

Recommendations from a Conference on  
**Advancing Compassionate,  
Person- and Family-Centered Care  
Through Interprofessional Education  
for Collaborative Practice**

Emory Conference Center • Atlanta, Georgia • October 30 – November 1, 2014



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## Advancing Compassionate, Person- and Family-Centered Care Through Interprofessional Education for Collaborative Practice

### Conference Executive Summary

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Compassion is essential for effective collaboration among healthcare professionals, staff, patients and families. But despite evidence supporting the importance of compassionate healthcare, the concepts and skills related to empathy and compassion, and that are needed to provide person-/family-centered and relationship-based care, are not routinely taught, modeled and assessed across the continuum of learning and practice. To change this paradigm, the Schwartz Center for Compassionate Healthcare and The Arnold P. Gold Foundation, in collaboration with the Josiah Macy Jr. Foundation and the Bucksbaum Institute for Clinical Excellence at the University of Chicago convened 84 healthcare experts — from patients, family members and advocates to clinicians, health professions educators, licensure and accreditation agency representatives, funders and administrators — with the goal of discussing and recommending timely steps to integrate compassion and collaboration into health professional education and clinical care.

Participants agreed that compassionate, collaborative care, or “The Triple C,” is essential if we are to achieve “The Triple Aim” of improving health and experiences of care while controlling costs. They shared their own experiences, listened to and discussed patient, family member and provider stories and cases and commented on a prepared discussion paper and a Compassionate, Collaborative Care Competency Framework of requisite attributes and behaviors. During the conference, they formulated four actionable recommendations to advance “The Triple C” — details are summarized in the full conference report:

1. Involve patients and families as partners in health professional education, their own care and in co-designing healthcare delivery;
  2. Educate patients, families, professionals and staff about the importance of “The Triple C” and align salient competencies with existing education, assessment and standards;
  3. Conduct research to measure “The Triple C” at all levels (individuals, teams and organizations) and to study its outcomes;
  4. Incentivize and reward “The Triple C.”
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“The Triple C,” like “The Triple Aim,” is what practitioners want to provide and what patients and families want and need. The work ahead lies in understanding and leveraging the support needed to make “The Triple C” the standard of care in every healthcare organization and system — and in every encounter. Our organizations look forward to working with various stakeholders, including health professions educators, accreditation and licensure organizations, clinicians and administrators, and patient and family advocates to make this a reality.



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A significant body of research tells us that a tectonic shift in the culture and practice of healthcare is necessary if we are to rein in costs while improving the quality, experiences and outcomes of care, “The Triple Aim.” The required shift is toward collaborative, team-based, person- and family-centered care — physicians, nurses, social workers, pharmacists and other care providers working in equal partnership with patients and their families to achieve optimal health and healthcare. Interprofessional education is an important strategy for advancing that goal. Much progress has been made as many health professions and schools have endorsed “Core Competencies for Interprofessional Collaborative Practice,” created by the Interprofessional Education Collaborative (IPEC) of six American health professional education associations. A National Center for Interprofessional Practice and Education has been established to coordinate and study the advancement of collaborative, team-based health professions education and patient care.

But what is not yet explicit, what we must immediately and clearly articulate is the role of compassion in healthcare. Compassion — or feeling empathic concern and acting to ameliorate concerns, pain, distress and suffering — is fundamental to healthcare; it defines the higher purpose of our healthcare system and humanity behind the bottom line. It challenges all of us, providers and patients alike, to listen deeply to each other, to value each other’s experiences and expertise, and to build effective relationships in which empathy is generously expressed among all participants. Compassionate, collaborative care, or “The Triple C,” is essential if we are to achieve “The Triple Aim” and indeed, “The Quadruple Aim,” which adds the aim of supporting providers’ wellbeing.

Articulating the role of compassion as crucial to effective collaboration was the primary goal of a recent conference, *Advancing Compassionate, Person- and Family-Centered Care through Interprofessional Education for Collaborative Practice*. In the early stages of formulating this conference and throughout the grant period, the Josiah Macy Jr. Foundation was a critical thought partner in conceptualizing the vision and objectives of the conference

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and assisting The Arnold P. Gold Foundation and the Schwartz Center for Compassionate Healthcare team in articulating the potential value-added of integrating compassion into how health professionals are educated and practice together. With the Macy Foundation’s support, we created a unique conference sponsored by the Schwartz Center for Compassionate Healthcare and The Arnold P. Gold Foundation, in partnership with the University of Chicago’s Bucksbaum Institute for Clinical Excellence. We brought together 84 healthcare experts — from patients, family members and advocates to clinicians, health professions educators, licensure and accreditation agency representatives, funders and administrators — to consider and recommend timely steps to integrate compassion and collaboration into health professional education and our healthcare system (see Appendix 1).

“Imagine a provider team that implements a technically correct and coordinated care plan, but fails to address the concerns and needs of their patient because they haven’t asked the right questions or listened deeply. Now imagine the provider who is compassionate toward patients, but doesn’t have an effective team to help support, deepen and extend the care the patient and family want and need in their community,” said conference co-chair Beth Lown, MD, Medical Director of the Schwartz Center for Compassionate Healthcare, associate professor of medicine at Harvard Medical School and a practicing general internist at Mount Auburn Hospital in Cambridge, Massachusetts. “The first is uncaring and not patient-centered, while the second is ineffective and a candidate for professional burnout,” Lown said. “Both situations breed dissatisfaction and suffering. We need compassion and collaboration among all members of the healthcare team — patients, families, providers and staff alike. Without the knowledge and expertise each person brings to the table, without mutual caring and respect, without willingness to work together on behalf of the patient’s best interest, we won’t benefit from the outcomes that are important to us.”

While numerous studies highlight the importance of collaboration and communication in improving healthcare quality and health outcomes, fewer studies have attempted to link compassionate care with these outcomes. Nevertheless, emerging evidence does demonstrate improved patient outcomes — such as better control of and fewer hospitalizations for serious complications of diabetes, improved psychological adjustment after a cancer diagnosis, reduced end of life ICU utilization, increased immune responsiveness, and even shortened duration of the common cold — among patients of more empathic and compassionate clinicians.

Further, recent research suggests that compassion training has positive benefits for providers including enhanced sense of wellbeing. Research also demonstrates that patients rate their care experiences significantly higher at hospitals that recognize and reward compassionate staff and that support staff when they are distressed to prevent compassion fatigue and burnout.

Compassion is crucial to effective collaboration. But despite the evidence and patients’ and families’ demonstrated desire for compassionate healthcare, the concepts and skills related to empathy, compassion and building caring relationships are missing from existing educational

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frameworks for collaborative clinical practice. To change this paradigm, we must begin to recognize value, instill and nurture compassion as we encourage greater collaboration among healthcare professionals, organizations, institutions, and systems. But how do we do this?

“A model of ‘The Triple C’ necessitates that health professions educators and healthcare clinicians partner effectively with patients and their families,” said conference co-chair Sharrie McIntosh, Chief Program Officer and Senior Vice President at The Arnold P. Gold Foundation. “‘The Triple C’ must be co-created and co-produced by all partners to ensure that the needs, values and preferences of patients and families are reflected, attended to and leveraged — acknowledging that patients are the ultimate experts on their own health and healthcare.”

“Compassionate providers and educators,” McIntosh continued, “need to facilitate an environment in which patients and families can share their expertise. They must tell their stories, and we must listen. But this notion of ‘The Triple C’ and co-production cannot be nurtured solely at the individual or relational level. It also must be supported by systems and embedded into institutional cultures, policies and incentive structures.”

### **Defining Compassionate, Collaborative Care**

To help set the tone and provide common ground for the two-day, invitation-only conference, organizers drafted a discussion paper that proposed working definitions for “The Triple C” and set forth a vision for the future of healthcare.

*Compassionate care*, as defined by the conference organizers and based on cognitive and social neuroscience research, is the recognition, empathic understanding of and emotional resonance with the concerns, pain, distress or suffering of others, coupled with motivation and relational action to ameliorate these conditions.

*Collaborative care* is a process of “co-production,” meaning that patients, families and healthcare professionals construct a high-quality healthcare system by working interdependently. This requires all participants’ full commitment to collectively envisioning and implementing optimal processes to achieve desired outcomes.

With these definitions in mind, conference organizers drafted the following vision statement.

Our vision is to create and continuously improve interdependent systems of interprofessional education and practice with the goals of providing compassionate, collaborative, safe and effective care with patients, families, healthcare professionals and staff as partners in this effort.

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The conference organizers also articulated the guiding principles shown here:

### **Foundations of Compassionate and Collaborative Care**

“The Triple C” requires a shift from the traditional, hierarchical model based on power and control toward a more equal partnership- or relationship-based model among healthcare professionals, patients and families. This model rests upon values that prioritize respectful, caring relationships, emotional support, good communication, and shared empowerment to accomplish mutually determined goals. Including patients and families as equal members of the healthcare team is a key catalyst for “The Triple C.” Everyone is or could be a member of the healthcare team — patients, family members (or surrogate decision-makers), providers, staff, institutional leaders, managers and administrators alike.

### **Underlying Principles of Compassionate and Collaborative Care**

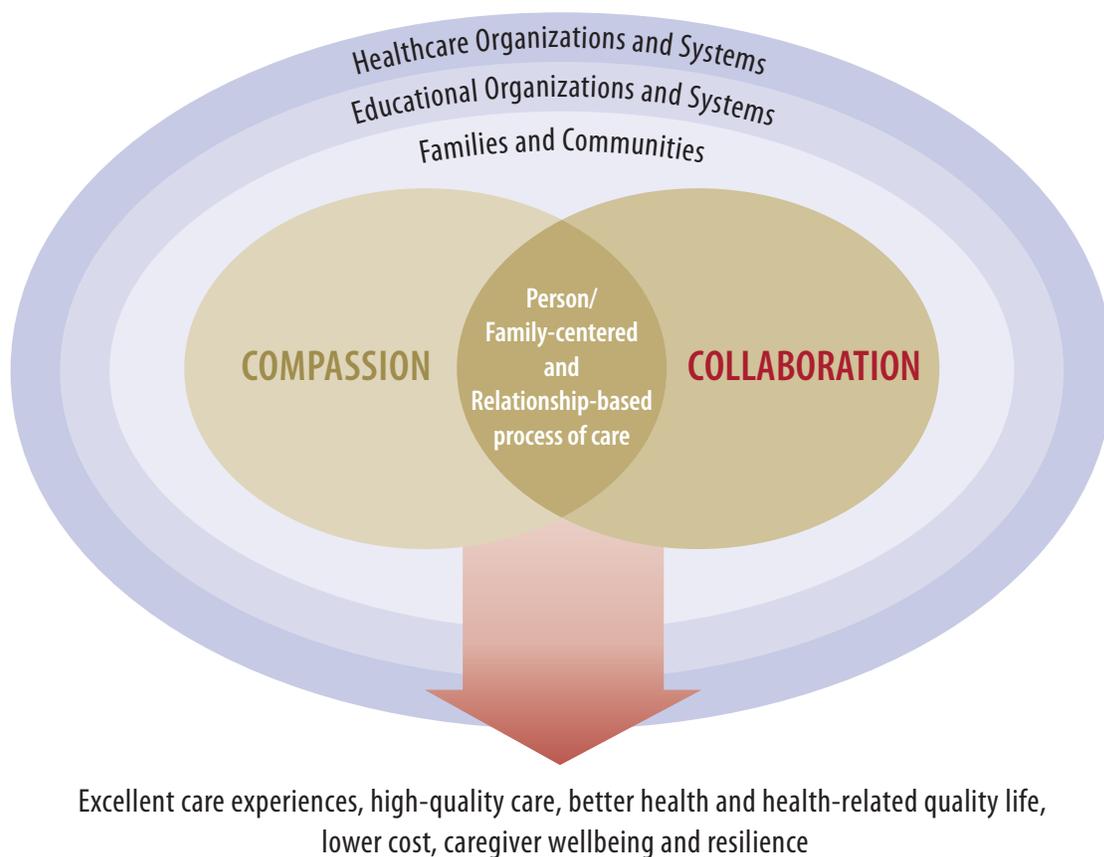
1. Patients and family members should be involved in health professional education and practice design in order to truly transform healthcare.
2. While honoring the preferences of patients and families who choose not to be so involved, healthcare professionals must share information and strive to facilitate patient and family participation as their comfort allows.
3. Compassion and collaboration involve attributes, values and skills that can be taught, modeled, learned and assessed and that must be integrated into health professional education and practice at all levels and continuously reinforced.
4. The wellbeing of professional and family caregivers is critical to their ability to function effectively. Promotion of caregivers’ resilience, and thus their ability to care for and heal others, must be proactively supported.
5. Leaders of healthcare and educational organizations and systems must create cultures and provide resources that support “The Triple C.”

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Conference organizers also prepared a draft competency framework that describes the attributes, behaviors and skills that patients and families should expect and that need to be cultivated among all members of the healthcare team in order to provide compassionate collaborative care.

The figure below shows “The Triple C” as a gateway to achieving “The Triple Aim” of improving patients’ health and experiences of care at lower cost and “The Quadruple Aim” of also supporting providers.

Figure: *Intersection of Compassion and Collaboration Creates Excellence in Healthcare*



### Conference Themes and Recommendations

While a variety of important discussion points came up during the conference, the themes and concepts noted below were raised repeatedly by participants and deserve to be highlighted because they provide important context for the recommendations that follow.

- Integrating “The Triple C” into clinical practice and health professional education is urgently needed for the immediate and continued wellbeing of patients and providers alike.

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- “The Triple C” is about supporting the whole person. This includes understanding the patient’s social context, addressing patients’ needs, values, goals and preferences; and accompanying patients on their personal journeys in addition to diagnosing and treating medical problems.
  - Providers must demonstrate culturally sensitive compassion for patients and families as well as for themselves, team members and other colleagues.
  - For compassion to thrive in healthcare, we must ensure transparent, non-punitive environments in which healthcare providers, patients and families can reflect together on what is working well and what is not.
  - Studies of the value, outcomes and cost effectiveness of “The Triple C” must be funded and the results broadly disseminated to healthcare administrators, educators, policymakers, funders, patients and families.
  - Leaders and clinicians should be shown compassion as they struggle with difficult decisions to make “The Triple C” possible.
  - As a nation, we must create and pay for a system that supports “The Triple C.”

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**Christina Brown, MS, CCLS**, director of child life services for the University of Florida’s Shands Children’s Hospital, emphasized the urgency and critical need to make “The Triple C” a healthcare priority. *“Every patient-caregiver encounter has the potential to be positive and growth-producing and to engage a patient with a sense of mastery and control,”* she said. *“At the other end of the spectrum, it also has the potential of being traumatizing and psychologically damaging and having long term negative impacts.”\**

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Building on these recurring themes, conference participants developed four actionable recommendations to advance “The Triple C.” These include:

1. Involving patients and families as partners in health professional education, their own care and in co-designing healthcare delivery;
2. Educating patients, families, professionals and staff about the importance of “The Triple C” and aligning salient competencies with existing education, assessment and standards;
3. Conducting research to measure “The Triple C” at all levels (individuals, teams and organizations) and to study its outcomes;
4. Incentivizing and rewarding “The Triple C.”

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***1. Clinicians, educators and leaders must encourage patients and families to participate as equal partners in health professional education and in the co-production of “The Triple C.”***

This will require significant cultural, attitudinal, behavioral and structural shifts and an appreciation for the relational aspects of care among providers, patients and families.

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**Juliette Schlucter**, director of the Center for Child and Family Experience, Sala Institute for Child and Family-Centered Care at NYU Langone Medical Center, a mother of two young adult children with cystic fibrosis and a passionate patient and family-centered care leader, noted that healthcare and the relationships among providers, patients and family members is like a tango — a dance whose steps need to be genuine, authentic and based in trust in order to reflect a true relationship based on partnership. *“I absolutely didn’t know how to do this dance well, not only with my lead clinician, but with a whole host of healthcare professionals that came into my childrens’ rooms on a regular basis.”\**

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Such a sea change necessitates setting new norms early and reinforcing them continuously throughout the education, training, and ongoing professional development of clinicians and staff as well as throughout the education of the entire citizenry as full and equal participants in the new healthcare.

***A. Involve patients and families in health professional education***

Conferees recommended that clinicians, educators and leaders in health professional education give patients and family members the opportunity, training and support to participate in the education and training of healthcare professionals at every level. They are, after all, the experts on whether care is compassionate and collaborative. This includes but is not limited to participating in:

- Student admissions processes and policies
- Curricula design and review as well as co-instruction and teaching of compassion and collaboration
- Assessment and feedback regarding health professionals’ competency in compassion and collaboration across the continuum of learning and practice
- Development of policies and standards for the education of health professionals, including licensure, program accreditation and board certification

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As suggested at a Macy Foundation Conference on Partnering with Patients, Families, and Communities to Link Interprofessional Practice and Education (April 3 – 6, 2014), this will require changes in the content and conduct of education and the formation of durable partnerships among education and healthcare organizations, patients, families and communities.

*B. Support patients' and families' involvement in their healthcare*

In involving patients and families in their own healthcare, conferees recommended that providers adopt a strength-based perspective by appreciating and understanding the expertise, knowledge and experience that patients and families bring to their own health and to their healthcare interactions. In addition, many patients and families do their own research, including obtaining information from local community groups, online patient communities and national condition-based advocacy groups. Providers should be cognizant of these resources and ensure that information is accurate and culturally and linguistically appropriate.

Conferees suggested the following actions to support patients' and families' involvement in their healthcare:

- Educators, researchers, patients, families and their associated organizations should build on existing programs and resources to help patients and families communicate and collaborate in decision-making, self-care and self-management.
- Healthcare organizations and funders should support patient and family involvement in programs that provide peer support and enable patients' self-care and self-management in partnership with health professional teams, patient-centered medical homes and community-based organizations. This must include working with patients, families and communities to identify and address community-based social determinants that impede health and healthcare.
- Funding should be made available to support research in patient activation and enablement and associated patient-reported performance measures and outcomes.

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**Maureen Kelley, MA**, a patient advocate and hospice care provider spoke of the relationship she had with her husband's palliative care doctor who helped her accept the gravity of her husband's illness, while respecting her readiness to do so. *"I didn't want to be out of control. I didn't want you to just come in and say 'hey, he's going to die, and you better get ready.' You never did that, but I came to it. And you gave me the freedom to come to it...There was someone there to companion me, there was someone there who promised me she'd keep walking to that pool of reality with me."*\*

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### *C. Involve patients and families in healthcare design and delivery*

Further, conferees recommended that leaders of healthcare organizations involve patients and families in co-designing and improving their experiences and quality of care, especially during transitions in care. Ultimately, education and organizational leaders will need to transform operational processes, policies and governance to truly integrate patients, families and communities as partners. Immediate actionable steps include the following:

- Clinical and quality and patient safety leaders should involve patients and family members in organizational decision-making at all levels. Expanding the number and influence of Patient and Family Advisory Councils (PFACs) would advance this goal.
- Providers can validate patients' perspectives by embedding their stories, personal histories, social context, values and goals of care into electronic health records to be shared with them and members of their healthcare team.
- Family members should have open access to visit and be with hospitalized loved ones at all times.
- Teams can implement processes that enable and empower patients or family members to initiate team “huddles” and care conferences in any healthcare setting to voice their concerns.

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**Alan Manning**, MPA, chief operating officer at Planetree, describing his family's experiences during his child's hospitalization said, “...[Patient] activation starts with access and inclusion. We talk about patient activation all the time. But, it starts with a simple thing, and that's inclusion. Just opening up and giving people access...At the end of rounds, the cardiologist bent forward and said, ‘What do you guys make of all this? How do you think your daughter is doing?’ And, I thought that was fantastic. I didn't have much to say. But, what it did was give me positive expectations. He was saying to me that day, ‘We want you to be part of this. We expect you to be part of this.’ There wasn't another day on rounds where I didn't have something to say, or a question to ask, or a clarification to make. But, it was a very, very simple thing that I was able to be activated only after I was given access to the conversation.”\*

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## **2. Health professional students, clinicians, faculty and institutional leaders along with patients and families must be educated about the importance of compassion and collaboration in healthcare and the skills necessary to demonstrate “The Triple C.”**

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While competencies in team-based care have been developed and implemented within some aspects of health professional education and training, a meaningful focus on compassion as a critical component of collaborative care is missing. Building directly on previous Macy Foundation conference recommendations to develop a competency framework for healthcare professionals to enhance partnerships with patients and families, the leaders of this conference convened a Framework Development Group to do so. This competency framework, which includes the values and skills necessary for compassionate, collaborative care, was presented at this conference and adapted based on participants' comments and subsequent review by a Framework Advisory Group. The Compassionate, Collaborative Care Model and Framework is shown in Appendix 2. Developing, adopting and integrating this competency framework into existing education, training, assessment and standards for accreditation and licensure is essential.

It is important to note that the Framework we developed describes the values and attributes of compassion and collaboration in explicit behavioral descriptors that can be mapped directly onto existing competency domains and standards across the health professions as shown in Appendix 3. For example, adding behaviors for screening, asking about and responding to concerns, emotional distress and suffering could map onto and enhance the skills described in the Association of American Medical Colleges' Entrustable Professional Activity (EPA) #1 (Gather a history and perform a physical examination) and EPA #9 (Collaborate as a member of an interprofessional team), the Accreditation Council of Graduate Medical Education Milestones related to professionalism and interpersonal/communication skills, and the American Association of Colleges of Nursing Essential #9: Baccalaureate Generalist Nursing Practice, Outcome 5 (Deliver compassionate, patient-centered, evidence-based care that respects patient and family preferences). It is also important to note that the behaviors for compassion and collaboration described apply equally to interactions with patients and families and interactions among healthcare professionals.

Among the action steps needed now are partnerships with the many national health professional education organizations, including the National Center for Interprofessional Practice and Education, to integrate the compassionate care competency framework into existing frameworks for interprofessional education, practice, assessment and standards.

Conferees recommend the following actions to spur efforts to integrate the "The Triple C" framework into clinical education and training:

- Healthcare professionals and educators must work with national and institutional leaders, those charged with curriculum development and reform, program and training directors, and leaders responsible for setting standards for accreditation, licensure, board certification and maintenance of certification — to advocate for embedding competencies for compassion and collaboration into health professional education, assessment practices and standards.

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- Health professional students, trainees, faculty and staff must work together to build new competencies into existing clinical processes, including team meetings and rounds, and to introduce new strategies to teach the skills needed for self-care, self-compassion, and team relationships.
  - Deans, department/division chairs, practice leaders and others must support faculty time and professional development in “The Triple C.” This includes protected time to develop and implement curricula and assess relevant learner and programmatic outcomes. This also includes time to teach and model ways to elicit patients’ and family members’ perspectives, to address their psychosocial, emotional, and medical needs and to engage in complex conversations during existing care processes, such as team and family meetings and rounds.
  - National health professional education organizations should collect and share best practices in education for “The Triple C.” Organizations could, for example, develop a “core curriculum” in “The Triple C” to be used for faculty and continuing professional development. They also could collect and share examples of ways in which health professions schools and healthcare organizations have integrated, implemented and assessed such curricula.

The Framework Advisory Group, subsequent to the conference, also recommended that we work with patient and family organizations and advocacy groups to understand how to use the Framework to set expectations for care.

### ***3. Additional research in “The Triple C” must be conducted and supported.***

While it is easy to argue in favor of “The Triple C” — and hard to argue against it — the most persuasive argument for many is its potential to improve patients’ care experiences and health and reduce costs.

While some research has been done in this area, it is an emerging topic that requires more rigorous exploration. Conferees suggested two important streams of urgently needed work: development of measures and methods to analyze and assess “The Triple C” as demonstrated by individuals, teams and organizations as a whole, and research into the comparative value and cost-effectiveness of compassionate, collaborative providers and teams.

One of the goals of the National Center for Interprofessional Practice and Education is to study and generate evidence about the efficacy and impact of interprofessional education and collaborative practice. To these goals, we suggest adding the goal of understanding the role and impact of compassion in both interprofessional education and collaborative practice. Therefore we recommend the following:

#### ***A. Develop measures and methods to analyze and assess “The Triple C”***

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- Cognitive psychologists, social neuroscientists, researchers, health professionals and educators should work together with patients and families to establish common definitions and taxonomies of compassionate and collaborative behaviors. This will make it easier to measure and assess the impact and effectiveness of “The Triple C.”
  - Interested stakeholders should be able to access shared web-based repositories of existing validated, reliable tools to assess “The Triple C” from multiple perspectives (such as those of patients, family members, clinicians and other healthcare staff). These could be housed on the website of the National Center for Interprofessional Practice and Education.
  - Researchers and other stakeholders should create valid and reliable measures to analyze organizational and system-wide compassion and collaboration among professionals, staff, patients and families.
  - Measures of organizational compassion and collaboration should be made available to the public and be included in accreditation processes.
  - Researchers should initiate and develop methods for collecting and analyzing qualitative data (stories/experiences/narratives) from patients, family members and care providers to deepen our understanding about the nature and impact of “The Triple C” and its facilitators and barriers. These methods should harness the collective power of stories and elevate them beyond “anecdotal” evidence.
  - Qualitative in addition to quantitative data should be used to inform quality improvement and patient experience initiatives.

*B. Study the value and cost-effectiveness of compassionate, collaborative providers and teams*

- Researchers, working with educational, organizational and community partners, should measure the impact, value and cost effectiveness of “The Triple C” (including benefits/cost, where benefits may include quality of care, safety, provider/team satisfaction, patient/family satisfaction, wellbeing, quality of life, clinical outcomes and functional capacity).
- Researchers should identify operational and structural variables that correlate with value and cost effectiveness of “The Triple C”. This might include staffing, panel or service size, workload complexity, time allotted per encounter and other variables.
- Researchers and quality experts should identify existing measures that are aligned with or represent “The Triple C” and work with national organizations to endorse them.

***4. All of us — as stakeholders in our own health and in our healthcare system — must work to align, incentivize and reward “The Triple C.”***

Identifying measures, demonstrating outcomes and documenting value are powerful tools to encourage healthcare delivery and educational systems to promote and integrate “The Triple C.”

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**Walter Ettinger**, MD, MBA, senior vice president and chief medical officer of the University of Maryland Medical System, remarked, *“There are all kinds of new payment mechanisms that would incent this kind of care, because the business case is there — it would help achieve the Triple Aim and would help lower costs. The only way to keep people from over-utilizing healthcare is to partner with them and engage them.”\**

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Currently, there is talk but insufficient action to support and recognize the consistent provision of “The Triple C” within healthcare organizations and systems — even though conferees believe it represents one of the best paths to improved, value-based healthcare. To prompt further action, conferees recommended the following:

- All stakeholders must advocate for sufficient time with patients and families, adequate staffing, and resources necessary to support compassionate and collaborative human connections and relationships in every interaction. Without these conditions “The Triple C” cannot be sustained.
- Schools and training programs of the health professions should include competencies for compassionate, collaborative care in standards for advancement and graduation.
- These competencies should be integrated into standards for professional licensure, maintenance of professional competence and accreditation of training programs and organizations.
- Health policy and other experts should create or support payment models that increase organizational and individual motivation to offer high-value, compassionate and collaborative care. These may include shared care and risk models in which collaboration among health professionals and patients’ experiences of compassion are incentivized (i.e., value-based reimbursement).
- Healthcare organizations and institutions should acknowledge and reward individual and team compassion with public recognition and awards, such as Daisy awards for nurses and compassionate caregiver awards.
- Key stakeholders should disseminate data regarding the value, outcomes and cost effectiveness of “The Triple C” to inform clinicians, clinical and quality leaders and the public.
- All stakeholders — including administrators, educators, clinicians, regulators, payers, patients and families — should view “The Triple C” as an “always event” and uncompassionate, uncoordinated care a sentinel event.

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## Conclusion

It is clear that compassion and collaboration between and among patients, families, care providers and other healthcare staff are critical if we are to make progress toward “The Triple Aim” of improving patients’ experiences of care and health while lowering costs, as well as the fourth pillar (“The Quadruple Aim”) of supporting providers’ wellbeing.

“The Triple C” (compassionate and collaborative care), like “The Triple Aim,” must be part of everyday practice. It is what practitioners want to provide and what patients and families want and need. Patient and family involvement in health professional education and practice, education in the competencies of “The Triple C,” research in the value and outcomes of such care, and incentives and rewards for its practice are essential if we are to support the health and wellbeing of every member of the healthcare team, including patients and families.

The work ahead lies in understanding and leveraging the support needed to make “The Triple C” the standard of care in every healthcare organization and health system — and in every encounter. The sense of meaning and rewards of providing and receiving “The Triple C” are great and the need is urgent. As Hala Durrah, a national patient and family advocate and mother of a chronically ill child implored, “I don’t have time to wait for this. I need this now.”\*

\*All quotes have been used with permission.

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The Report was authored by conference co-chairs **Beth Lown**, MD, Medical Director of the Schwartz Center for Compassionate Healthcare, and **Sharrie McIntosh**, MHA, Senior Vice President and Chief Program Officer, The Arnold P. Gold Foundation.

<http://www.theschwartzcenter.org/>

<http://humanism-in-medicine.org/>

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**Beth Lown**, MD (co-chair), Schwartz Center for Compassionate Healthcare

**Kathy McGuinn**, MS, RN, CPHQ, American Association of Colleges of Nursing

**Sharrie McIntosh**, MHA (co-chair), Arnold P. Gold Foundation

### **Conference Speakers**

**Hala Durrah**, MTA, Women and Children's Patient Family Advisory Council

**Juliette Schlucter**, NYU Langone Medical Center

**Christina Brown**, MS, CCLS, University of Florida Health Shands Children's Hospital

**Maureen Kelly**, MA, Catholic Community Hospice

**Karin Porter-Williamson**, MD, University of Kansas Medical Center

**Alan Manning**, MBA, Planetree, Inc.

### **Conference Break-out Group Facilitators**

**Richard Antonelli**, MD, Boston Children's Hospital and Harvard Medical School

**Carol Aschenbrenner**, MD (see above affiliation)

**Bill Branch**, MD (see above affiliation)

**Barbara Brandt**, PhD (see above affiliation)

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**Conference Break-out Group Facilitators** *(continued)*

**Liz Crocker**, Med (see above affiliation)  
**Calvin Chou**, MD, PhD (see above affiliation)  
**Susan Frampton**, PhD (see above affiliation)  
**David Hatem**, MD (see above affiliation)  
**Mira Irons**, MD (see above affiliation)  
**Ann King**, MA (see above affiliation)  
**Kathy McGuinn**, MS, RN, CPHQ (see above affiliation)  
**Mary Naylor**, PhD, RN (see above affiliation)  
**Sally Okun**, RN, PatientsLikeMe, Inc. (see above affiliation)  
**Helen Riess**, MD, Massachusetts General Hospital and Harvard Medical School  
**Steve Schoenbaum**, MD (see above affiliation)  
**Mark Siegler**, MD (see above affiliation)  
**Karin Porter-Williamson**, MD (see above affiliation)  
**Matt Wynia**, MD, American Medical Association

**Conference Abstract Presenters**

**Nichole E. Ammon**, M.S.Ed., PCC-S, CDCA, Northeast Ohio Medical University  
**Mary Thoesen Coleman**, MD, PhD, Louisiana State University Health Sciences Center  
**Deborah L. Dokken**, MPA & **Greg Adams**, MSW, Arkansas Children's Hospital  
**Stephanie Eisenstat**, MD, Massachusetts General Hospital  
**Constance T. Hixson**, MD, Quillen College of Medicine – East Tennessee State University  
**Monica E. Peek**, MD, MPH, University of Chicago, Department of Medicine  
**Andrew Bzowickyj**, PharmD, BCPS, CDE, University of Missouri – Kansas City School of Pharmacy  
**Lauren Collins**, MD, Thomas Jefferson University  
**Caitlin Fitzgerald**, PT, DPT, MS, MGH Institute of Health Professions  
**William Hay**, MD, University of Nebraska Medical Center  
**Barbara B. Richardson**, PhD, RN, Washington State University