Patient and Family Engagement

Design in Management Final Project
Weatherhead School of Management
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MAY 25TH, 2016
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Executive Summary

The project report contains all of the information needed to address University Hospitals’ problem with patient and family engagement, specifically oriented around the Patient and Family Advisory Councils (PFAC). A starting background necessary to fully understand the situation leads into the identification of the problem and potential solutions, this leads into further iterations of the solution culminating in the final product and its significance to University Hospitals.

Health systems see value in Patient and Family Engagement, however University Hospitals is not yet structured to realize the full potential of partnering with patients and families. In order to maintain a reasonable scope we focused on the PFAC groups and their interaction with the University Hospitals system. The disconnection between the current University Hospitals organizational operations and the PFAC groups led to a diminished impact and a false sense that they were addressing the problem properly.

In order to correct this disconnect between University Hospitals and patient and family engagement we propose a multi-channel system for engagement built to address three deficiencies: Communication, Governance, and Implementation. These three things were used as the pillars to build a better system of engagement, they were discovered through our research process consisting of interaction with current PFACs and University Hospital employee surveying. This system is the sum of smaller systems, as the individual channels could not be addressed with one overarching system. As the sum of smaller systems this will allow University Hospitals to slowly integrate them piece by piece into their system, choosing which they feel is the most critical to development of the their patient and family engagement system.
University Hospitals was one of the first hospitals to pioneer a council of patients and their families in order to gain insight into their experiences within their different departments. While early on it was considered a success, and the Seidman and Rainbow groups are still impactful, as a whole the rest of their PFAC groups have failed to deliver as big of an impact. As University Hospitals has evolved since the creation of these groups the groups have lagged behind slowly increasing the disconnect between the hospital and the once impactful PFAC groups. However just as the hospital evolved in a different direction for years the current landscape has shifted the focus back onto patient experience.

The recent change of incorporating HCAHPS scores, which are a patient driven metric about their experience and the quality of service, has forced hospitals to focus on incorporating patient feedback into their daily operations. This is where we found the disconnection for University Hospitals.

*Health systems see value in Patient and Family Engagement, however University Hospitals is not yet structured to realize the full potential of partnering with patients and families.*

These new shifts in the landscape have left University Hospitals in a precarious position where the disconnection between patients and family has a more pronounced adverse effect on their organization.
management in the organization. Inquiries to employees and staff at University Hospitals about PFACs often led to an acknowledgement of existence yet no interaction or knowledge of their use.

**Why Focus On PFACs?**

The Patients and Family Advisory Council provides a crucial link between the hospitals operations and the people they serve. This link provided our team with a great opportunity to enhance and exploit this link in order to gain valuable insight without giving patients too much responsibility. One of the biggest concerns from caregivers and hospital staff about empowering patients and family was that they had a highly localized viewpoint in the sense that they don’t understand the daily operations of the hospital.

**For Patients and Family:**

The ability to have their voices heard and to increase the quality of care at University Hospitals are huge factors. Hospitals are not usually a place you go once in your lifetime and when you do go the process should be as seamless as possible in order to most effectively treat patients. Thus the ability to improve the hospital to better satisfy patients’ quality of visit is intrinsically valuable. University Hospitals’ management unfortunately cannot have extended conversations with everyone at the hospital which can make the suggestion process feel like their ideas fall on deaf ears. The PFAC group aims to extend that reach of management in order to help patients feel more encouraged to give suggestions as the don’t “fall on deaf ears.”

**For Caregivers:**

Caregivers in a hospital are often very busy and do not have enough time to individually try to improve the University Hospital system. They however do innovate on a very local scale (patient to patient basis) the time restraint restricts them from pursuing these innovations further and the innovation leaves the hospital at discharge. The ability to help standardize processes that patients want will allow them to be more receptive to patients, the PFAC will be the group to further flesh out their ideas and help them become hospital procedures. The PFAC, with its mix of patients, family, and hospital staff, alleviates the concern about patients having too much control over operations and thus instituting processes that are infeasible.
For Management:

The reimbursement tied to HCAHPS has dictated that patient and family engagement is vital to long-term success of a hospital. The voice of the patient often isn’t loud enough to reach up the top levels but the PFAC allows them to be heard through a controlled manner that allows their voice to be incorporated but not control new hospital procedures.

Design Research

Methods used, approach taken

Framing the Problem

While framing the design challenge is more art than science, and we had to establish it in the realms of a paradox, there are a few key things that we keep in mind. One: Did the challenge drove us toward ultimate impact: Patient Experience. Two: Did it allow for a variety of solutions, and take into account context? We further refined it until it was the challenge we could understand and get excited about to tackle. Below are broadly the steps we took while framing the challenge:

STEPS

1. We took a stab at writing our design challenge again. It would have to be short and easy to remember, a single sentence that conveys what we wanted to do. We tried to phrase this as a question that would set the team up to be solution-oriented and would generate lots of ideas along the way.
“PFAC’s are used to reactionary measures to address poor performance (HCAHPS scores) when PFAC’s by their very nature should be a proactive measure against poor performance”

2. Properly framed design challenges drive toward ultimate impact, allow for a variety of solutions, and take into account constraints and context. We tried articulating it again with those factors in mind.

“Are the PFAC’s well-structured to realize the value expected of them?”

3. Another problem when scoping the design challenge was whether we were going too narrow or too broad. A narrowly scoped challenge won’t offer enough room to explore creative solutions and a broadly scoped challenge won’t give you any idea where to start.

4. Once we have run through these filters, a quick test we ran is to see if we can come up with some possible solutions in just a few minutes:

For Ex: Loaning some members from Seidman PFAC to other PFAC’s to see if we can replicate their success,

**Interviews**

Interviews were an important part of the Discovery phase. Human-centered design is about getting to the people you’re designing for and hearing from them in their own words. All the interviews were conducted in the interviewee’s space i.e. at UH. We tried to capture as many anecdotes and experiences as possible while conscious of understanding the relationship between patient engagement and patient experience. The interviews were conducted for a number of caregivers in the healthcare continuum and include Seidman MDs, head nurses, bedside nurses, and leader (Dr. Julian Kim-CMO). The format used for the interview was developed in close association with project sponsor, Chrissie Blackburn and looked like this:

Basic Questions for members and non-members:

1. Have you heard about Patient and Family Advisory Council are also known as PFAC?
   a. If yes,
   b. How did you hear about them?
   c. Have you ever experienced a PFAC meeting or met a PFAC member? (How was your experience)
2. What do you think the goals of a PFAC are?
3. Do you know who participates on the PFAC?
4. Do you know how to get in touch with a PFAC to share initiatives and ideas?
5. Do you know about any changes initiated by a PFAC?
6. What do you think patient and family engagement means?
7. What questions do you have about PFACs or what would you like to know more about them?

Providers:
1. Have there been any changes in how you provide care as a result of patient and family feedback?
2. What other ways do you use to solicit feedback from patients and families?
3. Do you have concerns about working with PFACs?
4. In what ways do you think PFAC’s work can contribute to your job?

Management:
1. In what ways do you think PFAC’s work can contribute to your job?
2. How are patient and family engagement initiatives implemented and who drives them?
3. What other ways do you use to solicit feedback from patients and families?
4. Do you have concerns about working with PFACs?
5. How does Patient and Family engagement contribute in decision making within the organization?

Patients and Family members:
1. How do you communicate your ideas and feedback to the organization? (Members and no members)
2. Tell me about an experience where you felt engaged as a patient and/or family member in UH? (Members and no members)
3. How actionable are items discussed in PFAC meeting? (For members)

Definitions:
1. A Patient and Family Advisory Council is a formal council made up of current and former patient and family members, also known as patient and family advisors, within a hospital. The council is also made up of hospital administration. They meet regularly to discuss new ideas and initiatives to improve patient experience, safety, and quality.

2. A Patient and Family Advisor (PFA) is a current or former patient or family member of the hospital, who goes through appropriate interviewing, training, and volunteer services to partner on PFACs and other hospital committees. They are loyal to the organization and want to see it be the best it can be. PFAs have multiple experiences, with a careful balance of negative and positive.

3. Patient experience is the perception of care across the continuum.
4. **Patient and family engagement** is actively engaging patients and families in policy and protocol at the point of care on patient and family advisory councils, and at governance levels. It is a set of behaviors by providers, provider organizations, and patients and families to enhance quality, safety, and patient experience.

**PFAC Meetings & Group Sessions**

As part of its research, the team also attended a regular PFAC meeting anchored by the MedSurg department of UH and later held a larger conversation session with joint PFAC members from different departments. The purpose of these sessions is to validate consistency of feedback across different stakeholders and also gain critical insights on the PFAC process in UH. Much of the recommendations are sponsored by the unique insights gained by the team members during their meeting with different stakeholders.

**Visualization**

We’re strong believers in visualization—whether it was with a pen or a quick sketch, a graph, or a timeline, all of these examples were a fantastic way to keep a record of our research. We also used visualization to organize our thoughts visually and generally spur ideas and conversation in a different way than talking. For example, we took turns to draw everything we learned in the meeting, or map out all the functions that we could recognize. These visualizations and journey maps are sequentially highlighted in the process book attached with this document.

**Other Research Methods:**

We referred the Press Ganey¹ surveys and the key insights highlighted in such surveys on patient experience. Below is an important excerpt from an interview² done with Dr. Merlino from Press Ganey:

“If you look at relationships with customers where is it more personal than in healthcare? There’s no place. But yet we are in the ultimate service delivery business where the customer is not always right. We have to do things to patients that they don’t like. We create pain, we cause suffering and so we have to design our

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¹ [www.pressganey.com](http://www.pressganey.com)

processes around delivering high service but at the same time engaging those customers so that they understand that it’s not just about when there’s a service failure it’s layering on something nice and new. It’s being able to communicate, have the discussion, helping people to understand what’s going on. So, I think the complexity of our service interactions is greater in healthcare. And what I would say to private industry is that you can learn from healthcare, because when we do this well, we manage to say no in a much better fashion than I think a lot of industries are capable of saying no at.

I think it’s first asking the question: What do you want the experience to be? What kind of organization are you? Ask your employees, ask your customers and you’ll identify and pinpoint. You’ll identify their wants and desires. Number 2 I think it’s using data to understand where you’re at. It’s measuring what does the current state look like? And then number 3 – how do you execute? So you know that this is where you want to be. You agree that we’re going to make the customer or patient a strategic priority. We understand our data. So ask the question how do we execute? What are the processes that we need to put in place? What are the best practices that we need to adopt? How do we create training programs to make sure that our people are aligned around our customer? How do we incorporate talent management strategies so that we’re getting the right people into our organization that adopts our values and our mission that are driving our culture? So I think you can approach it from a very practical business perspective of really laying out almost a business plan to develop a strategy to develop a great customer experience.

**Question Posed to Merlino:** ...how do you turn your customers or patients into advocates? How does social media play into this? How does just pure and simple word of mouth work in a healthy customer experience environment?

**JM:** I once read something that providing a great customer service or patient experience is about doing nothing wrong and a few things really well. So I think it’s about really operationalizing your process and making sure that you’re doing things well. You’re not making any mistakes. That’s the first step. But then it’s understanding along that journey as customers, or in our case patients, as they march through healthcare what are the critical tactics? What are the critical touch points that are really going to get them walk away that they’re carrying the brand with you? What are the wowing experiences? What I think are the wowing experiences in healthcare for instance is number one how we communicate. Does the patient and their family have a clear understanding of what’s going on? What are the next steps? Do they feel like when we did communicate with them that we cared? That
we drove compassionate care? Do they feel like the care was connected? So I think communication is probably a critical tactic in healthcare to drive great experiences.”

How Might We:

By defining themes and insights, we tried identified problem areas that pose challenges to effective patient experience. Reframing our insight statements as How Might We questions to turn those challenges into opportunities for design. We use the How Might We format because it suggests that a solution is possible and because they offer you the chance to answer them in a variety of ways. While the How Might We session doesn’t suggest a particular solution, but gave us a frame for thinking in the right thinking.

PR
System of Engagement

Our product consists of an integrated system formed by 3 main parts, a system of engagement, a governance model that facilitates decisions and a project implementation support model.

**Getting Patient Feedback:**

The research insights especially from the stakeholders’ feedback showed that the information recollected from patients had to be meaningful and represent the diversity that University Hospitals serves. The perception of Patient and Family engagement through PFACs is defined by the quality of input, quality meaning, diverse, current and impactful.

Shown below are the tools that will facilitate the interactions throughout the care continuum between caregivers and patients and families. This new system of engagement for patients gathers suggestions, comments, ideas and recognitions from patients and families about their interactions with UH. Patients and families can submit this information at the point of care and through My UHCare. After this information is submitted, PFACs manage to synthesized and communicate according to priority metrics, the most meaningful and actionable feedback.
**Engaging the Staff:**

In addition, our research showed that this recollected feedback should also be synthesized in order to be implemented in patient experience projects developed by University Hospitals’ staff. UH current and future innovations that impact patient interactions and experience should integrate an appropriate number of iterations of patient feedback. Currently, internal innovations are eager for meaningful and impactful feedback however there is no defined channel that would facilitate this process, this is why we create a patient feedback protocol for UH projects.

The new protocol should be integrated within the best practices of University Hospitals’ project management. First of all, we created a web portal that can be placed in the intranet of the employees, this portal will facilitate the communication between employees seeking for patient feedback and PFACS from the related area of interest (this may require not only one PFAC but also the collaboration among a few). In addition, this portal will also grant visibility and awareness to PFAC projects and initiatives which will encourage collaboration and participation of UH staff.

On the other hand, PFAC members’ interactions will change from meetings to PFACs in action. That is, PFAC members will be trained in Human-centered design methods in order to empower them with tools that will enhance their work such as problem statement, gathering insights and prototype in this way they will also represent the culture of Innovation of University Hospitals.

PFACs in action: Providing co-creation tools and space to PFACs and employees that will ensure the exercise of meaningful interactions converted into insights.
**GOVERNANCE**

In order for this project to be successful, it has to be a collaborative effort between different areas of the organization. Starting with the patient experience department, innovations department and quality department. Although it sounds challenging, by creating a centralized steering committee University Hospitals will encourage a system that facilitates decision making and grants accountability to PFAC members and UH employees involved in the co-creation of projects.

The two main principles to be implemented are:

1. PFACs become the filter of Patient and Family input as well as the point of contact to integrate this input into UH projects.
2. Integrate other sources of patient feedback such as HCAHPS comments.

**IMPLEMENTATION SYSTEM**

When we talk about implementation we are framing and measuring the integration of patient and family feedback. First of all, we took into consideration that the volume of input from patients could be significantly large and not all of it actionable and meaningful. In order to synthesis the information gathered from patients, University Hospitals could develop a number of categories to group the ideas according to the area of interest of the hospital operations, the frequency and volume of input. Afterwards, a Pareto analysis will help to identify patterns, identify real-time issues and understand drivers of satisfaction and recommendations.
The implementation of the system will have two parts:

1. Visualization and analysis of the data:

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency/Quantity</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room</td>
<td>75</td>
<td>26%</td>
</tr>
<tr>
<td>Visitors &amp; Family</td>
<td>47</td>
<td>40%</td>
</tr>
<tr>
<td>Discharge</td>
<td>37</td>
<td>65%</td>
</tr>
<tr>
<td>Overall Assessment</td>
<td>28</td>
<td>75%</td>
</tr>
<tr>
<td>Tests &amp; Treatment</td>
<td>24</td>
<td>95%</td>
</tr>
<tr>
<td>Nurses</td>
<td>22</td>
<td>100%</td>
</tr>
<tr>
<td>Meals</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>Admissions</td>
<td>20</td>
<td>83%</td>
</tr>
<tr>
<td>Physician</td>
<td>16</td>
<td>80%</td>
</tr>
<tr>
<td>Personal Issues</td>
<td>15</td>
<td>76%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>305</strong></td>
<td></td>
</tr>
</tbody>
</table>

2. Each PFAC will have a project champion that will track and communicate to members about the status of the projects during the implementation process.

**Supporting Argument**

"Understanding patients’ social, cultural and emotional needs, in addition to their clinical needs, could improve care and reduce claims." — Press Ganey

Input

Clinical Care

Output

To Heal
To Discover

PFAC = Filter
P&F Suggestions

Medium to have more/almost all patient and family members engaged

Communication cycle and patient engagement

Emotional
Cultural
Social
Clinical

Iliess
Dx
Px

How do we incentivize people to respond?

Capture a better representation of population

Building a Relationship
Building TRUST

Input

Patient Experience

Output

To Heal
To Discover

Input

P&F Engagement

Patient Experience

How do we incentivize people to respond?

Capture a better representation of population

"Understanding patients’ social, cultural and emotional needs, in addition to their clinical needs, could improve care and reduce claims." — Press Ganey

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Clinical Care

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Clinical

Iliess
Dx
Px

How do we incentivize people to respond?

Capture a better representation of population
Business Case

The Centers for Medicare & Medicaid Services (CMS) implemented hospital quality incentive and penalty programs as part of the Affordable Care Act, and they are the starting points for transitioning to value-based payment. Not only do the programs affect hospitals’ bottom line, but they also could affect their market position because of the transparency of results. Thus, creating an effective strategy to succeed under these programs is important. The CMS quality-based and value-based incentive and penalty models will collectively put up to 6% of hospitals’ Medicare payments at risk by 2017. The three CMS programs are the Value-Based Purchasing (VBP) program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Conditions program. As part of healthcare reform, these programs are designed to transition hospitals to more value-based reimbursement by incentivizing or penalizing providers on the basis of their performance on certain quality metrics. These three programs reflect a fundamental change in how Medicare reimburses hospitals for services and in how hospitals manage and monitor quality performance.

The VBP program is technically a payment redistribution program in that eligible hospitals contribute a set percentage of base operating payments to a VBP payment pool; the percentage is 1.75% for fiscal year 2016 and 2% for fiscal year 2017. This VBP payment pool is used to provide a bonus to hospitals for performance on the VBP criteria, which are grouped into the domains of process of care, outcomes, patient experience, and efficiency. Thus, all hospitals pay into the pool, and if they do not perform well, their bonus could be less than the amount of their contribution—and a net penalty will be incurred. On the other hand, hospitals that perform well receive a payment that is more than the amount they paid in—and therefore will receive a net bonus.

Ignoring the CMS quality programs may soon result not only in the penalties stemming from CMS reimbursement, but also in patients selecting other hospitals with better performance under these programs. All hospitals should understand how their performance and the transparency of results affect their reputation and the value they deliver. As hospital quality metrics become easier to access, potential patients will have the opportunity to comparison shop, and will choose the hospital that they feel will

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provide them with the positive patient care experience they desire. Thus, hospitals need to focus on patient experience with care—because it may drive patient volume more than technical acumen alone.

Final Thoughts

Still, there is a great divide between what hospital and health system leaders think would positively impact the patient experience versus what patients report as their top choices for improvements. A 2012 Health Leaders Media survey asked hospital executives about priorities for improving the patient experience. The top recommendations were interactive bedside computers, quiet time to ensure rest, new facilities, private rooms, and food on demand. In contrast, the results of ongoing CMS satisfaction scores reveal that what patients desire most are cleaner rooms, friendly staff, greater respect, improved communication, and attentiveness to their needs and concerns.\(^5\) According to Health Leaders Media, 92% of healthcare leaders rank patient experience among their top three priorities, but only 56% report that delivering what the patient values is part of their patient experience program. All too often, hospitals and health systems don’t have the necessary level of insight into patient’s feedback to make informed and effective improvements. Moreover, over the next three years, only 30% of healthcare leaders expect to focus on instituting a system to learn about more about specific patient needs.\(^6\) While the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey provides hospitals with some information, it’s usually six to eight weeks behind. Collecting and analyzing data through feedback cards and My UHCare are two straightforward ways to gain real-time insight into patient perceptions. For healthcare organizations to make a real impact on the patient experience, they must first identify exactly what patients find to be the most important aspects of their care. When healthcare leaders fail to design their patient experience strategies around the needs identified by their patients, value suffers.