RURAL HOSPITAL

Patient and Family Engagement

2021 TOOLKIT

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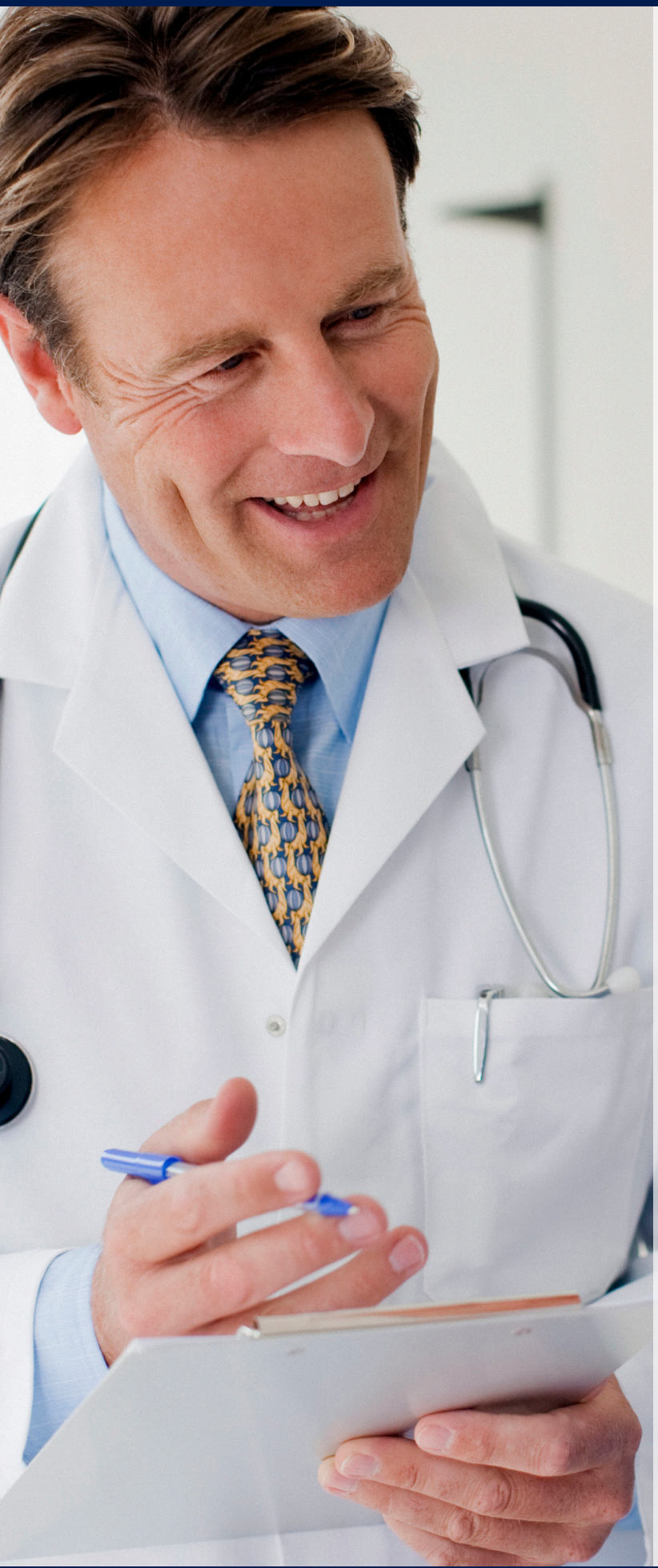
Colorado Hospital Association



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Background

The Communication Climate Assessment Toolkit (C-CAT) is an assessment tool developed by the University of Colorado Center for Bioethics that has been validated in a variety of health care settings throughout the United States. The C-CAT consists of a coordinated set of patient, staff and leadership surveys, as well as an organizational workbook. The survey assesses nine communication domains: leadership commitment, data collection, community engagement, workforce development, individual engagement, cross-cultural communication, language services, health literacy, and performance evaluation. Each of these domains contributes to the overall assessment of an organization's communication climate and have been found to be significant predictors of quality of care and trust.[1] Between 2018-20, C-CAT surveys were done in rural hospitals in Colorado to understand the impact of the communication climate of rural hospitals on patient and family engagement (PFE). The results of those surveys guided the creation of this toolkit, which focuses on four domains of the C-CAT surveys which rural hospitals can specifically address to improve PFE.

Summary of Key Findings

The C-CAT analyses revealed important insights that can help inform rural hospital leadership as they seek to develop PFE practices that are valuable for patients, families, staff, and the organizational culture. While hospitals nationwide tend to score highest on the leadership domain compared to the other domains, several rural Colorado hospitals struggled with leadership commitment to PFE. Leadership engagement includes commitment by all leaders to improve PFE in multiple domains, as well as a commitment to provide resources dedicated to improving communication and trust in the hospital. One pattern among Colorado's rural hospitals was a discrepancy between how leaders rated their own engagement compared to how staff rated leadership engagement. Leaders consistently reported they had taken steps to create a more welcoming environment for patients, as well as reward staff that worked to improve communication. Yet less than one third of staff agreed with those same statements. Although leadership may strongly support PFE, focusing on a few targeted improvements could make that commitment more tangible and recognizable by staff and patients.

Results revealed additional discrepancies between responses of leadership, patients, and staff. For instance, one team of executive staff affirmed the existence of a policy for staff members to ask patients to repeat instructions. Further, they reported that the process currently functions well. Yet, only one third of patients in that hospital reported that their doctor asked them to repeat instructions. Examples such as this were common, even among high-performing hospitals. The results indicate that hospitals may be implementing the appropriate policies, procedures, and trainings that emphasize PFE but are not evaluating the performance of these measures once they are in place.

Given the discrepancies in the responses to the executive, staff, and patient surveys, it is not surprising that all hospitals consistently scored lowest in the domains of data collection and evaluating performance. Although hospitals nationwide struggle with these domains, the C-CAT revealed Colorado hospitals scored lower on the data collection domain compared to hospitals nationally.

Summary of Key Findings continued

Data collection and evaluation are essential for guiding improvements and ensuring that improvement efforts are monitored for success. Hospitals have invested tremendous time and effort into establishing patient and family engagement councils (PFACs) and developing policies to better engage with patients, but without consistent data collection and evaluation, hospitals cannot ascertain the impact of these efforts.[2,3] In a survey of 22 Colorado hospitals on PFE practices, half reported that they did not use metrics to track implementation of PFE strategies. Improvement efforts cannot be refined without proper evaluation.

This lack of evaluation may also play a key role in patients' lack of access to language services, the other domain in which hospitals consistently scored poorly. Access to interpreter services allows patients whose preferred language is not English to understand and navigate their hospital experience. The absence of these services prevents these patients from effectively engaging with their care and their providers.[4,5] Although many hospitals offer interpreter services, both patients and staff report that they are frequently not able to access those services due to extensive wait times or that the quality of these services is poor. Hospitals have taken the time and resources to set up services they know their patients need, and yet a large gap remains. Results from the C-CAT surveys show rural hospitals in Colorado consistently falling below the national average in language services, suggesting that both patients and staff are impacted by the difficulty in accessing these services and assuring the quality of these services. At the most fundamental level of care, patients will not be able to trust the care they are receiving if they cannot communicate effectively, or at all, with those providing the care.

This toolkit provides key strategies to improve upon efforts to address the domains in which hospitals struggle the most, including leadership commitment, data collection, evaluation, and language services. Although not all domains are addressed, the strategies for improving in each of these domains overlap. For example, language services cannot become commonplace without leadership commitment to such services and those services cannot be improved upon without proper evaluation. Further, focusing on these four domains is likely to impact other initiatives in the hospital setting. For example, the data collection domain focuses on a need to standardize the approach to collecting patient demographic data, which will aid any hospital working on the Hospital Quality Incentive Payment (HQIP) program metric focused on reducing peripartum racial and ethnic disparities. By focusing on these key domains, hospitals will be able to take the essential steps to build trust and support a successful communication climate.

Domain: Leadership Commitment

Leadership commitment to PFE can encompass many elements and is an essential piece of effectively engaging with patients and families and transforming care in the process.[6,7] Many guides on PFE emphasize leadership engagement as an essential element.[7–9] For instance, in Leading a Culture of Safety: A Blueprint for Success from the American College of Healthcare Executives and the Institute for Healthcare Improvement (IHI) Lucian Leape Institute, organizational culture is explored in depth as a way to improve patient safety in a variety of health care environments. A key strategy emphasized throughout this comprehensive guide is for the top leaders of an organization to set an organizational vision that embraces patients and families as key members of the health care team. Without leadership engagement it will be difficult or impossible to make changes in any other communication domain. In its analysis of six Colorado rural hospitals, CCAPS found a strong and significant correlation between the leadership domain in the C-CAT survey and hospital PFE scores, indicating improving PFE practices and leadership commitment to meeting the needs of the hospital's population are inextricably linked.

STEPS TO IMPROVEMENT:

C-CAT Survey Components:

- Prioritize communication by rewarding staff and departments that work to improve communication.
- Develop policies that make effective communication a top priority.
- Help staff create a welcoming environment by developing policies that increase accessibility, visiting hours, and patient-centric design, such as artwork.

TAKING ACTION:

A first step leaders can take to demonstrate commitment to PFE is to assess the current state of PFE across the organization and to transparently share the results of that assessment with their community. Hospitals that participated in the C-CAT survey took this critical step in improving their PFE practices. For hospitals that did not participate in the C-CAT, there are many resources for conducting internal evaluations of PFE practices.[10,11] Next, leaders must act upon their evaluation results; some actions they may take include: inviting patients and their families to provide input on the hospital's vision, committing to shared decision making in treatment plans, encouraging patients to share their stories at board meetings, and embracing the teach back method with patients.[8,12]

Additionally, Bokhour and colleagues[7] describe the following practices as essential to showing leadership commitment to PFE:

- Verbally expressing clear and regular support for PFE.
- Encouraging staff to take risks and think outside the box when considering what patients need.
- Modelling patient-focused care at every opportunity and encouraging other leaders to do the same.
- Involving other leaders in supporting PFE initiatives and allowing them dedicated time for such work.

RESOURCES TO EXPLORE:

- Addressing Consumer Priorities in Value-Based Care
- Family Centered Care Assessment Tool
- Advancing the Practice of Patient- and Family-Centered Care in Hospitals

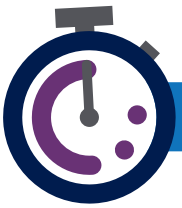
Domain: Data Collection

Throughout the United States, hospitals continue to struggle with health equity – ensuring that all patients have the opportunity to live healthy lives regardless of socioeconomic, demographic, or geographic characteristics.[13] Although many local, state, and national initiatives have aimed to improve health equity, it remains a persistent problem.[14] This has become even more evident during the COVID-19 pandemic, where race, insurance status, and income appear to play an outsized role in negative health outcomes.[13] Documenting accurate demographic data is a critical component of ensuring health equity. If a process is not being measured and tracked, improvements cannot be made. By systematically collecting this data, hospitals can identify clinical outcomes that may be impacted by health inequities and begin to work on addressing them.[15] Currently, electronic health records (EHRs) collect a limited amount of demographic data, and what is collected may not be accurate due to inconsistencies in collecting the data and the structure of the EHR itself.[15,16] By focusing on consistently and accurately collecting specific demographic data, hospitals can play an essential role in improving health equity for all patients.

STEPS TO IMPROVEMENT:

C-CAT Survey Components:

- Develop a process for asking about and documenting patients' race and ethnicity.
- Develop a process for asking about and documenting patients' language preferences and interpreter needs.
- Develop a process for asking patients if they would like help filling out forms.



TAKING ACTION:

Collecting demographic and PFE-focused data can support a wide array of initiatives. For instance, developing a process to collect accurate data on race and ethnicity can both improve how hospitals interact with patients and families and assist with other health equity initiatives, which are likely to be part of many value-based payment programs in coming years. Additional strategies for ensuring successful utilization of race, ethnicity, and language (REAL) data to make improvements in health equity include engaging senior leadership to prioritize health equity, defining and tracking goals for data collection and utilizing national, regional, and state resources.[17] For any quality improvement initiative, tracking the current process and any new changes put in place can allow for the detection of pain points and improvements that can be made. Further, collecting patient data such as language preferences can foster a deeper understanding of the hospital's patient population and what additional services might be offered in order to meet the particular needs of that population.[17] Lastly, as with all improvement initiatives, patients and families can be deeply involved in designing this process. They may assist in determining what data needs to be collected, how to collect it, and in interpreting the results to ensure these efforts are of the most value to the hospital's patient population and the community at large.[18]

RESOURCES TO EXPLORE:

- Improving Health Equity Through Data Collection and Use: A Guide for Hospital Leaders
- CMS: Building an Organization Response to Health Disparities
- IHI: Create the Data Infrastructure to Improve Health Equity

Domain: Language Services

Nearly 22% of Americans and 17% of Coloradans report speaking a language other than English at home, and several counties, including those in rural areas of the state, have a high need for interpreter services, yet do not offer those services.[19,20] Even when interpreter services are available, they may not be utilized.[4] Patients with limited English proficiency are likely to have trouble communicating with their health care providers leading to a number of health disparities and clinical complications.[4] Despite evidence showing that patients are less likely to experience negative clinical outcomes when using hospital interpreters compared to untrained interpreters (such as family members), physicians often forego the use of trained interpreters due to time constraints.[4,5] Language services overlap with many other domains in the C-CAT assessment. Language preferences need to be collected, language services need to be evaluated, and clinicians need to understand from leadership that these efforts are a priority. Additionally, language services appear to be strongly correlated with PFE practices.

STEPS TO IMPROVEMENT:

C-CAT Survey Components:

- Develop a process to ensure patients who needed an interpreter are always offered one.
- Develop a process to determine what documents need translation.
- Develop a process that allows staff to request translated documents.
- Dedicate an individual to coordinate interpretation services.
- Develop a policy that requires interpreters to be present for informed consent discussions.
- Create signage to be placed throughout the hospital announcing that the hospital offers free language interpretation services.

TAKING ACTION:

In addition to developing policies around language services, data collection also plays a key role in the improvement of language services. Although many hospitals provide basic language services, few hospitals ask every patient about their preferred language or track these services closely enough to monitor their effectiveness and make improvements as needed. The Robert Wood Johnson Foundation funded the "Speaking Together" quality collaborative that focuses on improving hospital-based language services and, among many suggestions, the collaborative makes clear the need to ask every patient their preferred language.[21] Additionally, they emphasize the importance of utilizing tracking measures to make rapid improvements in the availability and quality of language services. Metrics that may require tracking include: the frequency with which trained interpreters are used, how long patients wait for language services, and the frequency with which untrained interpreters or family members serve as interpreters.[22]

One C-CAT respondent noted that although they speak English at an intermediate level, they would still "like to have the info in Spanish to be sure about all procedures." Without asking, it would be impossible to know this patient's preference. Consider how this patient's care experience might differ if they were only given an explanation in English. Incredibly, the simple action of asking the patient about his or her preferences can promote engagement effectively. Further, frontline staff also want to be able to communicate effectively with their patients. One staff member specifically noted how much they would "appreciate if there were a designated place in the patient's electronic medical record to indicate the patient's preferred language." Focusing on language services can support two essential hospital missions: providing clinicians with the tools to effectively do their jobs and improving patient care.

RESOURCES TO EXPLORE:

- Speaking Together Toolkit
- Health Equity and Language Access
- Hospitals, Language, and Culture: A Snapshot of the Nation

Domain: Evaluating Performance

The concept of data can be daunting to many, perhaps eliciting nightmares of spending hours combing through charts or looking at reports of numbers that make little sense. Unfortunately, these nightmares are too often reminiscent of reality. However, data collection, monitoring, and evaluation are essential and do not need to be complex. Having an increased awareness of current work can make each initiative more successful by identifying barriers, providing feedback, and updating policies and procedures that might be causing roadblocks.[8] For instance, in the C-CAT survey, many hospitals reported providing interpreter services but few tracked whether those services were meeting the needs of the patients and staff. Allowing staff and patients to weigh in on whether they received interpreter services when they requested them and to rate the quality of those services can allow hospitals to improve upon a service where time and money is already being invested, improving patient, family, and staff experiences.

STEPS TO IMPROVEMENT:

C-CAT Survey Components:

- Tracking the following metrics:
  - When errors occur because of miscommunication
  - Communication-related complaints
  - How well the hospital meets written goals for effective communication
  - Patient and workforce surveys that ask how well staff members communicate with patients
  - Clinical quality measures across demographic groups

TAKING ACTION:

As hospitals consider which metrics to track, they need to be aware of the current state of PFE in their organizations. Hospitals just beginning the PFE process may focus on a simpler process metric, such as patient and family participation in a PFAC or an outcome metric such as services provided to patients and families.[22] Regardless of where hospitals currently stand in the PFE process, the organization must commit that results will drive change.[23] Further, developing and collecting metrics is an important opportunity to involve patients and families. Involving patients and families in conversations around what metrics will best capture types of engagement, level of engagement, and outcomes of engagement will allow for more complete and comprehensive metrics.[24]

Another option is to utilize measures the hospital is already collecting to minimize the burden of data collection while still gleaning important insights.[24] If even current data being collected is difficult to access or harness for improvement, consider using a basic measurement that unit staff can track.[2] For instance, if your team is implementing patient and family centered rounds, consider having a nurse, physician, or someone else who joins rounds keep a tally of how many times patients and families join or ask questions during those rounds. At the end of rounds each morning, put up a chart on the unit of that tally. At the end of the week, it should be clear whether patients and families are joining the patient centered rounds. This is a great first step in assessing if the initiative is achieving its fundamental goal, involving patient and families in rounds.

RESOURCES TO EXPLORE:

- Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care
- Patient and Public Engagement Evaluation Toolkit
- Patient and Family Advisor Survey

Appendix: C-CAT Sample Survey Components of Additional Domains

More information on the C-CAT survey tool can be found **HERE**

Community Engagement

- Involvement in the local community
- Providing access to community resources
- Partnerships with local educational institutions to train staff in communication
- Hospital committees focused on community ties
- Policies/procedures to inform staff about community resources

Workforce Development

- Recruiting employees that reflect the patient community
- Effectively communicating with diverse populations
- Creating goals for recruiting staff from the community
- Developing policies for training employees on how to communicate with patients
- Providing reimbursement for communication training

Individual Engagement

- Getting patients more involved in their health care decisions
- Developing policies that support respectful behavior and engaging patients in shared decision making

Cross-Cultural Communication

- Talking with patients about cultural and spiritual beliefs that might influence their health care
- Communicating with diverse populations
- Providing training for hospital employees on serving patients from diverse cultural and ethnic groups
- Ensuring educational materials are reviewed for appropriateness

Health Literacy

- Communicating with patients in plain language instead of using technical terms
- Checking whether patients understand instructions

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