A Sustainable Model for Person-Centered Care

How to balance patient and provider needs
The gold standard: person-centered care

Post-acute providers promote a personalized experience

“Our centers have a mission to consistently deliver high quality, person-centered care with dignity, respect, compassion and integrity”

Skilled nursing facility

“We reinforce a message that patients’ wishes and choices are respected and honored throughout their lives under our care.”

CCRC¹ and home care provider

“It's the patient-centered treatment policies, state-of-the art facilities and equipment, family-friendly environment, and supportive patient peer group.”

Long-term acute care hospital

Source: Post-Acute Care Collaborative interviews and analysis.

¹ Continuing Care Retirement Community.
Practical realities limit person-centered care

Model is not always clinically appropriate or financially sustainable

What person-centered care looks like in practice

Example one:

A frail patient wants to go to the bathroom alone

Patient goes by herself, falls, and has to be readmitted

Example two:

All patients want to bathe at 8:00 PM every day

Provider spends significant resources changing staffing model to accommodate

Source: Post-Acute Care Collaborative interviews and analysis.
Post-acute environment creates unique challenges

Emotional burden, length of stay, and staffing differentiate PAC\(^1\)

Three factors affecting post-acute experience initiatives

1. Emotional burden
2. Average length of stay
3. Staffing

Family members and caregivers also have their own unique needs, which may not align with those of the patient

Source: Post-Acute Care Collaborative interviews and analysis.
The post-acute patient journey is difficult

Post-acute care associated with aging and loss of independence

**Challenge**

**Potential for recovery**
In the long term, many post-acute patients won’t regain full functionality

**Impact**

Providers must manage expectations and help patients and families cope

**Sign of major life change**
Patients and families feel overwhelmed and frustrated by prognosis

Providers must educate patients and families about condition and lifestyle changes

Source: Post-Acute Care Collaborative interviews and analysis.
Extended stays present opportunities and challenges

Average LOS\(^1\) by setting, in days

<table>
<thead>
<tr>
<th>Setting</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital</td>
<td>5.0</td>
</tr>
<tr>
<td>IRF</td>
<td>12.5</td>
</tr>
<tr>
<td>LTACH</td>
<td>24.0</td>
</tr>
<tr>
<td>SNF</td>
<td>24.7</td>
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</table>

Q2 2017 – Q1 2018

Impacts of longer LOS

**Opportunity**

- More chances for staff to make a positive impression on patients and family members

**Challenges**

- Patients expect choices and amenities like they would have at home
- Patients want to build personal connections with staff members

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\(^1\) Length of Stay.
Staffing realities leave patients feeling unsupported

PAC staffing is limited by regulatory environment, reimbursement

Low staff licensure
*Care teams differ significantly from acute care*

- **Hospital**
  - Physicians
  - 24/7 RN coverage

- **SNF and home health**
  - Limited physician and RN coverage
  - LPNs\(^1\) and aides

High staff turnover
*2017 calendar year*

- Hospital: 14%
- HHA: 37%
- SNF: 69%

**Experience impact**

- Patient and family perception of safety and quality
- Trust in care team and care process

**Experience impact**

- Organizational culture
- Consistency of care team

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1) Licensed Practical Nurses.
Resources to help overcome staffing challenges

Low staff licensure in SNF

- **What to Expect from Post-Acute Care**
  *Patient-facing cheat sheets*

- **Three Things Direct Patient Care Staff Need to Know**
  *Infographic and best practices*

High staff turnover

- **The Guide to Reducing Turnover in Post-Acute Care**
  *Toolkit*

- **Home Health and SNF Turnover Benchmark Generator**
  *Data*

Source: Post-Acute Care Collaborative interviews and analysis.
The experience-expectation problem

Consumers expect both too much and too little from post-acute care

Patients expect more than we can give....

• A five-star experience that will make them feel like they're at home
• To be able to see the same care team every day
• Physician coverage similar to the acute care setting

...but also less than we're capable of

• “If I have to go to an assisted living facility, I’m completely giving up my independence”
• “I can’t trust these caregivers in my home”
• “These staff members don’t know anything about how to make me better”

Source: Post-Acute Care Collaborative interviews and analysis.
Who should drive decisions about patient care?

Finding the right balance between patient and provider priorities

**Provider-driven organization**
- Patient care plans are developed from standard care protocols
- Fixed dining and medication administration times
- Cost and quality, rather than patient preference, is the organization's top priority

**Patient-driven organization**
- Patients inform all decisions about care
- Staff respect patient choices, even if they disagree
- Organization works to achieve patient goals, despite other priorities

Source: Post-Acute Care Collaborative interviews and analysis.
### Breakout activity instructions

1. Work in small groups to prioritize real-life patient and family requests and preferences into three categories:

   - **Always**: meeting this request would improve the patient and family experience without interfering with other organizational priorities
   
   - **Sometimes**: this scenario would only occasionally be worth the investment—it may improve the experience, but could also result in some other negative outcome
   
   - **Never**: fulfilling this request would not be in the best interest of the patient, family, or organization

2. Meet back as a large group to discuss lessons learned

<table>
<thead>
<tr>
<th>Staff time</th>
<th>Cost</th>
<th>Safety and care quality</th>
<th>Payer source</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 minutes</td>
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Meeting patient needs without changing staffing hours

Hospice of Northwest Ohio addresses patient needs before the weekend

Volunteers and team leaders meet weekly to identify high-need patients

RN flags patient if he or she:
- Won’t receive a visit before the weekend
- Has had recent significant symptoms
- Is new to hospice care
- Has complex needs

Thursday meetings

Volunteers call each red flag patient to check on comfort, satisfaction

- Confidence in care over the weekend
- Current comfort or pain level
- Overall satisfaction with service
- Additional needs or questions

Source: Hospice of Northwest Ohio, Perrysburg, OH; Post-Acute Care Collaborative interviews and analysis.
CASE EXAMPLE

Hospice of Northwest Ohio

- Community-based hospice provider based in Perrysburg, Ohio
- Manages patients at home, in nursing facilities, and at two freestanding hospice centers

▶ Developed a Thursday morning call system to proactively identify patients who may need a weekend visit.

▶ Each week, an RN team leads identify which patients are at high risk of needing a weekend visit, and volunteers will call the patients on that list on Thursday mornings.

▶ After the calls, volunteers fill out a summary document for staff, and staff will adjust their schedules to make additional visits prior to the weekend as necessary.

▶ This program has helped reduce the need for additional weekend staff and instill patient and family confidence in Hospice of Northwest Ohio’s services.

Source: Hospice of Northwest Ohio, Perrysburg, OH; Post-Acute Care Collaborative interviews and analysis.
Thursday calls prevent the need for after-hours visits

Staff identify and visit high-need patients prior to the weekend

1. Volunteer fills out summary document for each call
2. Team lead reviews, identifies which patients need an additional visit
3. Staff visit identified patients to address needs before weekend

Benefits of Thursday call system

- Reduced the need for care team to make visits over the weekend
- Reassures patients and families that they are safe and well cared for

Calls made and needs identified, 2018

- Total calls answered in CY 2018: 838
- Patients indicated pain or discomfort: 25
- Patients had other needs that hospice could address: 62

Source: Hospice of Northwest Ohio, Perrysburg, OH; Post-Acute Care Collaborative interviews and analysis.
Low-resource strategies to improve the experience

Balancing patient and provider needs

- Assign an advocate to each patient
- Equip patients to express their care preferences
- Engage patients and families in improvement efforts

Process changes

Institutional change

Source: Post-Acute Care Collaborative interviews and analysis.
Assign a staff advocate to each patient

HCF Management’s constant caring ambassador program

Patients are matched with an ambassador at admission

Ambassador role filled by:
- Department heads
- Nurse administrators

What ambassadors do:

- Ask patient and family about their care experience
- Scan the room to identify any outstanding issues
- Address needs as able, otherwise elevate to administrator
- Report back challenges and solutions in team meetings

Benefits of regular check-ins with ambassadors

- Makes it easy for staff to proactively identify and solve service gaps
- Staff build relationships with patients and family
- Helps patients feel more comfortable and cared for

Source: HCF Management, Inc., Lima, OH; Post-Acute Care Collaborative interviews and analysis.
HCF Management, Inc.

- Skilled nursing and assisted living operator based in Lima, OH
- Operates 32 skilled nursing and assisted living facilities across Ohio and Pennsylvania

► Connects each patient with a Constant Caring ambassador, usually either a department head or nurse administrator, at admission.

► The ambassador will visit short term patients daily and long-term patients as often as the patient and family sees fit; ambassadors ask about their experience, scan the room for issues, and build relationships with patients and families.

► Ambassadors will report back the challenges and solutions they identified at team meeting every morning.

► The program has helped patients and families feel more connected to staff and equipped staff to proactively identify service issues.

Source: HCF Management, Inc., Lima, OH; Post-Acute Care Collaborative interviews and analysis.
Patient story booklet helps identify unique needs

Giving patients an outlet to express their preferences

**Patient preference booklet process**

- **Patients express what they value via a standardized question set at admission**
- **Staff translate the list into a booklet that stays with each patient**
- **Staff**
  - Adds goals to book as they change
  - Uses book as a way to express themselves between visits through journaling or drawing
  - Checks book at start of each visit
  - References document to start discussions and develop ideas for activities the patient would enjoy
- **Patient**

**Questions asked at admission**

- What activities that you currently are able to do bring you the most joy?
- What is something you used to enjoy doing but are not longer able to?
- Who is it most important that you stay in touch with at this time?

Source: Post-Acute Care Collaborative interviews and analysis.
Jamesway Health

- Network of community-based hospice, palliative and home health care services

- Focused on helping patients achieve their personalized care and lifestyle goals during the last months of life.

- Creates a story booklet that stays with each patient, in which they can draw and write what they are feeling and what they want help with.

- Staff refer to the booklet during each visit and use it to spark conversation and identify new ways they can make the experience better for patients and families.

1) Pseudonym. Source: Post-Acute Care Collaborative interviews and analysis.
Engaging patients and families in improvement efforts

Experience advisory councils give consumers a voice

Spaulding Rehabilitation Hospital Cape Cod’s patient and family advisory council (PFAC)

- Group made up of 9 patients and family members, 8 staff
- Meets at Spaulding every month for 90 minutes
- Spends time brainstorming how to improve the care experience
- Gives feedback to staff on potential new initiatives

Sample experience council projects

- Determining how to make patients and families feel more welcome at admission
- Helping translate clinical and quality information into patient friendly terms
- Providing input on upcoming renovations and facility design
- Developing new marketing material
- Starting new interest groups or programs for patients and families

Source: Spaulding Rehabilitation Hospital Cape Cod; Cape Cod, MA; Post-Acute Care Collaborative interviews and analysis.
Spaulding Rehabilitation Hospital Cape Cod

- Specialty rehabilitation hospital located in Cape Cod, MA
- Part of Partners HealthCare system

- Founded a Patient and Family Advisory Council (PFAC) to solicit feedback about the experience from staff, patients, and family members.
- The council, which consists of nine patients and family members and eight staff representatives, meets monthly for 90 minutes.
- Each meeting focuses on determining new ways they can improve the experience—through brainstorming sessions, giving feedback to staff on their initiatives, and breakout working groups.

Source: Spaulding Rehabilitation Hospital Cape Cod; Cape Cod, MA; Post-Acute Care Collaborative interviews and analysis.
How to run an effective experience advisory council

1. Establish a council structure
   • Set an agenda for each meeting
   • Use time to discuss problems, develop collaborative solutions
   • Focus on a new project at each meeting

2. Recruit staff, patient, and family advisors
   • Recruit from your existing base of volunteers
   • Host an information session for prospective advisors

3. Orient new volunteers
   • Help new volunteers understand the purpose of the council
   • Teach advisors how to contribute productively to the group

4. Lead effective meetings
   • Set an agenda for each meeting
   • Use time to discuss problems, develop collaborative solutions

Based on the setting you work in and ability level of your patients, determine if you should start a:

- Patient/resident council
- Family council
- Patient and family council

For step by step guidance
Access Four Steps to an Effective Experience Advisory Council at advisory.com

Source: Post-Acute Care Collaborative interviews and analysis
What will you commit to changing TODAY?
What type of experience will you provide?

Senior leaders must set tone, guide organizations toward a practical goal.

Setting a vision for the patient and family experience

- What would the ideal patient and family experience look like?
- What roadblocks are in the way, and where should I focus?
- How do I set a clear vision and keep my staff on track?

Source: Post-Acute Care Collaborative interviews and analysis.
Set an effective vision for your organization

An opportunity to reflect

1. “Top five” experience priorities

Example:
I want each patient and family that we care for to be:
• Greeted personally by me at the door
• Responded to within 10 minutes

2. Vision statement

Example:
We will provide a care experience that eases stress and makes patients and their loved ones feel comfortable throughout their stay with us.

Main points to consider when writing your statements

Think about the patient and family perspective—what is most important to them?

Be practical. Recognize the constraints we’ve talked about throughout the day.

Source: Post-Acute Care Collaborative interviews and analysis.
A sliding scale from provider- to patient-driven

Not a choice, but a continuum

Provider-driven organization

Balance will depend on:

• Specific patient or family requests and preferences
• Health of business, ability to fulfill personalized goals
• Vision you set as an organization

Patient-driven organization

Source: Post-Acute Care Collaborative interviews and analysis.
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