Hierarchy of patient centered care - as Maslow would have wanted it.

Alan Manning, MPA
Executive Vice President, Planetree
1. You are individually patient centered

2. Principles hold true across the continuum

3. Principles hold true around the world
“Something is wrong with Katie. Something is wrong with Katie’s heart. They came in and told me that they are transporting her.”
Complex  Difficult
Think about care like Maslow did

Choice
Activation
Inclusion
Access
Quality Care
Quality Care

"Our Director is honest, so I feel like I can be honest too and speak up if I see something that could improve." - staff

WHAT
- Treatment
- Service
- Interactions
- Food
- Transitions

HOW
- Leadership
- Staff Engagement
- Patient Involvement
- Challenge status quo
- Interdependent process

Serious medical errors involve miscommunication between caregivers during transitions. Joint Commission Online October 21, 2010

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“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

¹A.M. O'Connor et al, “Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids” Health Affairs, 7 October, 2004
Everyone is a caregiver, creating greater Quality
Access to Care

...to loved ones...to resources...to your medical team (hourly rounding)...to your medical record...to safe and unbiased care

82% say access their medical records is important

41% would consider switching doctors to gain access to their medical

80%

“Unrestricted visiting in the ICU doesn’t increase infection rates...it’s associated with lower rates of cardiovascular complications and mortality and lower stress hormone levels.” Fumagalli et al. 2011

Example of Access - 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 daily 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 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.
Inclusion in Care

Comprehensive care Planning
Patient and family partnership council
Bedside shift report

Medical professionals who communicate with empathy have higher patient satisfaction ratings. (Riess, 2012)

Patients who experience empathic care have better medical outcomes. (Hojat, 2011)

Adherence to treatment recommendations increases with compassionate care. (Halpern, 2010)

Communicating empathically increases clinician job satisfaction and reduces burnout. (Krasner, 2009; Shanafelt, 2009; West, 2011)

Enhanced empathic care and physician well-being are highly correlated. (Shanafelt, 2005)

Empathic clinician communication improves the quality of all interactions with others; patients, their families, colleagues, and loved ones. (Halpern, 2012)

Teaching Empathy

Eye contact
Muscles of facial expression
Posture
Affect
Tone of voice
Hearing the whole person (context)
Your response

Helen Reiss, Empathetics

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Steps to Building an Effective PFPC

1) Determine the Scope of the Council  
2) Select the Team  
3) Determine a Budget  
4) Confirm Team Members  
5) Conduct the Orientation Meeting  
6) Conduct Regular Council Meetings  
7) Elicit Public Relations Support & Community Engagement  
8) Conclude With a Meeting  
9) Measure Success  
10) Sustain the Partnership Model

Inclusion in Care

Comprehensive care Planning        Patient and family partnership council        Bedside shift report

<table>
<thead>
<tr>
<th>Criteria</th>
<th>6 months prior to implementation of bedside report</th>
<th>6 months after implementation of bedside report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses treat you with courtesy/respect</td>
<td>82</td>
<td>94</td>
</tr>
<tr>
<td>Nurses attitude toward requests</td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td>Attention to special/personal needs</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>Nurses kept you informed</td>
<td>86</td>
<td>90</td>
</tr>
<tr>
<td>Staff include you in decision re: treatment</td>
<td>90</td>
<td>94</td>
</tr>
<tr>
<td>Staff worked together to care for you</td>
<td>88</td>
<td>96</td>
</tr>
</tbody>
</table>

Spirit and Intent of Hourly Rounding
- More frequent touch-points
- Security to patients
- Moves from reactive to proactive
- 4 P’s- Pain, Personal Needs, Positioning, Placement

Bedside shift report as a time saver
- Sharp decline in the number of call lights
- Nurses have reported a better ability to prioritize cases
- Overall decrease in staff time post-implementation

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Example of **Inclusion**

A shared space for Bi-directional communication
Activation in Care

Know them

Empower them

Strengthen them

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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Activation in Care

Know them

- We interrupt before we interrupt patients
  - 23 secs
  - JAMA. 1999

- We don’t include patients that have questions
  - 50%
  - Circulation. 2008

Empower them

- We don’t inform

- We intimidate

Strengthen them

2013 Health Affairs study found that Shared Decision Making:
- Reduced the overall cost of care by 5.3%
- Reduced admissions by 12.5%
- Reduced preference sensitive surgeries by 9.9% (20.9% for heart surgeries)

3 STEPS to Enhancing Communication

- Focus on 1-3 key, need to know items
- Avoid medical jargon. Teach & define. Use concrete terms.
- Focus on what the patient needs to do!

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Activation in Care

Know them

Empower them

Strengthen them

From our Designation Criteria

IV.: A comprehensive formalized approach for partnering with families in all aspects of the patient’s/resident’s care, and tailored to the needs and abilities of the organization, is developed. An example is a Care Partner Program.

“The doctor told me that I could have surgery and explained the risks. He also said I could take a “wait and see” approach. Then he made sure that I understand both options. He asked me which option sounded the best to me based on what I wanted. He cared about my goals.” -patient

Assist with menu selection and feeding
Personal care, baths, manicure, dressing
Discharge planning and preparation
Care coordination
Change dressings, flush catheters
Take temperature, monitor tube feedings
Take blood pressure

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Example of **Activation**

- 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.”
Choice in Care

Choice without education & empowerment will lead to less than optimal results
Think about **care** like Maslow did

- Choice
- Activation
- Inclusion
- Access
- Quality Care
The Black and white of Patient Engagement

- Better clinical indicators (Greene, J. et al. 2015)
- Improved health outcomes (Hibbard, J. and Green, J. 2013)
- Improves the quality of all interactions (Halpern, 2012)
- Better medical outcomes (Hojat, 2011)
- Adherence to treatment recommendations (Halpern, 2010)
- Increased clinician job satisfaction/reduced burnout (Krasner, 2009)
- Physician well-being (Shanafelt, 2005)
Purpose  Process  Practice
Designation- a structured pathway

**Purpose**

I.A: A multi-disciplinary task force, including patients and family members, is established to oversee and assist with implementation and maintenance of patient-centered practices

II.F: Formalized processes are in place to promote continuity, consistency and accountability in care delivery, and which allow staff the opportunity and responsibility for personalizing care in partnership with each patient/resident.

**Process**

III.A : A policy for sharing clinical information, including the medical record and the care plan, with patients has been approved, staff are educated on this policy and the process for sharing the record and care plan, an effective system is in place ...

IV.B: A comprehensive formalized approach for partnering with families in all aspects of the patient’s care, and tailored to the needs and abilities of the organization and its facility, is developed. An example is a Care Partner Program.

**Practice (culture)**

I.F: Leadership exemplifies approaches that motivate and inspire others, promote positive morale, mentor and enhance performance of others, recognize the knowledge and decision-making authority of others and model organizational values.

XI.D: Staff and patient/resident/family members are actively involved in the design, ongoing assessment and communication of performance improvement efforts. The organization consistently utilizes data to identify and prioritize improvement over time.
HOPE IS COMING
Thank you

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