Patient and Family Engagement in Critical Access Hospitals: A Flex Program Story

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Overview

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Federal Office of Rural Health Policy's (FORHP) Medicare Rural Hospital Flexibility (Flex) grant program. Under MBQIP, state Flex Programs support critical access hospitals (CAHs) to improve quality of care across a variety of domains and measures. While not a specific MBQIP measure, an active Patient/Person and Family Engagement (PFE) program is an excellent way for hospitals to ensure they are incorporating the patient perspective into all areas of care, and has the potential to improve the outcomes of many MBQIP measures, most notably the patient experience as measured by the Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS).

This resource shares how the Kansas State Flex Program, in contract with the Kansas Hospital Education and Research Foundation (KHERF), developed a program to support CAHs in their PFE journey. It includes:

- A description of the program team and the challenge they faced
- Details of how the program was organized and evaluated, as well as lessons learned
- One hospital's experience with the program in an interview question and answer format
- Links to useful resources for getting started with PFE.

Program Background

The Centers for Medicare & Medicaid Services (CMS) has defined five key metrics related to PFE, a primary focus of the Partnership for Patients:

1. Prior to admission, hospital staff provide and discuss a discharge planning checklist with every patient who has a scheduled admission, allowing for questions or comments from the patient or family (e.g., a planning checklist that is similar to CMS's Discharge Planning Checklist).
2. Hospital conducts shift change huddles for staff and does bedside reporting with patients and family members in all feasible cases.
3. Hospital has a person (or functional area), who may also operate within other roles in the hospital, who is dedicated and proactively responsible for Patient & Family Engagement and systematically evaluates PFE activities (i.e., open chart policy, PFE trainings, establishment and dissemination of PFE goals).
4. Hospital has an active Patient and Family Engagement Committee (PFEC) OR at least one former patient that serves on a patient safety or quality improvement committee or team.
5. Hospital has at least one patient who serves on a Governing and/or Leadership Board and serves as a patient representative.

The Kansas Hospital Education and Research Foundation (KHERF) formed a committee to look deeper into the challenges related to PFE implementation in rural hospitals. What they found was confusion regarding the PFE metrics; many CAHs simply did not know where to begin with implementing all five metrics within their organization. For hospitals that did not have a solid PFE foundation from which to start, the thought of Patient and Family Engagement could be overwhelming, as many associate PFE with the development of a patient and family advisory committee (PFAC) as described in metric 4. A new approach was developed in the form of the Kansas Rural Hospitals Optimizing Performance (KRHOP) Patient Satisfaction Learning Community (PSLC). The PSLC was comprised of simple, bite-sized steps focused on the first three PFE metrics. As such it is a great complement to the work of the Kansas Healthcare Collaborative which serves as the Kansas Hospital Innovation and Improvement Network and focuses on the fourth PFE metric.

Project Funding and Partners

This project was funded by the Kansas Office of Rural Health in fulfillment of grant expectations for the Kansas State Flex Program. The Flex grant was awarded to the Kansas Department of Health and Environment (KDHE) by the Federal Office of Rural Health Policy, Health Resources and Services Administration.

The Kansas Office of Rural Health at KDHE partners with KHERF on KRHOP. The KRHOP PSLC was developed by Susan Runyan, Kansas KHERF Consultant; Susan Cunningham, KHERF Scholarship Program Manager; and Jennifer Findley, KHERF Executive Director, KHA Vice President of Education and Special Projects.

Program Process

KHERF developed a nine month long pilot project, with five to seven recruited CAHs focused on the first three PFE metrics. The project timeline included an in-person kick-off event, individual hospital site visits within one month of kick-off, an in-person mid-point meeting, a second individual hospital site visit with mock patient survey, and an in-person wrap-up meeting. In addition, there were monthly touch-base phone calls with updates on PFE activities, sharing of resources, and opportunities to ask questions or request assistance, including regular email communication.

Kickoff and Site Visit

The kickoff began with education developed and provided by Patient and Family Engagement Specialist/Performance Improvement Coach Amy Vanderscheuren, a national subject matter expert. Education included what PFE is and how it can positively affect patient safety, patient satisfaction, and staff satisfaction. Participants also learned about the first three CMS PFE metrics: what they are, what they mean, and how hospitals can meet them. Much of the kick-off focused on laying the groundwork for implementing bedside shift report, including addressing perceived barriers. Additionally, there was a review of the HCAHPS survey, an explanation of the five PSLC survey questions that were used for the duration of the project (see Evaluation below), and an analysis of how the two surveys compare. Participants were able to network and learn from one another through learning activities and round table discussions, and left with a binder of helpful information and resources they could refer to during the project. Each hospital received a site visit from the PSLC project team within one month of kick-off, providing an opportunity for additional staff education.

Mid-Point Meeting

An in-person mid-point meeting was held roughly four months into the project, offering an opportunity for hospitals to reenergize. A hospital with a strong and established PFE program was invited to present their story, and participants shared their own successes and challenges to date. The mid-point focus was on CMS PFE metric 1: contacting patients prior to admission. Many CAHs identified the challenge of not having scheduled admissions, and therefore struggled to meet the spirit of the measure. One solution identified was use of a pre-planning or admission checklist – staff can use the checklist to help educate patients on what to expect during their stay and explain ways they can be more involved in their care. Baseline PSLC survey results were shared (see Evaluation below) representing both the baseline and performance to date across the cohort.

Site Visit with Mock Patient Survey

A second site visit was scheduled with each hospital after the mid-point meeting. Hospitals expressed a desire for more assistance with effective bedside rounding and asked that mock patient surveys be conducted. During site visits, project leaders acted as patients for a mock bedside shift report, stopping nurses anytime they didn't understand something that was said. Feedback from staff was extremely positive; this exercise helped nurses to recognize the need to use less medical jargon and phrase things differently in a way that patients will understand.

In-Person Wrap-Up

A project wrap-up was held at the end of the nine-month timeline. Each participant was asked to present on specific topics (next steps, sustainability plan, etc.) and PSLC survey results were shared both in the form of collective results with the whole group, and individual reports provided privately. Each hospital shared their sustainability plan and verbalized any additional needs they had of the project team. All participants indicated they were confident they could keep moving forward with the PFE work with the ultimate goal of implementing PFE metrics 4 and 5.

Evaluation

There were multiple layers of evaluation involved in this project, as participating hospitals sought to assess the impact of their interventions on patient experience, and KHERF sought to assess the impact of the project on the participating hospitals.

Patient Evaluation

Participating hospitals evaluated patient experience utilizing a standard set of questions, some of which are similar to but not duplicate of HCAHPS survey questions (see Appendix A). This PSLC survey was administered immediately post-discharge before the patient left the hospital, using either an electronic or paper version, and all responses were anonymous. Using the PSLC survey allowed for more real-time patient satisfaction measurement of changes being made. A baseline was collected right after the kick-off utilizing the first five questions on the survey.

Subsequent results were tallied monthly, and incorporated a sixth question to obtain patient feedback about their experience with bedside shift reporting. Hospitals were free to add other questions if there were additional measures they felt were important to include in the project work. Feedback from participants indicated that nurses and leadership looked forward to seeing the PSLC survey results and felt that the frequency of results allowed them to implement changes in more real-time. Results from both the PSLC measures and the statewide PFE measures demonstrated steady improvement over the course of the project.

Participating hospitals were aware of the potential for confusion with the PSLC survey and HCAHPS; all were careful to explain the differences between the two and remind patients that they would receive a survey sent to their home after discharge that they should respond to as well.

Hospital Staff Evaluation

In addition to gathering standard participation feedback at every meeting and training, KHERF developed an evaluation tool to gather specific input from staff involved in the mock patient

survey conducted at the second site visit (see Appendix B). This information will be used to inform future iterations of the project.

Key Lessons Learned and Words of Advice

KHERF plans to offer this opportunity to additional hospitals and the process continues to evolve. The coordinating team is taking the lessons learned from each cohort to inform and improve subsequent cohorts. The first iteration of this project was scheduled for five months, but the pilot group requested more time, along with the second site visit during which project team staff role-played as a patient. Nine months has proven to be feasible for the amount of change anticipated.

Words of advice from the project team to potential hospital participants:

- Determine if the time is right for your organization to tackle the change. Do you have other large initiatives taking place? Is leadership on board? Is the organizational culture ready for the change?
- Nursing Leadership (DON, CNO, or ADON) must attend Kick-Off and be an active part of the hospital team.
- Be systematic and go slow, take small steps that can add up.
- Build a strong foundation and communicate, communicate, communicate! Make sure everyone knows and understands what they are doing and why.
- Education on CMS PFE metrics 1, 2, and 3 is a must, particularly how the measures can be met in a CAH.
- When communicating with patients and families, think in terms of third grade level healthcare literacy – explain things in a way that people can understand.

Hospital Spotlight

Sheridan County Hospital, part of the Sheridan County Health Complex in Hoxie, KS, is one of 85 CAHs in Kansas, with 18 beds and an average daily census of 3.1. Hoxie is the county seat for Sheridan County. Sheridan County is classified as a frontier county and has a population of approximately 2,550 people. Hoxie has a population of 1,250. The nearest tertiary hospital is about 1.5 hours away. Hannah Schoendaler, the Chief Nursing Officer, shares her team's experience with the PSLC.

1. How did you get involved in the PFE project and what were your goals?

    - We participated in the PFE work with the Kansas Hospital Innovation and Improvement Network (HIIN), and would get energized and excited during the meetings, but when we returned home we felt overwhelmed and not sure where to start. We realized we weren't quite ready to start a patient and family advisory committee (PFAC); we needed to do some foundational work first. We learned about the PSLC program through the Flex program and MBQIP. It sounded like exactly what we needed – a strong implementation of PFE measures 1-3 could be the missing link to our readiness to implement a PFAC.

2. What strengths were you able to build upon during the project?

    - Sheridan has a team of people all passionate about different things, allowing each person to focus on and drive what was important to them, whether it be bedside rounding or discharge planning.
    - We communicated about PFE as much as we could, in meetings and mandatory education, so that everyone heard the term, what it is, why it is important, what will be going on, and how all departments can be positively affected by PFE implementation.

3. What challenges did you face going into the project and during the course of the project?

    - Approximately 20 years ago an event took place that resulted in a father/son physician team leaving the community. The event divided the town, and the hospital has been working to repair the damage and bring the community back together ever since. PFE work has allowed the organization to partner with the community and give patients and families a safe place to voice concerns where staff could acknowledge the concerns without having to agree – a voice with "bumpers" – so that patients and families and staff then could begin to work together to make positive changes. This partnership has positively changed perceptions of the hospital in the community.
    - Bedside rounding had been rolled out in March 2016, but it was primarily a location move; the shift report itself didn't change at all, it was now simply done at the bedside. With the introduction of the PFE work and better tools for staff to partner with patients and families, patients began to be included in the process. The way the work was presented (small steps) really took the anxiety out of the changes and made it foolproof for us.

4. As you went through the project, which aspects did you find most helpful?

    - There were several helpful aspects! The small, intimate level made all the difference! We were able to build amazing relationships with the other organizations and share tools and resources. It was easier networking with a smaller group, we had fewer examples/tools from others to try which made things less overwhelming, and everyone was at the same level. We were all doing something – maybe just doing it a bit differently or calling it by another name. Switching to using the same terminology was helpful too.
    - The subject matter expert (Amy Vanderscheuren, Patient and Family Engagement Specialist/Performance Improvement Coach) that spoke at the kick-off was from a smaller organization, and understood CAH challenges versus those of a larger hospital. That helped us remove roadblocks we set for ourselves simply because we are a CAH.
    - The messaging of "Do not make this your director of nursing's (DON) project" was important. Work must be spread among the team if it is going to be successful. The DON needs to be aware of and participate in the work being done, but does not have to be the chair or spearhead the work.
    - The project timeline (nine months) provided the perfect amount of time without being too rushed, while giving enough time to get your head around new concepts and see

and try tools from other participants. The fact that it was less than a year kept you focused without being too rushed. It gave us time to be successful!
- The onsite visits were the cherry on top of the project – the KHERF project team acting as test patients helped staff better understand their own strengths and weaknesses when communicating with our patients. That objective viewpoint really helped us make improvements much faster.
- The energy and passion that Susan and Jennifer bring to the work makes everyone else excited to be a part of it.
- We were receiving immediate feedback through the PSLC patient evaluations which allowed us to make changes more rapidly.

5. Did you have any big surprises or any "a-ha's" as the project unfolded?

    - We really didn't have any negative surprises. One happy surprise was the way that bedside rounding gave everyone a chance to make a great impression with patients and families. Also, the number of patients that identified staff by name in patient experience surveys skyrocketed – we think it was most likely due to the formal introductions and warm hand-offs from shift to shift.

6. Any tools that were especially useful?

    - We did have a few great tools! The most helpful was a bedside report checklist and the pre/post assessment we did with staff to gauge their readiness and understanding. Questions on the pre/post assessment included:
        - What benefits do you see coming from patient family engagement?
        - What benefits will proper bedside shift rounding bring?
        - What concerns do you have about proper bedside shift report?
        - What questions do you have about this new approach?
        - What do you feel we are already doing that aligns with this model?
        - What can we improve on?

7. What are your next steps?

    - We feel the groundwork has been laid and we are closer to tackling the PFAC. Our measures are in place, leadership is behind us, we have one person sitting on the board, and are working on getting another patient on our quality committee. The next step will be to start our PFAC. In rural areas, it can be easy to become stagnant – the staff pool is small and may not change for decades. By better engaging our patients, especially those that go to other systems, we can tap into new ideas. Patients can help us to be more proactive, provide new and different services, and drive the improvements we know we need to make and allow us to think more futuristically.

8. Lastly, what advice do you have for a hospital just getting started on the PFE journey – if they can do just one thing, where should they begin?

- Start small and work your way through the measures. Trying to jump in and start with PFE metric 4 (starting a PFAC) can be overwhelming and difficult to accomplish without a solid foundation of staff and patient involvement – implementing the first three PFE metrics can help provide that foundation. None of the changes were earth shattering or costly. Leadership supported the idea of PFE, and the understanding that PFE is beneficial for everyone – staff and patients – and includes activities we should be doing anyway.

National PFE Resources

There are a lot of great resources available to support patient/person and family engagement in healthcare, including many at the state and local level. This list provides some suggestions for where to start.

Agency for Healthcare Research and Quality (AHRQ): Guide to Patient and Family Engagement in Hospital Quality and Safety

https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html
Research shows that when patients are engaged in their health care, it can lead to measurable improvements in safety and quality. To promote stronger engagement, AHRQ developed a guide to help patients, families, and health professionals work together as partners to promote improvements in care.

Centers for Medicare & Medicaid Services (CMS): Partnership for Patients

https://partnershipforpatients.cms.gov/about-the-partnership/aboutthepartnershipforpatients.html
The Partnership for Patients initiative is a public-private partnership working to improve the quality, safety, and affordability of health care for all Americans.

Institute for Patient- and Family-Centered Care (IPFCC)

http://ipfcc.org/
IPFCC, a non-profit organization founded in 1992, takes pride in providing essential leadership to advance the understanding and practice of patient- and family-centered care. By promoting collaborative, empowering relationships among patients, families, and health care professionals, IPFCC facilitates patient- and family-centered change in all settings where individuals and families receive care and support.

Appendix A – Patient Satisfaction Survey

Improving Patient Satisfaction Survey

1. What month were you discharged? ______________________________________

2. During this hospital stay, do you feel like the nurses listened carefully to you?
   [ ] Never listened
   [ ] Sometimes listened
   [ ] Usually listened
   [ ] Always listened

3. During this hospital stay, were things explained in a way you could understand?
   [ ] Never understood
   [ ] Sometimes understood
   [ ] Usually understood
   [ ] Always understood

4. During this hospital stay, did hospital staff explain your medications in a way you could understand?
   [ ] Never understood
   [ ] Sometimes understood
   [ ] Usually understood
   [ ] Always understood

5. During this hospital stay, did hospital staff discuss what you will need to know to care for yourself when you get home?
   [ ] Yes
   [ ] No

6. During this hospital stay, staff involved me and my family or caregiver with decisions about my care.
   [ ] Never involved
   [ ] Sometimes involved
   [ ] Usually involved
   [ ] Always involved

Appendix B – Hospital Site Visit and Mock Survey Evaluation

1. Did you know what to expect prior to KHERF Staff arrival? (Circle One) **Yes** **No**
If not, how could it have been made more clear?

____

____

2. Rate your confidence in bedside shift change report prior to the exercise (Circle One):

   Very Confident **Slightly Confident** **Neutral** **Slightly Uncertain** **Very Uncertain**

3. Rate your understanding of the value of bedside shift change report prior to the exercise (Circle One):

   Very Clear **Slightly Clear** **Neutral** **Slightly Unclear** **Very Unclear**

Complete the following after the exercise

4. Rate your confidence in bedside shift change report following the exercise (Circle One):

   Very Confident **Slightly Confident** **Neutral** **Slightly Uncertain** **Very Uncertain**

5. Rate your understanding of the value of bedside shift change report following the exercise (Circle One):

   Very Clear **Slightly Clear** **Neutral** **Slightly Unclear** **Very Unclear**

6. Participating in the practice exercise was a good use of my time. (Circle one) **Yes** **No**

7. I think bedside shift reports are a useful tool for communicating with patients. (Circle One)

   Strongly Agree **Slightly Agree** **Neutral** **Slightly Disagree** **Strongly Disagree**

8. What parts of the visit were most beneficial for you?

____

____

9. What could have made this a better experience for you?

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10. Any additional comments for KHERF Staff:

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