

Patient-Family Councils Make the Difference

By CAMILLE HAYCOCK, RN, M.S.

Kim Moore became a pioneer for patient engagement several years ago, when a new patient care tower was being built at Saint Elizabeth Regional Medical Center in Lincoln, Neb. “We wanted more than just a beautiful building made of bricks and mortar — we wanted the community and patients to have input into what went on *inside*,” declared Moore, who was then the hospital’s chief nursing officer and vice president for patient care services.

She helped establish the hospital’s first patient and family advisory council — a committee of about a dozen individuals, including community members and former patients. Hospital leaders quickly discovered the council members’ perspective was far different from that of health care providers. And it didn’t take long for the advisory council’s views to help spur positive changes.

When patient satisfaction surveys suggested a “lack of respect” on the part of hospital employees in the short-stay unit, the advisory council took a close look. Respect had very different connotations for patients than for staff, and the council discovered that patients felt so rushed in the short-stay unit that they interpreted it as a lack of respect.

Based on that insight, the hospital developed action plans for educating both staff and patients about the *benefits* of being at the hospital for the briefest period of time possible. Moore and others also revised the information provided to patients over the phone, in a video “welcome” and upon their arrival at the short-stay unit for outpatient surgery. The educational program had a quick and dramatic impact. In two years, patient-satis-

faction scores went from the 31st percentile to the 86th percentile as perceptions about the short-stay unit shifted for both providers and patients.

“Before we made these changes, many patients basically felt we were pushing them right out the door,” Moore said. “We had no idea this was happening. The involvement of the advisory council played a huge role in how we resolved this.”

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Moore, who was named chief executive officer of 265-bed Saint Elizabeth in August 2011, said, “The patient and family advisory council helps us keep our eye on the ball amidst the many competing priorities of hospital administrators. We certainly need to keep our intense focus on our patients.”



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Saint Elizabeth's advisory council, whose 15 members include nine from the community, served as the model for a national initiative by Englewood, Colo.-based Catholic Health Initiatives (CHI), the nation's third-largest faith-based health system, to establish similar committees at each of the organization's 76 hospitals. With planning that kicked off in 2009 and an implementation process that debuted in 2010, CHI has successfully established advisory councils at all of its

acute-care facilities in 18 states as part of its emphasis on person-centered care.

Person-centered care is a principal tenet of today's rapidly evolving health care environment, where coordinated care across the continuum serves as a foundation for quality improvement and patient satisfaction. It also clearly highlights the mission, vision and values of the Catholic health care ministry.

Indeed, more hospitals than ever before are partnering with physicians and other providers in the hopes of delivering coordinated care with higher quality and less cost. Providers sometimes tend to make unilateral decisions on care, yet patients and their families have become increasingly well-informed, using the power of information to challenge traditional health care roles. They have become outspoken consumers.

CHI heightens and encourages the involvement of patients and their families, and the advisory councils are an important demonstration of that commitment, said Kathleen Sanford, RN, FACHE, who is CHI's senior vice president and chief nursing officer. Individual council members have unique vantage points, she noted, and their personalized perspective provide a rich backdrop to the more traditional, clinical approach of doctors, nurses and other health care providers.

FROM INPUT TO PROTOCOLS

To many observers, person-centered care means doing what is best for patients. But if providers presume that they are the only ones qualified to figure out what is best for patients — as many still do — they may not seek out important input from the patients they are treating.

“Most of us — health care providers — have a knowledge base as a patient that most people simply don't possess,” Sanford added. “That knowledge or perspective might change what we ask for and how we receive care when we are patients at our own facilities.



HOW CHI ROLLED OUT ITS NATIONAL PROGRAM

For its national approach to patient-family councils, CHI created an evidence-based toolkit to deploy at all acute care facilities across the system. The toolkit, available electronically, includes an introductory section, guidelines for implementation and analysis, a method to audit and verify progress and a host of resources to help communicate the process — everything from key messages to internal staff to suggested newsletter articles and an orientation manual.

The documents for the toolkit were posted on the evidence-based practice page on the CHI intranet, giving all markets easy access to preprinted templates that could be filled in with local information.

One vital element of the toolkit, said Kathleen Sanford, RN, FACHE, who is CHI's senior vice president and chief nursing officer, was a message about the patient as customer.

"We sent a clear message about the councils," said Sanford. "People can get confused. This is not a board — not a fiduciary board. What we are talking about here is helping to make things better for our customers — that is, our patients. In years past, we thought our customers were physicians and that patients were consumers. Not anymore. Patients are customers. It's not just morally or ethically right to treat them as customers — it's good business, too."

The kit sets timeline goals for implementation including structure, process and outcome measurements. Additionally, measures of success were introduced with a reporting process to CHI's national office.

Most patient and family advisory councils are made up of about a dozen or more individuals, and they meet every two to three months. In addition to providing input on positive changes for patients, the advisory council members are regarded as community ambassadors, spreading the word about the hospital and ensuring that

the clinical staff remains person-centered.

Hospitals within CHI use a variety of methods to recruit patients to serve on the patient and family advisory councils. Some hospitals posted ads in local newspapers, others solicited members during hospital rounds. One of the more creative recruitment methods used patient complaints as recruitment opportunities. All council members are volunteers, and one patient volunteer typically co-chairs the council with a hospital administrator. The councils meet quarterly, reporting their work to

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each hospital's community board. It is imperative that hospital leadership not only believes in the value of these advisory councils but also entrusts decisions to them — specifically in the area of patient experience.

"It's an expectation of all of our managers — we have guidance from our national office to be certain that these councils are effective," said Sanford.

Without this sustained, empowered participation by patients and families, hospitals will lose this important perspective, she added.

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that might not have been the greatest, and they are interested in making sure they help others."

CHI's local councils receive support from a national patient and family advisory council, with about half of its membership composed of patients and/or families who have received care at CHI hospitals. Earl Kinnear, who co-chairs the national advisory council, provides a unique, all-encompassing perspective. A retired primary care nurse practitioner who once worked at CHI, Kinnear also serves on the advisory council at Albany Area Hospital and Medical Center in Albany, Minn. Kinnear, his wife and his three children all have been patients at the 17-bed hospital, which is located in the central section of the state. He said one emphasis for the council is reviewing patient-satisfaction scores to help identify positive and negative trends.

"These surveys help tell us how we're doing and the progress we're making — as well as our weak points," said Kinnear. "It helps to guide us as hospital providers and allows us to be leaders rather than followers."

He said the active, engaged advisory councils around the system are spurring even greater interest from other patients and family members, helping to sustain and build momentum.

"My goal — and the goal of the advisory councils — is to help patients understand *health care*, and to have health care [providers] understand patients," said Kinnear. "I've always found that doctors sometimes don't communicate with nurses, and nurses sometimes don't communicate with doctors. And doctors and nurses sometimes don't communicate with patients — and vice versa. My goal is to involve patients in their decisions, to help them understand why doctors do what they do, and why nurses do what they do."

We might not want to admit it, but we might not be getting the exact same treatment as the typical patient receives. That's not how we want to operate. We need that input from the typical patient."

The definition of person-centered care at CHI comprises three integral components: personalization according to patient and family needs, preferences and values; comprehensiveness — that is, care that covers the body, mind and spirit — and collaboration, providing a direct link between providers and patients and their families. That link now also includes key community stakeholders — the members of the patient and family advisory councils. The creation of the advisory councils has helped to spread this definition and philosophy across all of the organization's hospitals, providing a new opportunity for quality care and a focused spotlight on patients and their families.

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"For CHI, person-centered care is not a matter of semantics, but vitally important to how we think about delivering care," said Milt Hammerly, MD, vice president for medical affairs at CHI's Institute for Research and Innovation. "We are

privileged to be a part of the lives of the persons we serve — and *not* vice versa."

The health care literature is replete with examples of hospitals and health systems trying their best to effectively describe patient-safety concerns from the perspective of patients and families. Patient and family advisory councils, like those created across CHI, represent a natural outgrowth of those concerns and are an important step in empowering patients about their health care decisions. Indeed, these councils can be a rich source of information that hospitals can use for significant improvements in quality and patient safety.

For example, the Saint Elizabeth advisory council learned from patient satisfaction surveys that patients were confused, or did not receive enough instruction, about operating the nurse call button in rooms. The council's input led to a new protocol to ensure that patients and their families received additional instruction — and the hospital's "welcome" video added more call-button information, too.

"This discussion led directly into another discussion on pain management," said Libby Raetz, the hospital's vice president for nursing services. "As we looked into that issue, we decided to add specific instructions in the video for patients and families, especially around the issue of patients' expectations."

Surveys and conversations with members of the advisory council also prompted leaders at Saint Elizabeth to provide clearer signage and directions about where families should pick up patients upon discharge. Until members of the advisory council mentioned the issue, no one recognized the confusion that sometimes existed.

Saint Elizabeth established a "mystery shopper" program to help provide leaders with an unvarnished, objective peek at the professionalism of staff and the cleanliness of facilities, among other key areas. "We hear what delighted them

— and what concerned them,” said Raetz. “It’s another way to step back and see what we’re doing from the eyes of a patient.”

At 69-bed St. Vincent Medical Center North, located in a suburb of Little Rock, Ark., the advisory council created new policies and procedures to improve “way finding” when patients, families and visitors entered and exited the building. It also identified an issue that had become something of a cliché or stereotype about hospitals: cafeteria food. The advisory council developed a plan to work with the director of food services to review the quality and selection of items as well as the timeliness of delivery to patient rooms.

Meantime, the advisory council at St. Anthony Hospital, a critical-access facility with 25 beds in Pendleton, Ore., provided several suggestions for improving care and access, including the creation of designated parking spots for senior citizens and additional spaces for vans.

Based on input from the advisory councils, St. Joseph— Martin, a CHI facility in Martin, Ky., has implemented customer-service training for staff in addition to improvements in the patient-registration process. The result: Improved patient-satisfaction scores.

GIVING COUNCILS TEETH

CHI created a patient and family advisory council on the national level made up of 10 members — an even mix of national officials and representatives from the markets. The combination helps to encourage a free flow of information to and from the national office in a suburb southeast

of Denver.

Each of CHI’s patient and family advisory councils is autonomous, but the national organization has established expectations to ensure these committees aren’t simply window dressing without any real power to make significant changes.

The councils have three priorities over the next year: responsiveness of staff (including call-button issues); focus on patient advocates (the family surrogate or patient navigator); and the overall professionalism of staff. This work will parallel a national effort to continue to integrate the work of the advisory councils into evidence-based practices and clinical-quality initiatives.

“We provide guidance from our national office to ensure that our patient and family advisory councils are truly involved in key areas of safety and quality,” Sanford said. “It would be easy to pull together a group of people and say, ‘Well, we have an advisory council,’ and leave it at that. But if you don’t work with these groups on substantive issues, they will lose interest. They need to know that they are making a difference.”

“We’ve begun to hear some very good stories about the impact of the advisory councils,” she said. “Patients and advisory councils are beginning to tell us things that we should do differently — things we should do better. It’s too early at this point to gauge any real impact systemwide, but we will be closely studying the reports and suggestions to help us become more effective at true person-centered care.”

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