well that should be shared with other PFACs?
16. What in this PFAC report stands out to you as amiss and in need of attention?
17. What, if any, suggestions do you have for improving our review tool or process for next year?

Appendix B

PFAC Orientation Descriptions: Sufficient and Insufficient

Below is an example of an orientation description determined sufficient, even exemplary, for patient and family member representatives to a PFAC:

- "A formal Orientation program was created to fulfill the requirements of Volunteer Services and to provide PFAC-related information. Each session is 2.5 hours, is led by the Council co-chairs and staff liaison, and includes the following: General Overview, Welcome and Introductions, Organizational Mission, PFAC Mission and Bylaws, History of the Council, Accomplishments, Handbook, Understanding Patient- and Family-Centered Care, Definition of Patient & Family Centered Care, Massachusetts regulations requiring PFACs in every hospital, Council Membership, Membership categories, Staff Membership role, Mentoring Program, Methods of Communication, PFAC-Specific Projects, Council Membership, Monthly Meetings, Committees and Projects, Expectations of members, Council Member Role, APFAC Service Description, Council Member vs. Volunteer, Transitioning from patient to APFAC member, Confidentiality, PFAC Office, Logistics."

Below are examples of elements included in some orientations that Consumer Council members strongly encourage be included in all orientations:

- There should be a PFAC-specific orientation in addition to the one given to all hospital employees.
- One would expect an orientation re: each PFAC member's task(s) or duties with service-line departments or with initiatives (i.e. safety, quality, etc.). There's verbiage that notes "information is provided on an as-needed basis."

Appendix C

The Consumer Council developed this outline for what should ideally be included in all hospitals' PFAC annual reports.

Patient and Family Advisory Council Annual Report Template

Hospital Name:

Date of Report:

Year Covered by Report:

Year PFAC Established:

Staff PFAC Contact (name and title):

PFAC Purpose, Membership, and Structure

1. Describe the purpose and mission of the PFAC.
2. How do you recruit PFAC members?
3. What is your selection process?
4. How do you elect officers?
5. Is the PFAC chair or co-chair a patient or family member?
6. Is there a staff liaison(s) for the PFAC? In what department is the PFAC situated?
7. What is the size of the PFAC?
8. Are at least 50% of PFAC members current or former patients or family members? How many patient and family members and how many staff members are on the PFAC?
9. What is the term of service for PFAC members?
10. What are the hospital's attendance expectations? How often does the PFAC meet?
11. Do you reimburse PFAC members for any costs associated with attending meetings and/or provide any other related assistance (eg. free parking, babysitting, etc.).
12. Are PFAC members representative of the hospital's service community? Explain.
13. Who sets agendas for PFAC meetings?
14. Does the PFAC have subcommittees? If yes, please describe them.

15. To what extent does the PFAC have access to the hospital Board of Directors?
16. Are PFAC meeting minutes submitted to the hospital board?
17. Is there a PFAC section on the hospital website? What is the URL?
18. To what extent did the PFAC communicate with PFACs at other hospitals?

Orientation and Continuing Education

19. Describe the PFAC orientation for new members. Include in description how often it is given, by whom, and the content covered.

20. What continuing education was provided to PFAC members this reporting year?

PFAC Impact and Accomplishments

21. On what hospital committees or boards have you placed PFAC members?
22. In what ways did the PFAC influence quality of care at this hospital? Describe the PFAC's accomplishments over the past year. Also note for each initiative undertaken, did the idea arise directly from the PFAC or did a department, committee or unit request PFAC input on the initiatives? (Questions 23-26 below can inform your responses.)
23. The law allows a hospital to engage its PFAC in a broad consulting role. Did the PFAC advise the hospital on any of the following (please circle):
    a. patient and provider relationships
    b. institutional review boards
    c. quality improvement initiatives
    d. patient education on safety and quality matters
24. Did the PFAC engage in any of the following (please circle):
    a. reviewers of publicly reported quality information (see #25 for more specifics)
    b. members of task forces
    c. members of hospital standing committees that address quality (list committees and how many PFAC members serve on each)
    d. members of awards committees
    e. members of advisory boards
    f. participants on search committees and in the hiring of new staff
    g. co-trainers for clinical and nonclinical staff, in-service programs, and health professional trainees or as participants in reward and recognition programs
25. Was any of the following information on hospital performance shared with the PFAC? (please circle):

a. Serious Reportable Events
b. Healthcare-Associated Infections
c. DPH information on complaints and investigations
d. staff influenza immunization rate
e. other

26. Did PFAC quality of care initiatives relate to any of the following state and/or national quality of care initiatives, (please circle):

a. Healthcare acquired infections
b. Public reporting of hospital performance
c. Rapid response teams
d. Hand-washing initiatives
e. Checklists for surgical procedures
f. Checklist for nonsurgical procedures
g. Disclosure of harm and Apology
h. Fall prevention
i. Informed decision making/informed consent
j. Improving information for patients and families
k. Health care proxies/substituted decision making
l. End of life planning (e.g., hospice, palliative, advanced directives)
m. Care transitions (e.g., discharge planning, passports, care coordination & follow up between care settings)

PFAC Annual Report

27. Do PFAC members participate in the development of the PFAC annual report?
28. Does the hospital share the PFAC annual reports with PFAC members?
29. Did the hospital share the PFAC annual report with the Board of Directors/Trustees? How?
30. Do you make the PFAC report accessible to the public? How?
31. Is the annual PFAC report posted to the hospital's website for public access? When was it posted?

Goals

32. What goals or quality improvement strategies, if any, has the PFAC set for the coming year? (Please list.)

Appendix D

PFAC Annual Reports Were Received for the Following Hospitals by October 2012

ANNA JAQUES HOSPITAL
ATHOL MEMORIAL HOSPITAL
BAYSTATE MEDICAL CENTER-
BERKSHIRE MEDICAL CENTER INC
BETH ISRAEL DEACONESS HOSPITAL - NEEDHAM
BETH ISRAEL DEACONESS MEDICAL CENTER
BEVERLY HOSPITAL (Northeast Hospital System)
BOSTON MEDICAL CENTER
BRAINTREE REHABILITATION HOSPITAL
BRIGHAM & WOMEN'S HOSPITAL
CAMBRIDGE HEALTH ALLIANCE
CAPE COD HOSPITAL
CARNEY HOSPITAL
CHILDREN'S HOSPITAL
CLINTON HOSPITAL
COOLEY DICKINSON HOSPITAL
DANA FARBER CANCER INSTITUTE
EMERSON HOSPITAL
FAIRVIEW HOSPITAL
FALMOUTH HOSPITAL
FAULKNER HOSPITAL
GOOD SAMARITAN MEDICAL CENTER
HALLMARK HEALTH SYSTEM LAWRENCE MEMORIAL
HALLMARK HEALTH SYSTEM MELROSE-WAKEFIELD
HARRINGTON MEMORIAL HOSPITAL
HEALTHALLIANCE HOSPITAL-LEOMINSTER CAMPUS
HEYWOOD HOSPITAL
HOLY FAMILY HOSPITAL & MEDICAL CENTER
HOLYOKE MEDICAL CENTER
JORDAN HOSPITAL
KINDRED HOSPITAL-BOSTON
LAHEY CLINIC HOSPITAL
LAWRENCE GENERAL HOSPITAL
LOWELL GENERAL HOSPITAL
MA EYE AND EAR INFIRMARY
MARLBOROUGH HOSPITAL
MARTHA'S VINEYARD HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL
MERRIMACK VALLEY HOSPITAL
METROWEST MEDICAL CENTER
MILFORD REGIONAL MEDICAL CENTER
MILTON HOSPITAL
MORTON HOSPITAL
MOUNT AUBURN HOSPITAL

NANTUCKET COTTAGE HOSPITAL
NASHOBA VALLEY MEDICAL CENTER
NEW ENGLAND BAPTIST HOSPITAL
NEW ENGLAND REHABILITATION HOSPITAL
NEW ENGLAND SINAI HOSPITAL
NEWTON-WELLESLEY HOSPITAL
NOBLE HOSPITAL
NORTH ADAMS REGIONAL HOSPITAL
NORTH SHORE MEDICAL CENTER
NORWOOD HOSPITAL INC
QUINCY MEDICAL CENTER
RADIUS HEALTHCARE CENTER
SAINTS MEMORIAL MEDICAL CENTER
SHRINERS HOSPITALS FOR CHILDREN-SPRINGFIELD
SHRINERS HOSPS FOR CHILDREN-BOSTON
SIGNATURE HEALTHCARE BROCKTON HOSPITAL
SOUTH SHORE HOSPITAL
SOUTHCOAST HOSPITALS GROUP
SPAULDING REHABLITATION HOSPITAL
ST ANNES HOSPITAL
ST ELIZABETH'S MEDICAL CENTER
ST VINCENT
STURDY MEMORIAL HOSPITAL
UMASS MEMORIAL MEDICAL CENTER
WINCHESTER HOSPITAL
WING MEMORIAL HOSPITAL

Thank you to the following volunteer members of Health Care For All's Consumer Health Quality Council who put in many hours of work to gather the PFAC reports, create the survey instrument, analyze the reports and record findings, develop a list of questions for hospitals to answer in future reports, and write this summary report. Their efforts will help Massachusetts hospitals to continue moving forward on patient and family engagement.

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