Patient- and Family-Centered Perinatal Care
Partnerships With Childbearing Women and Families

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Providing patient- and family-centered care is not a simple endeavor. It requires a transformation in organizational culture that is reflected in a myriad of details at the departmental, clinical, and individual provider and patient levels. Patient- and family-centered practitioners know that it is not a recipe or formula of specific practices, but an evolving approach that guides policy and program development, facility design, decision making, and daily interactions throughout the healthcare system. Today, momentum for patient- and family-centered care continues to build. It is supported by a growing body of research and by prestigious organizations that are committed to involve patients and families in care and in the redesign of healthcare for the 21st century to meet the recommendations of the IOM report. This article outlines the concepts of patient- and family-centered care and describes how they link with and differ from traditional concepts of family-centered maternity care. Partnerships with childbearing women and their families in clinical settings and in healthcare redesign that enhance quality, safety, and experience of care are described. Key words: childbearing women and families, family-centered maternity care, partnerships, patient- and family-centered care, perinatal care

This article outlines the concepts of patient- and family-centered care and describes how they link with and differ from traditional concepts of family-centered maternity care. Partnerships with childbearing women and their families in clinical settings and in healthcare redesign that enhance quality, safety, and experience of care are described. This article shares vignettes of successful patient- and family-centered care initiatives in perinatal care.

INTRODUCTION

Crossing the Quality Chasm: A New Health System for the 21st Century,1 the landmark publication of the Institute of Medicine (IOM), calls for a transformational change in healthcare to ensure quality and safety. Greater patient participation in decisions about their own healthcare and creating partnerships with patients in the redesign of the healthcare system are 2 key components of the transformation that the IOM envisions (Table 1).
Family-centered care is consistent with all of the IOM report’s recommendations. The Institute for Family-Centered Care defines it as “an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Patient- and family-centered care applies to patients of all ages and may be practiced in any healthcare setting.”

It is not a singular intervention but an approach to care that recognizes the strengths and needs of patients and families and the essential roles that family members play in the promotion of health and the management of illness (Table 2).

The definition of patient- and family-centered care provides greater emphasis for the role of the family than the IOM recommendations. In patient- and family-centered care, the patient defines the “family” and how family members will be involved in care and decision making. As a result, the word family is broadly defined and not limited to a biological relationship. Reflecting this perspective, the American Academy of Family Physicians adopted a new definition of family in 2003. This definition states, “the family is a group of individuals with a continuing legal, genetic and/or emotional relationship” and is consistent with that adopted by providers who actively practice patient- and family-centered care. Advancing the practice of patient- and family-centered care in maternity settings has lagged behind that of pediatrics and newborn intensive care. Most hospital and community maternity programs have not yet created the internal structures to support collaboration with childbirthing women and families in care and in shaping policies and programs.

The trust, respect, and collaboration among patients, families, and providers that are inherent to patient- and family-centered practice will help to address some of the enormous challenges facing the obstetrical field: the medicalization of birth, high litigation rates, reduced numbers of medical students selecting obstetrics as a specialty, and experienced practitioners leaving the field.

### FAMILY-CENTERED MATERNITY CARE

Family-centered maternity care as originally defined did not include the concept that women and their families had important perspectives, insights, and experience that would benefit the development of childbirth education programs, breastfeeding support, quality improvement, patient safety, and work redesign efforts for obstetrical services.

However, Phillips unequivocally asserts that family-centered maternity care, in its truest sense, is designed to meet the informational, social, emotional, and physical needs of pregnant women and families during pregnancy, childbirth, and the postpartum period. It emphasizes education and preparation for childbirth and encourages the mother and family to assume active caregiving and decisionmaking roles. It invites the family’s presence during labor and birth, focuses on enhancing and supporting the normal birth, screens for deviations from normal birth, and intervenes only if deviations occur.

The International Childbirth Education Association (ICEA) defines birth as a vital life event rather than a medical procedure. It respects a woman’s individuality and sense of autonomy. It realizes that the decisions she makes are based on many influences, of which the expertise of the professional is only one. It requires that all relevant information be provided in order to achieve goals, and that families be guided, not directed, by the professionals she has chosen to share the responsibility for her care and that of her infant.

### Table 1. Simple rules for the 21st-century healthcare system*

<table>
<thead>
<tr>
<th>Recommendations for care based on:</th>
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<tbody>
<tr>
<td>Continuous healing relationships</td>
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<tr>
<td>Patient needs and values</td>
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<tr>
<td>Patient as the source of control</td>
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<tr>
<td>Shared knowledge and the free flow of information resulting in unfettered access to their own medical information and to clinical knowledge</td>
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<tr>
<td>Cooperation among clinicians, as well as patients and their families, to ensure an appropriate exchange of information and coordination of care that leads to informed decisionmaking</td>
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*Adapted from IOM Committee on Quality of Health Care in America report.

### Table 2. Key principles guiding patient- and family-centered practice*

<table>
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<tr>
<th>Principle</th>
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<tr>
<td>People are treated with dignity and respect</td>
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<tr>
<td>Healthcare providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful</td>
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<tr>
<td>Patients and family members build on their strengths by participating in experiences that enhance control and independence</td>
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<tr>
<td>Collaboration among patients, family members, and providers occurs in policy and program development and professional education, as well as in the delivery of care</td>
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*From the American Hospital Association and the Institute for Family-Centered Care.
According to Zwelling, given the current lack of childbearing women's involvement at the policy and programmatic level, family-centered maternity care is likely to be more staff-centered than family-centered. Unfortunately for many hospitals family-centered maternity care has become little more than a marketing message. As such, it refers more to amenities, furniture, and decor rather than the way in which staff and providers communicate and collaborate with women and families.

The Listening to Mothers Report, for example, demonstrated that women generally feel that professional caregivers treat them well. However, women's requirements for information, as well as their desire to be involved in decision making, are not homogenous. Upon searching the literature for this article, the authors discovered that Google, the Internet search engine, displays more than 9500 published research results of women's satisfaction with maternity care. These reports stem from countries as diverse as Finland, Cambodia, the United States, Australia, Canada, and Russia. The measures studied included a combination of dimensions of satisfaction including the delivery itself, medical care, nursing care, information received, participation in the decisionmaking process, and physical aspects of the labor and delivery rooms. A meta-analysis of 3000 studies revealed that women rated satisfaction with matters directly related to the delivery, such as pain intensity, complications, and length of labor, as the most important factors. Participation in the decisionmaking process was the most critical determinant of women's satisfaction with care. Quality of information received was the major determinant of satisfaction with nursing care.

The mutually beneficial partnerships inherent in a patient- and family-centered approach to clinical care and in policy and programmatic development can help address many of the issues concerning care for women and infants today. These partnerships result in greater patient and family, staff, and physician satisfaction, and create a less litigious environment.

EXAMPLES OF PARTNERSHIPS WITH CHILDBEARING WOMEN AND FAMILIES

Over the last 2 decades partnerships with women and families have played a pivotal role in shaping exemplary maternity and newborn intensive care programs across the country. If the vision of the IOM report is to be realized, partnerships such as these will become the norm for creating quality perinatal programs in the future.

Evergreen Hospital Medical Center, Kirkland, Wash: A program guided by an enduring philosophy of care

Evergreen Hospital Medical Center is a county hospital in a community east of Seattle. Today, more than 4000 infants are born at Evergreen’s Family Maternity Center each year. Evergreen’s evolution from a medical model of care to an educational model began in 1984, when a group of nurses and physicians decided that they wanted to care for patients and families in a different way—a way that departed from traditional practices in maternity care.

The hospital committed itself to creating an environment where families could become knowledgeable and informed to take an active role in their own healthcare and in the childbirth experience. Staff, physicians, patients, and families came together to imagine what care could be like for childbearing families in the community. They held discussions, conducted interviews and site visits to learn about new ways to provide care, education, and support. In 1985, the commitment to change was formalized in their written philosophy of care statement.

All subsequent decisions, whether related to facility design, staff training and recruitment, family education, or systems improvement have been based on this philosophy of care. Families actively participate in all decisions. As one staff member says, “We learned how to collaborate.”

During the past 20 years, the hospital has evolved and programs are continually reinvented to reflect and anticipate the growing needs of the community, using a patient- and family-centered approach. Physical facilities have evolved in step with the new philosophy of care. The facility now features single rooms in all clinical areas, a 36-bed LDRP Family Maternity Center, a 13-bed GYN/antepartum unit, and a Level II/III Newborn Intensive Care Unit. There is a Breastfeeding Center, where mothers receive lactation consultations from an IBCLC-certified counselor, and a Postpartum Care Center where mothers and infants are seen by an IBCLC-certified nurse 3 or 4 days after birth.

WOMEN AND THEIR FAMILIES AS ADVISORS AND LEADERS IN PERINATAL CARE

As the nation’s health providers move forward to realize the goals set forth by the IOM, suggestions for ways to involve women and families in planning, implementing, and evaluating perinatal programs have been proposed. Guidance developed by the Institute for Family-Centered Care offers a sound foundation for such efforts (Table 3).
Table 3. Women and families as advisors and leaders in perinatal care

<table>
<thead>
<tr>
<th>There is a functioning patient and family advisory council that reports to the perinatal program or hospital leadership</th>
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<tr>
<td>The council meets at least 8–10 times a year and has a formal place on the hospital’s organization chart</td>
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<tr>
<td>Women and family members comprise at least 75% of the membership of the council</td>
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<tr>
<td>The hospital has at least 1 paid position for a patient or family leader who facilitates the development of patient- and family-centered initiatives</td>
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Women, who have experienced pregnancy, birth, or perinatal loss, and their family members serve as members of hospital committees and task forces such as:
- Patient and family education
- Facility design planning
- Quality improvement
- Pain management
- Patient safety
- Ethics
- Discharge/transition planning
- End-of-life care
- Bereavement support
- Diversity/cultural competency
- Service excellence
- Research and evaluation

Women and families collaborate with leaders, physicians, and staff in:
- Developing the philosophy of care statement and the definition of quality
- Planning for renovation and construction projects
- Developing and evaluating educational materials and programs
- Developing and evaluating documentation forms and procedures (eg, birth plans, developmental care plans)
- Evaluating and revising policies
- Providing peer support and serving as mentors
- Planning and conducting staff and physician orientation and continuing education programs
- Teaching students and professionals in training
- Designing and implementing quality improvement initiatives
- Developing tools to measure patient and family perceptions of care and responding to information gathered through such tools
- Hiring staff and physician leaders

*From the Institute for Family Centered Care Intensive Training Seminar—Hospitals Moving Forward with Patient- and Family-Centered Care April 2006.14

Evergreen Hospital was honored as the first Baby Friendly® Hospital in North America. The internationally defined term “Baby-Friendly” may be used only by maternity services that have passed external assessment according to the UNICEF Global Criteria (Table 5).

Table 4. Evergreen Hospital Medical Center philosophy of care

<table>
<thead>
<tr>
<th>Birth is one of life’s most special events</th>
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<tr>
<td>Birth and parenting occur with greater ease, comfort, and joy when parents assume their roles with knowledge</td>
</tr>
<tr>
<td>Birth is a natural, physiological process which can be a positive time of growth</td>
</tr>
<tr>
<td>Parents can make decisions and accept responsibility for their own healthcare</td>
</tr>
<tr>
<td>Childbearing women, families, visitors, nurses, physicians, midwives, and all hospital personnel are regarded with dignity and respect</td>
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Evergreen offers a comprehensive educational program that begins as families are pondering parenthood and continues through the infant’s first year. Women served by the Maternity Center have collaborated with staff to develop and revise this education program over time.

Having a well-trained, caring nursing staff is the key to the success of the program. It is essential to hire the right people and then invest in them. In hiring nursing staff, interviewers probe not just for clinical skills but also for attitudes and behaviors. During typical interviews, job applicants are asked to describe a memorable patient or family and what they love about being a nurse. New staff are partnered with experienced mentors who are especially skilled teachers. They convey the idiom that “Attitude is everything.” With education and support, novice nurses gain a sense of fulfillment by giving valued care and focusing on the unique preferences and needs of each woman and family. They learn how to share information so women and families can make informed decisions about care. Nurses
Table 5. Baby-friendly designation

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<th>Baby-friendly designation</th>
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<tr>
<td>Baby-friendly hospital is a designation awarded by the World Health Organization and the United Nations Children’s Fund to hospitals worldwide that foster breastfeeding over formula feeding according to stringent criteria. The award recognizes facilities that offer mothers the information, confidence, and skills needed to successfully initiate and continue breastfeeding their babies. The program restricts use of free formula or other infant care aids provided by formula companies. More than 15,000 facilities worldwide are accredited as “Baby-Friendly,” including 52 in the United States. The criteria for designation as Baby-Friendly include:</td>
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<tr>
<td>1. A written breastfeeding policy that is routinely communicated to all healthcare staff</td>
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<td>2. Train all healthcare staff in skills necessary to implement this policy</td>
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<tr>
<td>3. Inform all pregnant women about the benefits and management of breastfeeding</td>
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<tr>
<td>4. Help mothers initiate breastfeeding within 1 hour of birth</td>
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<tr>
<td>5. Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants</td>
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<tr>
<td>6. Give newborn infants no food or drink other than breast milk, unless medically indicated</td>
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<td>7. Practice rooming in—that is, allow mothers and infants to remain together 24 hours a day</td>
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<tr>
<td>8. Encourage breastfeeding on demand</td>
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<tr>
<td>9. Give no pacifiers or artificial nipples (also called dummies or soothers) to breastfeeding infants</td>
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<tr>
<td>10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic</td>
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develop confidence to think and act on their judgment and work with families in flexible and collaborative ways. Evergreen’s enduring philosophy of care, appreciating the significance of the woman’s birth experience, and emphasizing respect and open sharing of information has served the program well over time.

The Birth Center, United Hospital, St. Paul, Minn:
Honoring women’s voices and choices

For more than 2 decades, the Birth Center of United Hospital, St. Paul, and the Newborn Intensive Care Unit of Children’s Hospitals and clinics of Minnesota-St. Paul campus have collaborated with women and families to plan services, facilities, and care for mothers, infants, and their families. This work began when United and Children’s Hospital-St. Paul executive leadership teams joined forces to consolidate maternal and neonatal care in one building to support low- and high-risk care for mothers and infants. The service, named the Perinatal Center of United and Children’s Hospitals-St. Paul, opened its doors in 1979.

It soon became evident that the new center was not completely successful in meeting women’s needs. The hospital did not attract the anticipated greater numbers of childbearing women. Some women expressed concern that “going to United meant something was wrong.” Mothers who anticipated an uncomplicated pregnancy and birth preferred to deliver elsewhere. Many of these women felt that the term perinatal was technical and cold. It did not fit with their thoughts of an ideal birth experience.

The hospital sought input from its patients. In 1985, in response to feedback from women and their families who desired a more homelike birth, a single-room, low-risk maternity unit within the Perinatal Center was created. Nonetheless, some women still perceived the Perinatal Center as a high-risk, not high-touch, center. They did not believe that it would offer the patient-and family-friendly birth experience they were looking for.

In 1990, the Perinatal Center gathered women from the community to seek insight and recommendations for changing this perception. Staff learned that, more than anything, women wanted choices about their birth experience. They wanted to play a part in deciding about how their pain was managed, how their care was delivered, and when and how their family could be present. They wanted information when they needed it, in a format that was understandable and useful. All the mothers wanted high-quality, safe care for themselves and their infants. Some were concerned primarily with the technical expertise of the staff, and others were more interested in the amenities the hospital offered. All agreed it would be ideal if they could have both.

As a result, the Perinatal Center was renamed the Birth Center. The hospital reorganized services to reflect the women’s choices. Changes were made to parent and family education classes; for example, a weekend birth-preparation course was introduced. The center began a prenatal baby care class, “All about Babies,” to prepare parents to care for their babies, as well as prenatal breastfeeding classes. Classes were offered for both inpatients and outpatients, taught by parent educators in a classroom format, and held at regularly scheduled times during hospitalization.

The mother’s bedside caregivers reinforced information presented in the classes. To ensure that mothers continued to have access to information following discharge, a follow-up phone call program was initiated. Parent education instructors called all mothers
within 7 days of discharge to answer questions, reinforce education, and connect mothers to needed resources. A monthly newsletter about infant care and development is mailed to each family for 1 year after the birth.

The new program did not overlook women at risk. Conversations with these women revealed that they felt that they missed experiences that form the “rites of passage” of pregnancy. Many felt unprepared for labor and perceived lack of control over the birth experience. In response, the hospital began to offer birth-preparation classes to mothers who could not attend regular classes. A visit from a neonatologist and a member of the NICU team that would attend the delivery is now part of the education plan. A tour of the NICU is provided for mothers. If mothers cannot tour, a video tour is available to watch during hospitalization and the father or other designated support people are given a tour. The video is distributed to referral hospitals so mothers can see where the infant was transferred. Mothers said that it is very helpful to visualize where their infant is until they could visit themselves.

The educator assisted women to plan their birth experience. All mothers and families had the opportunity to make choices, participate in decision making with their caregivers, and be involved in planning their care. Families with prenatal diagnoses of anomalies requiring intervention shortly after birth, as well as anomalies incompatible with life, have the opportunity to communicate with physicians, certified nurse midwives, staff nurses, and other providers to plan for the best possible family experience.

The next step forward occurred in 1997, with the formation of the Birth Center Parent Advisory Council. This group quickly became involved in all aspects of Birth Center operations. Members participated in the redesign of obstetrical services at United Hospital. They consolidated parent education materials into a single manual. They made recommendations for grief support for families who had experienced a perinatal loss. A parent member was invited to join the Perinatal Loss Committee.

The council tackles issues both large and small; for example, members recently worked with staff to develop strategies to address the issue of women who did not show up for clinic appointments. The council reviews policy, procedure, and organizational support for families to ensure that services are patient- and family-centered. Members advise leadership and staff on facility design, programs and services, education, marketing, and communication materials.

Recently the John Nasseff Heart Hospital at United created a Patient Advisory Council modeled after the Birth Center Parent Advisory Council. The 2 councils collaborate to advise leaders on educating childbearing women and their mothers about heart health. They work together across patient populations to address areas of common interest.

University of Washington Medical Center, Seattle: Insight into patient needs, support for medical education

This large academic medical center began a long-term, systematic effort to advance the practice of patient- and family-centered care in 2002. It created a high-level interdisciplinary patient- and family-centered steering committee for the organization, appointed an executive sponsor (the chief nursing officer), and designated the Director of Patient Education to provide facilitation and coordinate efforts to collaborate with patients and families. The hospital strategically selected 3 clinical areas to begin this work and created a Council for Rehabilitation Medicine, a Council for Cancer, and a Council for Perinatal/NICU Care. In 2006, the Council for Perinatal/NICU Care broke into 2 groups, the Council for Perinatal Care and the NICU Council. The move was made because members of the Council determined that they could better accomplish their goals if a single group could focus all its attention either to newborn intensive care or to perinatal issues. The parents believed that the issues were too wide-ranging to be covered in depth by a single group.

A unique feature of family involvement at the University of Washington Medical Center is their role in the selection of OB/GYN residents. A parent advisor is an integral, decision-making member of the team that interviews candidates and chooses residents. Applicants for residency positions are asked to define patient- and-family-centered care and to discuss one dimension of the philosophy that is most significant to them. The interview team, consisting of interns, residents, faculty, a nurse, and a parent, considers this dialogue one way of demonstrating the center’s commitment to patient- and family-centered care.

Family involvement continues once the residents are hired. All first-year residents spend time during orientation with council members. Families developed a resource for medical students and residents to assist them in expanding communication skills. At the residents’ request, family advisors meet with them again during their second year to review and to enhance their ability to communicate effectively with families. At the heart of family-centered care is the certainty that providers and family are partners, working together to best meet the needs of the patients and their families.
MILITARY TREATMENT FACILITIES

On May 10, 2005, Vice Admiral Michael Cowan reported to the Congress of the United States that the US Department of Defense (DOD) provides medical services for approximately 9.1 million beneficiaries, half of whom are women. Maternity care is one of the largest service lines within military medicine. He stated, “Increasingly, military treatment facilities (MTFs) are developing patient- and family-centered approaches and involving patients and families in care and decision-making.”

This is in part due to the results of the 2002 inpatient childbirth survey mailed to a random sample of women who received maternity care at a military hospital between July 1 and September 30, 2001. The survey covered data for 11 dimensions of women’s care and experiences. Analysis revealed that 2124 women who gave birth at 1 of 44 MTFs responded to the survey. Less than 50% of respondents said that they would recommend the military hospital to family and friends. Women who responded positively identified important factors in their satisfaction. These included the courtesy and availability of staff, confidence and trust in provider, being treated with respect and dignity, information and education, physical comfort, involvement of friends and family, continuity and transition, and involvement in decision making.

In 2003, determined to incorporate these respondents’ opinions into its system of care and to improve the experience of care for women and families, the DOD asked the Institute for Family-Centered Care and others to assist MTFs nationwide in advancing the practice of patient- and family-centered care. Some of these hospitals have created patient and family advisory councils, revised visiting policies, expanded educational resources for women and families, and are conducting rounds to include women, and, according to their preferences, their families.

According to the chief medical officer of TRICARE, the military’s health benefits plan, improvement efforts are ongoing, and strategies to measure changes in women’s perceptions of care are in place. Providers are receiving additional training to be more receptive to patients’ questions, to help develop individualized birth plans, to encourage more family member involvement in the childbirth experience, to expand individual patient and family education, and to ensure that patients receive coordinated care throughout their OB experience.

DOD continues to make improvements in hospital facilities so that families may enjoy more privacy and comfort during this important time. Many military hospitals are offering special parking during pregnancy and postpartum; enhanced 24/7 lactation support for mothers who want to breastfeed; convenient enrollment of infants in the Defense Enrollment Eligibility Reporting System (DEERS); and greater availability of follow-up appointments.

Darnell Army Medical Center, Fort Hood, Tex

Darnell Army Medical Center in Fort Hood, Tex, proudly describes their family-centered care philosophy before, during, and after childbirth. “Families are at the heart of our mission.” For families, this means:

- Respect for your emotional well-being, privacy, and personal preferences.
- Empowerment through honoring your family’s personal and cultural beliefs.
- Choices in treatment, including pain management, medications and tests before, during, and after childbirth and newborn care.
- Flexibility to welcome fathers, significant others, and siblings to be part of your birth experience.

Darnell offers many classes that help women learn about the childbirth process, anesthesia options, and care options. These classes support thoughtful and informed decisionmaking during pregnancy, delivery, and beyond. Classes are regularly updated to provide current practices and new information.

The Center of Excellence for Medical Multimedia is an initiative from the Office of the Surgeon General aimed at supplying the most powerful interactive technologies available to Medical Treatment Facilities. Pregnant women at Darnell Army Medical Center are invited to track their pregnancy through an individualized interactive computer program called Pregnancy A to Z, an information bank containing hundreds of articles covering virtually every important aspect of pregnancy.

Naval Hospital Pensacola, (Fla)

In the past 2 years, Naval Hospital Pensacola (Fla) has developed many family-centered care programs that include an “incredibly robust and popular Labor and Delivery program.” In April 2002, the hospital introduced the community to 6 new, state-of-the-art labor, delivery, recovery and postpartum (LDRP) maternity suites.

The Department of Defense national overall survey average for repeat maternity business at military hospitals is about 60%. Over the past 20 months, NH Pensacola surveys indicated that 84% of women report that the birthing experience was meaningful and they would return to the hospital for another delivery. NH Pensacola provides comprehensive perinatal
care, preconception classes for those planning a pregnancy through the postpartum care visit and prolonged breastfeeding support.21

Naval Medical Center, San Diego, Calif

The family-centered care team at Naval Medical Center, San Diego, Calif, offers individualized care with emphasis on continuity and choice of provider. This new family-centered care initiative also offers improved access to gynecological care, first-trimester appointments, stork parking, assistance with scheduling future appointments, individualized prenatal education, and to the maximum extent possible, private postpartum rooms and lactation support programs.19

All of these initiatives combine the expertise of the military services and offer expectant mothers and their families coordinated services starting with the first obstetric visit and continuing after the birth of the child.

Family-centered care is now a priority for all of the armed forces—the Army, Air Force, and Navy. The work has focused initially in maternity care, newborn intensive care, and pediatrics, but it is intended to become the standard of care for all of military medicine across the lifespan.

SUMMARY: KEY COMPONENTS OF PATIENT- AND FAMILY-CENTERED CARE

Providing patient- and family-centered care is not a simple endeavor. It requires a transformation in organizational culture that then is reflected in a myriad of details at the departmental, clinical, and individual provider and patient levels.22 Maternity and newborn intensive care programs that are successful in adopting a patient- and family-centered approach have strong and consistent leaders with clearly defined personal beliefs about the experience of care. Nursing staff is hired for their attitude and beliefs about the experience of care as well as for their clinical and collaborative skills. Such programs attract physicians who share the same values about partnership with childbearing women and families and practice in ways that encourage collaboration within and across disciplines. Successful clinical programs usually have developed the infrastructure to support patient- and family-centered practice. There is a written philosophy of care consistent with patient- and family-centered principles and a definition of quality that includes the experience of care. Position descriptions and performance appraisal systems convey the expectation for patient- and family-centered behaviors and define healthcare as a collaborative partnership between provider, patient, and family. They have revised outdated policies and practices. Patient and family advisors have assisted staff and physicians in planning, implementing, and evaluating these changes.25

Patient- and family-centered care practitioners know that it is not a recipe or formula of specific practices. It is an evolving approach that guides policy and program development, facility design, decision making, and daily interactions throughout the healthcare system. Today, momentum for patient- and family-centered care continues to build. It is supported by a growing body of research and by prestigious organizations that are committed to involve patients and families in care and in the redesign of healthcare for the 21st century to meet the recommendations of the IOM report. As the examples in this article demonstrate, the effects of patient- and family-centered care can be transformational, both for individuals and for institutions alike.

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