



Co-Designing Care with the Patient

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TOP 3 Concerns of Patients

1. Dismissal / trivialization of the patient voice
2. Absence of caring attitudes from providers
3. Lack of continuity in care

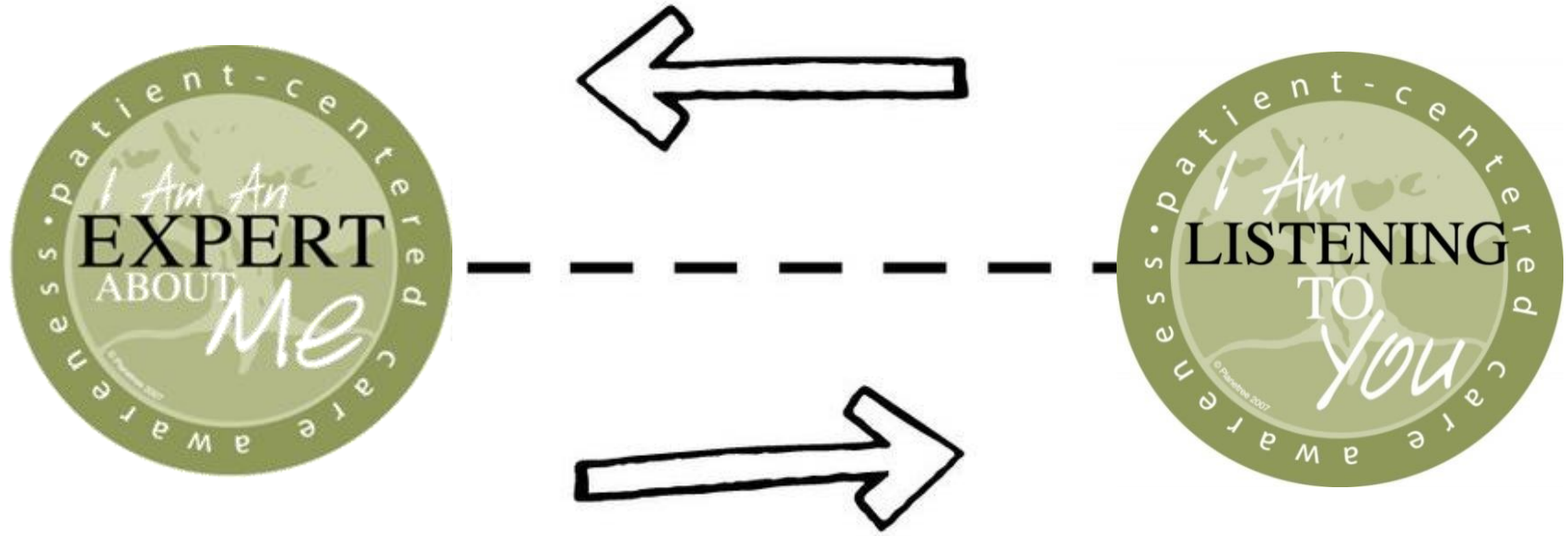


POWERED BY
PATIENTS

How Planetree advances innovation



The crux of patient-centered communication



Reality Check

We interrupt

23 secs

before we
interrupt patients

JAMA. 1999

We don't include

50%

Of physicians don't
ask if patients have
questions

Circulation. 2008

We don't inform

<1 min

Spent discussing
new prescriptions

Pat Educ and CnsIng. 2009.

We intimidate

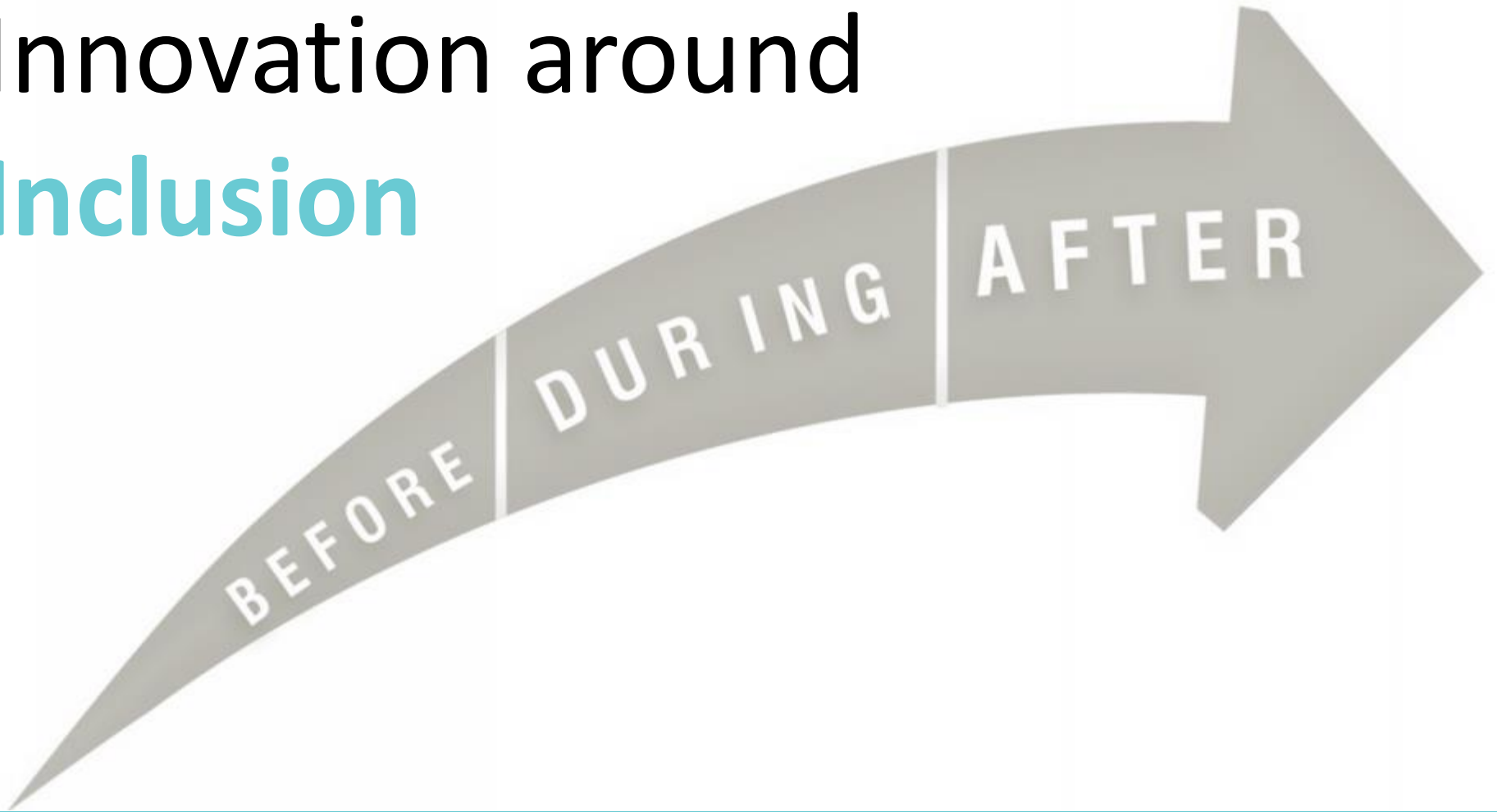
FEAR

Of appearing to
challenge, keeps
patients from
asking questions

Health Affairs, 2012



Innovation around Inclusion



AGENDA



1. Reframe customary interactions to focus on ***what matters most*** to patients.
2. Re-engineer processes to **enhance patient-centered communication**.
3. ***Redesign*** patient and family inclusion at a structural level.



Changing questions to **enhance interactions**

Goal: Gather Information



Goal: Start constructive conversations

What is your chief complaint today?

- What concerns are you having?

Do you have any questions today?

- What questions do you have for me today?

Do you understand?

- I want to be sure I explained everything clearly. Can you explain it back to me so I can be sure I did?

Rate your pain on a scale of 0-10.

- How is your pain affecting your quality of life? Are you able to concentrate on a book or film. Are you able to perform self-care easily. Are you able to enjoy socializing? Based on what you said rate your pain on a scale of 0-10.



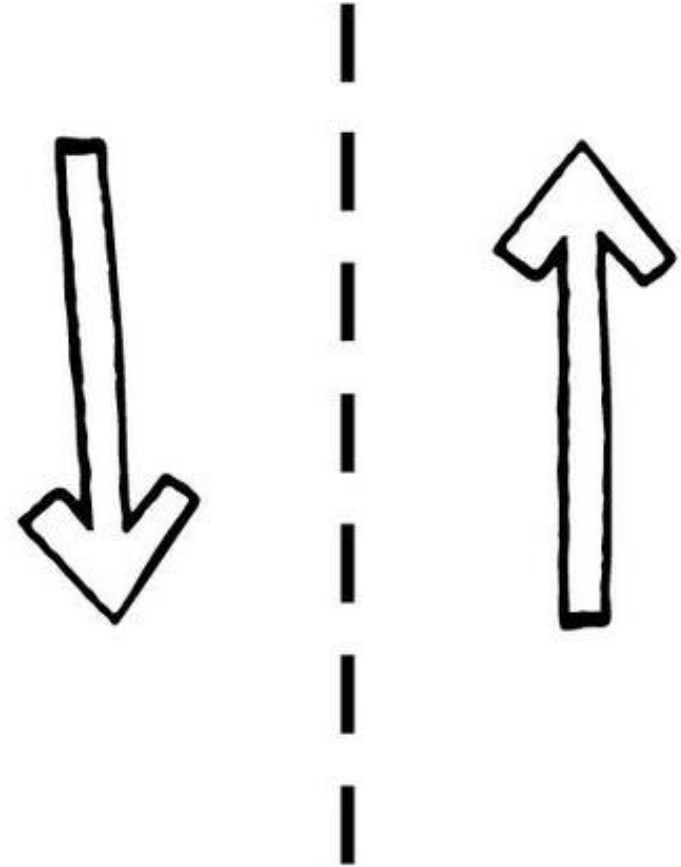
It's a two-way street

Come prepared – with questions, journal for notes, your medication list and any other pertinent personal healthcare information.

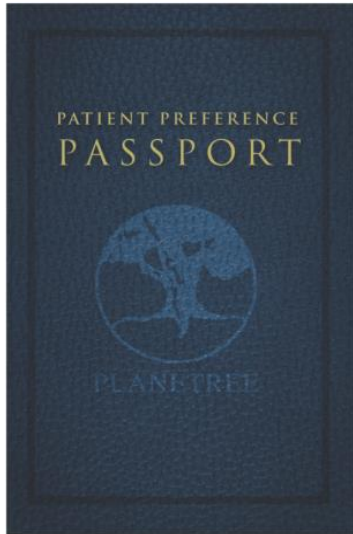
Ask what to expect. When plan deviates from expectations, ask why.

Speak up if you don't understand. Ask your provider to explain in different terms if you are having difficulty.


Engage a family member as an extra set of eyes and ears.



Tools for promoting more constructive conversations



What is the **main** concern you would like to focus on today?
If there is enough time available today, what other concerns would you like to discuss?



Agenda Setting Form

In order to ensure your most pressing health concerns are heard and prioritized, please complete the following questions. Once finished, return the completed form to your nurse who will look over it together with you.

Thank you!

Name: _____ Date Of Birth: _____

1) Are you signed up on FollowMyHealth?
Yes _____ No _____ I'm not ready to use FMH at this time _____

2) What is the main concern you would like to focus on today?

3) If there is enough time available today, what other concerns would you like to discuss?
1) _____
2) _____
3) _____

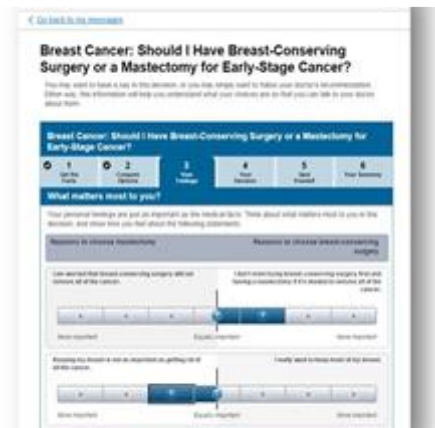
4) Do you need any prescriptions refilled today?
No _____
Yes. Please List _____

5) Have you been to the Hospital, ER, Urgent Care, or specialist(s) since your last visit?
No _____
Yes. Please list dates, facility, and specialist(s) _____

6) Have you had any of the following performed since your last visit?
Lab Tests. Please list type and when: _____
X-Rays. Please list type and when: _____
Other Tests. Please list type and when: _____



Constructing a better methodology–Shared Decision Making

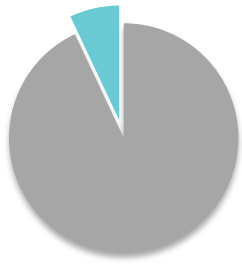


“the process of **interacting** with patients who **wish** to be involved in arriving at an **informed, values-based** choice among two or more medically reasonable alternatives”¹

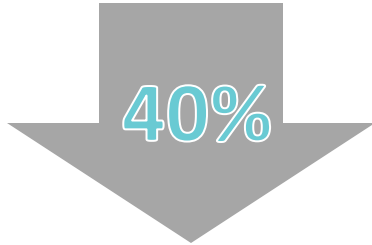


<https://decisionaid.ohri.ca/docs/das/opdg.pdf>





Doctors believe 71% of patients with breast cancer rate keeping their breast as top priority. **The figure reported by patients is just 7%.**



Once patients are informed about the risks of sexual dysfunction after surgery for benign prostate disease **40% fewer prefer surgery.**



Only 41% of Medicare patients believe that their treatment reflected their preference for palliative care over more aggressive interventions.



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Re-engineered processes that work



Shared Medical
Records



Bedside Shift
Report



Communication
Boards



Care Partner
Program

Patient Pathway

Congestive Heart Failure (CHF)

Welcome to Griffin Hospital. This patient pathway has been designed as an aid to inform and prepare you for what you can anticipate during your stay with us. Please keep in mind this is only an outline of the

Patient Pathways



Access to Information- Shared Medical Record

Beyond sharing the real-time record...



Invite patients and family members to document their comments.

[illegible]

Inclusion in Care Process- Communication Boards

506A 502-3534

Your Health Care Team	About You
Nurse:	Name Preference:
Nurse Assistant:	Diet:
Charge Nurse:	Activity:
Doctor:	Special or Personal Needs:
Family or Friend: Name: Contact Info:	
Goals for Today:	Patient / Family Comments and Notes
	Questions For Your Doctor
Last Done: Next Due:	

A shared space for
Bi-directional communication



Participation in treatment conversations– Bedside Shift Report



More than a change in location.

Engage patients and family in:

- Reviewing their status
- Establishing goals for the day
- Sharing their understanding of the plan for the day



Education on what to expect– Patient Pathways

Day One

(Admission—First 24 Hours)

Your disease: We think you may have congestive heart failure (CHF). Congestive heart failure means that your heart is not pumping the fluid well. A water pill (diuretic) helps you get rid of the fluid. Also, fluid follows salt. So you will likely follow a low salt diet. We need to check your weight closely to see how the fluid is doing. Your nurse and your doctor will give you more information about your disease and what you can do to stay healthy.

Consults – Your doctor may request a specialist in cardiology to examine you (consult). This may happen at any time during your stay.

Tests – We may draw blood for testing. Other possible tests are:

- An ECG (electrocardiogram)
- An ultrasound of the heart (echocardiogram)

Both these tests tell us how your heart is doing.

Vital Signs – Your temperature, pulse and blood pressure will be checked as per your doctor. We need to weigh you every day.

Treatments – You may receive oxygen. An intravenous (IV) line to give medications and fluids will be started.

Medications – Your doctor will order your medications. Tell him/her which medications you are taking at home. You

Activity: Your doctor will decide if you can get out of bed. Tell your nurse if you have:

- shortness of breath
- chest discomfort or
- tiredness

Diet – You may be given a low salt diet. You may also have a limit set on the amount of fluids you can drink.

Discharge Plan – Your nurse will ask you questions about how you live at home. She/he will tell our Case Management Department if they feel you need special services when you leave the hospital. A Case Manager will meet with you about plans for leaving the hospital. Your doctor or nurse will explain how you will be cared for at home.

Teaching – The “Speak Up” program helps you become more involved in your care. Your nurse will tell you more about it. You will be advised about the importance of your activity level. Diet and salt restriction will also be covered. Fluid balance and daily weights will also be discussed. Your doctor or nurse will review your plan of care with you.

Day Two

Tests – Blood for testing may be drawn. An ECG and/or x-ray may be done if ordered by your doctor.

Vital Signs – Temperature, pulse, blood pressure and respirations will be checked as ordered by your physician.

Treatments – Oxygen and your IV may be continued depending on your physician's orders.

Weight – You may be weighed daily. Your nurse will explain why this is important.

Medications – You will continue to receive a water pill if necessary. The doctor may change the doses of your medications as needed. Ask your doctor or nurse to explain your medications if you do not understand what they are for.

Activity – Your activity will become more active as you feel better.

Diet – You will continue on a low salt diet with possible limit on fluids.

Discharge Plan – Your Case Manager may meet with you today to discuss discharge plans with you and your family.

Teaching – Your nurse will review with you your plan of care for today. Ask questions if you don't understand something.

Day Three

Tests – There may be no tests for today. Your doctor may discuss a weight goal with you. He will tell you ways for you to achieve and/or maintain it.

Vital Signs – Your temperature, pulse, blood pressure, and respirations will be checked as per your doctor.

Treatments – Your oxygen and IV may be discontinued today.

Medications – Continue to ask questions about your medications if you do not understand what they are for.



Care Partner Program

- Family formally engaged as integral member of care team
- A partnership between family and staff
- Provides a source of continuity
- Prepares loved one for post-discharge

“They showed my husband how to do my dressing changes so I don’t have to come here every day. They asked him questions: Can you see it? Do you understand? For him to see, he was very informed.”



We want you, and your family to play an active role in your care and recovery. Care Partners are important. They are invited to participate in patient education, therapy and treatment. Your Care Partner will receive information from your clinical team so they know your course of treatment in the hospital as well as your post-discharge instructions.

What a Care Partner Does:

- Acts as family spokesperson
- Assists in meal selection
- Is authorized to retrieve additional linens and snacks
- Learns skills to prepare for home or post-discharge care
- Serves as a patient advocate
- Provides emotional support and a hand to hold

What a Care Partner Will Receive:

- Health education materials specific to the needs of that patient
- Information to assist the patient's transition from hospital to home
- An opportunity to be involved in the patient's care
- Meals at a discount
- Access to our chapel, business center and other amenities

Ask our staff about naming or becoming a Care Partner.

East Jefferson General Hospital

EJGH Guest Services: 504-454-4887

www.ejgh.org



Making Connections



Value of Innovations on Health Outcomes

- Higher levels of patient activation were associated with 9 out of 13 better health outcomes—including better clinical indicators, more healthy behaviors, and greater use of preventive screening tests—as well as with lower costs two years later.*
- Emerging evidence indicates that customized interventions that support an individual's activation level can effectively increase patient activation, and improve health outcomes.**
- Practices associated with greater patient activation and engagement by ACOs included leadership commitment, goal-setting supported by adequate resources, extensive provider training, use of interdisciplinary care teams, and frequent monitoring and reporting on progress.***

*Greene, J. Hibbard, J. et al. When Patient Activation Levels Change, Health Outcomes And Costs Change, Too. Health Aff March 2015 vol. 34 no. 3431-437.

**Hibbard, J. and Green, J. What The Evidence Shows About Patient Activation, Hlth Aff Feb 2013 vol. 32 no. 2 207-214

***Shortell et al. Early Assessment of ACOs' Efforts to Engage Patients and Their Families. Med Care Res Rev October 2015 vol. 72 no. 5 580-604



Value of innovation on patient and staff experience



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Gaining Traction?

% of hospitals with a **Patient and Family Advisory Council**.



"I came into this process with a great deal of skepticism as to the value of this approach. The outcomes have been truly eye-opening. Having the patient and family participate as improvement collaborators has also allowed us to ensure we are actually moving in the right direction."

-Nephrologist



Approx. 17% of hospitals include patients/ family members on hospital committees.



Activate

“...to render more reactive; to excite.”

Position the council as a catalyst for change by:

- Integrating diverse voices and perspectives –*mix of patients, family members, staff*
- Not being shy of recruiting critical patients/family members

Council members need to know they are making a difference. Ensure members know their voice matters by:

- Being available outside of scheduled meetings
- Building and maintaining council's visibility
- Creating access to leadership



Engage

“...to involve somebody in an activity, or become involved or take part in an activity.”

Create **ownership** and **engagement** through a REAL charter

- Purpose/Mission
- Meeting frequency and duration
- Reporting structure
- Member roles and responsibilities
- Participation and term limits
- Outcome measures



Enable

“...to provide somebody with the resources, authority, or opportunity to do something.”

Enable members to facilitate meetings through a standard agenda format:

- Warm-up
- Business Items
- Dialogue
- Reflection
- *Feedback (remember the intent)*



Energize

“...to supply somebody or something with strength or power”

Energize your council through education and connect that education to their work as a council:

- Patient Experience
- Disease Specific
- Building design and function
- Marketing
- Department Services

...the possibilities are endless!



Enhance: Close the Feedback Loop

“...to increase the clarity, degree of detail, or another quality”

Close the feedback loop with the council:

- 1) Provide regular feedback from the organization
- 2) Find a path to ‘yes’ for their suggestions
- 3) Communicate transparently with the council

Integrate with organizational quality initiatives

- 1) Gives the council weight
- 2) Develops an inclusive decision making process in the organization
- 3) Energizes the council to serve the greater good, impacting more people
- 4) Integrates the importance of the council in the organization

How about putting
a PFPC member on
your Board?



Evaluating Success Differently

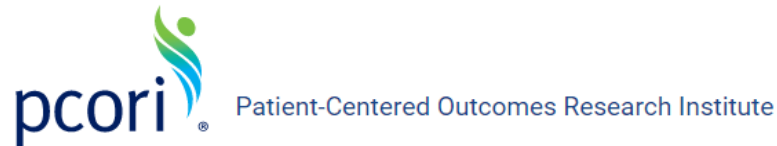


PRACTICES that engage patients/families in research activities

Patients work with clinicians to co-design research on outcomes ***they define as important***

MISSION: ...producing and promoting high-integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader healthcare community

...the meaningful involvement of patients, caregivers, clinicians, and other healthcare stakeholders throughout the research process—from topic selection through design and conduct of research to dissemination of results.



PCORI Funding Levels and Opportunities

Funding:

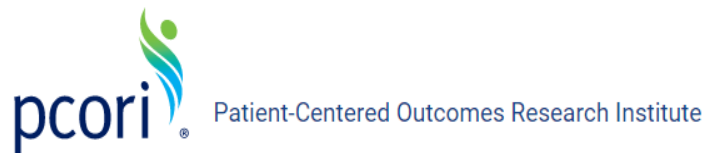
2010- \$10 million

2011- \$50 million

2012-2019- \$150 million per year

13 Areas of Funding Focus, including:

- Engagement Awards
- Communication-Dissemination Research
- Assessment of Prevention, Diagnosis and Treatment Options

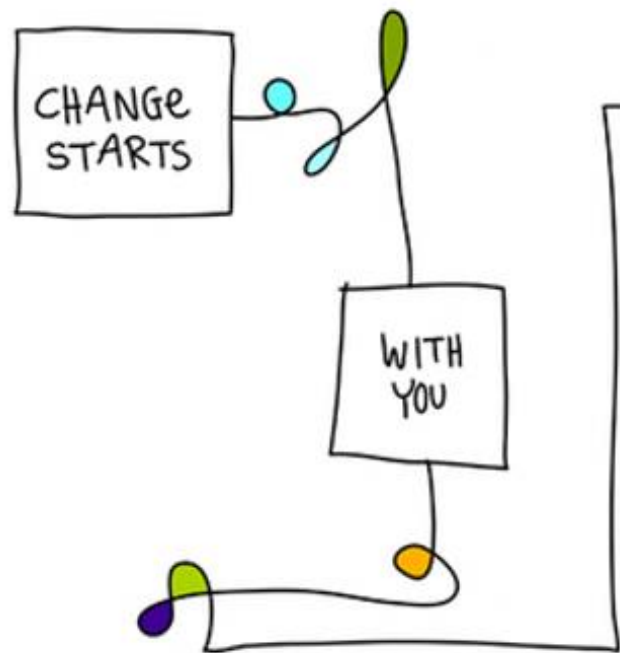


Specific Example of Patient Centered Outcomes Research (PCOR)



- Describe awareness, relevance, and use of PCOR by PFACs.
 - Determine factors that may promote and/or limit engagement with PCOR by PFACs.
 - Develop a comprehensive education manual for PFACs about PCOR.
- The Johns Hopkins Hospital (Baltimore, Maryland)
 - Vanderbilt University Medical Center (Nashville, Tennessee)
 - Maury Regional Medical Center (Columbia, Tennessee)
 - Fauquier Health Hospital (Warrenton, Virginia)
 - Carolinas Medical Center-Mercy (Charlotte, North Carolina)
 - Bellevue Hospital Center (New York, New York)
 - Northport Veterans Affairs Medical Center (Northport, NY)
 - New York Presbyterian-Westchester Division (White Plains, NY)
 - Northern Westchester Hospital (Mount Kisco, New York)
 - Brattleboro Retreat (Brattleboro, Vermont)
 - Longmont United Hospital (Longmont, Colorado)
 - Enloe Medical Center (Chico, California)
 - University of Washington Medical Center (Seattle, Washington)
 - Griffin Hospital (Derby, Connecticut)
 - Stamford Hospital (Stamford, Connecticut)
 - Boston Children's Hospital (Boston, Massachusetts)
 - Brigham & Women's Hospital (Boston, Massachusetts)
 - Amita St. Alexius Medical Center (Hoffman Estates, Illinois)
 - Laser Spine Institute (Tampa, Florida)





@gapingvoid





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