Patient/Family Advisory Council
Glendive Medical Center

I. Vision

A compassionate health care community that listens, learns, and responds with patients/families.

II. Mission

The mission of the Patient/Family Advisory Council is to promote patient/ family-centered care and advocate for patients' and their families, using experiences, wisdom, and diverse points of view, to promote positive changes to the total patient experience.

III. Objectives

For Patients/Families:

- Promoting patient centered care;
- Gaining a better understanding of our health care system;
- Appreciating being a part of the program, being listened to, and having their opinions valued;
- Becoming advocates for Glendive Medical Center;
- Learning to be advocates for their family and friends.

For Glendive Medical Center:

- Learning what the priority concerns are for patient/family;
- Hearing directly from the patients/families;
- Transforming our culture toward patient/family-centered care;
- Developing programs/facilities that are directed toward our patients' needs;
- Improving patient/family satisfaction, which leads to stronger patient loyalty;
- Strengthening community relations.

For Providers:

- Becoming more aware of the patient's perspective;
- Learning to provide care from a patient/family-centered approach;
- Recognizing the role of other caregivers, such as family and friends;
- Appreciating barriers—and opportunities—for patients that were previously not understood;
- Identifying system/facility issues that need to be addressed to provide patient/family-centered care;
- Receiving higher satisfaction ratings by -our patients as we collaborate in a patient/family-centered care model.

Patient/Family Advisory Council Application

(Please Print)

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (_____) _____

E-Mail Address: _____

This form and its contents will be shared with the appointing council. By completing this form, you acknowledge and approve of the disclosure of the information contained on this form.

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Program/Department/Services involved in your care?

Your care was primarily:

___Inpatient
___Outpatient
___Both inpatient and outpatient
___Emergency care
___Other programs, departments or services

Why would you like to serve as an advisory council member? Please include what special interest or experience you would like to offer the council.

What issues would you like to see the advisory council address?

What issues are of special interest to you and why?

[Type text]

This does not give access, or authorize disclosure to the council for any encounters or visits you have had with Glendive Medical Center.

Confidentiality Statement

A federal law called "HIPAA" (Health Insurance Portability and Accountability Act) defines "protected health information" and sets standards for health care providers to protect that information. The law also defines stiff penalties (fines and even imprisonment) for violating those privacy provisions.

Protected health information includes any information regarding a patient's visit at any Glendive Medical Center facility. That information includes, but is not limited to, name, address, phone number, date of birth, financial information, diagnosis, and treatment information.

In addition to defining protected health information, the law requires that we must define the minimum necessary information which employees, volunteers, contracted agencies, and other individuals can have access to. As a non-employed committee member, you may have access to protected health information. It is important that you recognize that any protected health information can only be used and disclosed as permitted by law. For example, this information cannot be shared by written, verbal, or e-mail communication at school or home; with friends or family; or outside the Glendive Medical Center facility(s) unless specifically permitted by law.

The easiest way to remember how to implement this law is the saying "What you say or hear here, must remain here." We require your cooperation in following these rules.

Please sign below that you have reviewed this information, understand it, and agree to it.

Thanks you.

I have reviewed the information above, understand it, and agree to abide by it.

Name (please print) _____
Signature _____
Date _____

August 12, 2011

Dear Judy:

The Board of Directors Quality Committee has been working on an exciting strategic plan project related to a Patient/Family Advisory Council. At the last meeting the subcommittee identified membership for an exploratory team to convene a planning meeting to discuss logistics, budget, projects, operating guidelines, membership and recruitment. Laura Glueckert from the Board Quality Committee will be chairing this exploratory committee.

The subcommittee of Board Quality over the past few months has worked hard at defining the vision and mission statement for this council as well as the objectives for our patients/families; for Glendive Medical Center and for our providers. We are now ready to move forward with the real work of the council.

You have been identified as person who would be a vital member to this exploratory team. I am inviting you to join this exciting project and assist us in fulfilling the mission to promote patient/family centered care. As a team member we will be providing you with information and education regarding the background on the concept of patient/family advisory councils.

A meeting will be scheduled in the near future. Please respond to Mona Humphrey at Ex. 2603 by August 19, 2011 if you are able to participate on this team.

Sincerely,

Laura Glueckert, Chair
Board Quality Committee