Healthcare for the Aging Citizen and the Aging Citizen for Healthcare: Involving Patient Advisors in Elder-Friendly Care Improvement

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Abstract

With an aging population and a healthcare system that is overly reliant on providing expensive and sometimes problematic hospital-based care for older Canadians, driving improvements that promote elder-friendly care has never been more critical. The Acute Care for Elders (ACE) Strategy at Toronto's Mount Sinai Hospital is the focus of a pan-Canadian collaborative delivered by the Canadian Foundation for Healthcare Improvement in partnership with the Canadian Frailty Network. The intent is to spread the ACE Strategy's elder-friendly models of care and practices to 18 participating healthcare delivery organizations. A key element of the ACE Collaborative is the inclusion of patient advisors as members of the 18 teams. This article considers the development of elder-friendly care models and practices, with lessons for patient advisors and organizations on the necessary skill-mix, as well as lessons for providers and managers on ways to more effectively engage patient advisors in health system improvement to better serve an aging population.

Introduction

While in hospital, older adults can face greater safety and quality of care concerns than younger patients, from falls and mobility loss to hospital-acquired infections and poor care transitions (Sinha et al. 2014a, 2014b). Screening for, and proactively responding to, the needs of frail, at-risk patients and focusing on enhancing care continuity and integration are among some of the ways the hospitals and the healthcare system can reduce risk, improve quality of care and lower costs. In 2010, Toronto's Mount Sinai Hospital (MSH) initiated its Acute Care for Elders (ACE) Strategy to increase its capacity for delivering elder-friendly care (Sinha et al. 2014a, 2014b; The Commonwealth Fund, 2016). In 2016, the Canadian Foundation for Healthcare Improvement (CFHI), in partnership with the Canadian Frailty Network (CFN), launched the ACE Collaborative. In total, 17 and 1 healthcare organizations (Box 1) in Canada and Iceland, respectively, are adopting the ACE Strategy evidence-based and informed approaches through the support of the 12-month quality improvement (QI) collaborative. All of the Canadian teams involve patient advisors working alongside physicians, nurses and advanced practice nurses, social workers, therapists, pharmacists and dieticians. The ACE Strategy and Collaborative provide useful lessons for healthcare organizations looking to partner with patients and for patients interested in participating in QI – all toward the end goal of capacity-building towards elder-friendly care improvement.

BOX 1.
Participating healthcare delivery organizations

1. Centre intégré de santé et de services sociaux (CISSS) Chaudière-Appalaches (Québec).
2. Geraldton District Hospital (Ontario).
3. Halton Healthcare (Ontario).
4. Hamilton Health Sciences (Ontario).
5. Horizon Health Network (New Brunswick).
6. London Health Sciences Centre (Ontario).
7. Montfort Hospital (Ontario).
8. National University Hospital of Iceland.
9. Nova Scotia Health Authority (Central/Western Zone).
10. Nova Scotia Health Authority (South Shore Regional Hospital).
11. Orillia Soldiers' Memorial Hospital (Ontario).
12. Queensway Carleton Hospital (Ontario).
13. Quinte Health Care (Ontario).
14. The Scarborough Hospital (Ontario).
15. Thunder Bay Regional Health Sciences Centre (Ontario).
16. University Health Network (Ontario).
17. Whitehorse General Hospital (Northwest Territories).
18. William Osler Health System (Ontario).

Spreading Elder-Friendly Care

The ACE Strategy at MSH is an approach to improve care for hospitalized older adults and those in the community at a high risk of future hospitalization. The ACE Strategy includes over a dozen evidence-based and informed interventions that span three broad areas:

- screening all older emergency department patients to provide those at the highest risk with additional support from Geriatric Emergency Management nurses;

- prioritizing high-risk medical patients to be cared for as part of an ACE care order set and, when possible, on a designated ACE inpatient medical unit customized to the needs of older patients (e.g., featuring low-height falls-prevention beds, opportunities for communal meals, encouragement for physical activity and night-time environments conducive to sleeping); and
- preventative and follow-up supports including post-discharge phone calls and more intensive short- or long-term home and community supports (CFHI 2015; Sinha et al. 2014a, 2014b).

At MSH, the ACE Strategy has led to real improvements for patients aged ≥65 years, including shorter hospital stays; improved quality and safety of care; a greater chance of returning home rather than to an institution such as long-term care; fewer readmissions to hospital; and improved patient and staff satisfaction (Sinha et al. 2014a, 2014b; Commonwealth Fund 2016). The strategy has also resulted in significant financial savings at MSH attributable to ACE – $6.7 million in fiscal 2014/2015 alone, largely thanks to a 23% reduction in the cost of care per patient, given that patients aged ≥65 years are being discharged more quickly.

Developing and rolling out the strategy is a team effort, led by the MSH Geriatrics Steering Committee, which includes patient advisors and further engages (external) home, community and primary care providers. The CFHI–CFN ACE Collaborative teams are taking their cue from this approach, each involving patients as members of their improvement teams, which was a requirement for participation in the ACE Collaborative. What was encouraging was that patient engagement was not a foreign concept to the participating teams; however, it was not something that the majority of team members had direct experience with. Indeed, the pre-ACE Collaborative survey of members of the 18 improvement teams found that:

- 48% (44/92) reported they had worked with patient advisors or representatives, e.g., on various committees;
- 31% (28/92) reported they were experienced in engaging patients and families in QI;
- 29% (27/92) reported they regularly seek input from patients, e.g., through surveys, interviews or focus groups;
- 18% (17/92) reported they rely on hospital compliments and complaints mechanisms to garner patient input; and
- 12% (11/92) reported they involve patients in organizational strategic planning.

Participating in this Collaborative offers teams an opportunity to strengthen their skills in working with and engaging patient advisors to advance elder-friendly care improvement.

Examples of Patient Advisory Roles and Skills

Patient advisors are patients, family or community members who bring valuable lived experience and perspectives – whether about their own care, the care of a loved one, or the functioning of the healthcare organization or system – to the decision-making in healthcare. Patient advisors can assist healthcare decision-makers to better understand what matters most to patients and families, and influence them in providing the best possible care. Generally, patients may serve roles in direct care, organizational design and governance, and policy making (Carman et al. 2013).

Thus far, within the ACE Collaborative, clear examples of involving patients and families either in direct care or in organizational design and governance activities have emerged. When it comes to direct care, the William Osler Health System has developed a patient and family booklet on delirium and functional decline, which includes an "All About Me" section, where patients can log information to share with their healthcare providers. Several organizations such as Hamilton Health Sciences offer the Hospital Elder Life Program (HELP), which includes highly trained volunteers – many of whom are caregivers – offering various supportive activities such as going for a walk or providing company during meals or engaging in conversation. When it comes to design, The Scarborough Hospital involved patient and family advisors in "waste walks" as part of Lean exercises to identify redundancies and improve efficiencies throughout the hospital; they also involved their advisors in developing information packages for patients and families about what to expect upon discharge from the ACE unit. At Queensway Carleton Hospital, the patient and family advisory committee reviewed and advised the design and plan for the newly built ACE unit.

Building from the experience of having patient advisors as members of the MSH Geriatrics Steering Committee, key advice has emerged that can help ensure success of patient advisors (Box 2). Arguably, this skill-mix is transferable to patient advisors working beyond elder-friendly care. Many ACE teams continually express a growing interest and need to specifically involve patient advisors who – in addition to the skills presented in Box 2 – bring lived experience as recipients of elder-friendly care, e.g., as an older adult, as a caregiver of an older adult or to shed light on hard-to-reach or high-risk populations (e.g., low-income seniors).

Advice for Healthcare Leaders and Providers

Patient engagement and empowerment is one of five areas of healthcare innovation the Federal Advisory Panel on Healthcare Innovation recommended that the federal government focus on to spur innovation in healthcare across Canada (Advisory Panel on Healthcare Innovation 2015). Emerging from the patient engagement literature is a growing body of evidence that suggests that patient engagement can lead to significantly

better health outcomes (Epstein and Street 2008), contribute to improvements in quality and patient safety (Coulter and Ellins 2007; Advisory Panel on Healthcare Innovation 2015; Baker et al. 2016), improve work satisfaction (Lavoie-Tremblay et al. 2014a, 2014b) and help better manage healthcare costs (Charmel and Frampton 2008). Involving patients is also a useful way to help them better understand the healthcare system and the complexities in providing care, while helping providers understand the perspectives of patients and families and their experiences in navigating care. Even with all these rationales, in practice, many providers, managers and patients and families struggle with how to devise meaningful patient advisor roles.

BOX 2.

Useful skills and advice for a patient advisor

- Believe in the value of a patient advisor role.
- Bring a positive attitude to discussions.
- Speak up and share suggestions and potential solutions to help improve care for others.
- Talk about both positive and negative care experiences and share your thoughts on what went well and how things could be done differently.
- Be a good listener and think about what others say, even when you disagree. Talk about your experiences as a patient or family member – but also think beyond your own personal experiences.
- Develop your health and healthcare literacy. It's important to be a student of your own health while also developing a growing knowledge of healthcare services and the system. If serving on a particular board/committee, then advisors should learn about its issues and direction, as well as the many acronyms that are frequently used – understanding the world *behind* the acronym makes one literate.
- Gain experience or training in group decision-making and situational leadership. Working well in a group setting is a valuable ability for patient advisors so their concerns and ideas are part of the decision-making processes. Understand that information you may hear as an advisor is private and confidential.

In an ACE Collaborative mid-point webinar poll of participating patient advisors:

- 6/7 reported their team was clear on their role as part of the QI team and worked with the clinical staff to develop new educational materials for staff and patients.
- 5/7 reported they had provided ideas and timely feedback to improve care or service delivery and reported that they regularly attend steering committee meetings.
- 3/7 reported their contribution keeps team members grounded in the reality of the patient/family members' experience.

Some of the conditions we have observed that appear important towards successfully setting the stage for true partnerships with patients/families – whether at the bedside, in the boardroom or in QI – are presented (Box 3).

BOX 3.

Tips on engaging new patient advisors

1. Provide all essential information in plain language prior to meetings, in the format that works best for the patient advisors.
2. Provide facilitator support in meetings and coaching for the new advisor, and develop a mentorship program for advisors.
3. Promote equality by using first names.
4. Be hands-on and engage patient advisors everywhere you are – at the bedside or in the boardroom.
5. Develop materials and consistent messaging to increase awareness of, and explain opportunities for, patients and families to partner in organizational design and governance.
6. Develop and implement standardized training programs that explain roles, outline expectations, and prepare patients and families for partnering with healthcare organizations, including helping them understand organizational structures, unfamiliar terms, quality improvement processes and how to effectively share their stories and input.
7. Provide training for providers – beginning with the basics of how to listen and engage with patient advisors.
8. Consider joint-training for patients and providers (learning together can help in understanding one another and build relationships). *This is a key finding from innovation panel case studies.
9. Determine the "engagement capability" of patients, providers and the system within which you work and consider how they can grow.
10. Measure the value of engagement.

Discussion/Conclusion

With an aging population comes the need to proactively plan and deliver elder-friendly care. Increasingly, patients want to serve a role in planning and evaluation, and providers want to help them do so. The ACE Collaborative presents some insights for enabling patients to take on a more active role and for healthcare leaders and providers to more effectively engage patients in their efforts to design and deliver elder-friendly care. Our early fieldwork is lending insights that are relevant beyond elder-friendly care. Importantly, this work contributes to a growing body of knowledge about involving patients and families in engagement for improvement (Baker et al. 2016; CFHI n.d.). Emerging evidence from other initiatives that focused squarely on partnering with patients and families in QI may provide greater insights into strategies for leaders, staff and patients in creating environments that support meaningful engagement and effective co-design. For example, Partners Advancing Transitions in Healthcare (PATH) involved "a community coalition of cross-sector providers and seniors/caregivers to redesign how care is delivered, addressing problems that were identified together" (Change Foundation n.d.), and a recently launched book, "*Patient Engagement – Catalyzing Improvement and Innovation in Healthcare*," profiling 10 case studies of co-design in practice and lessons for creating "engagement-capable environments" (Baker et al. 2016). HQ

Acknowledgements

The authors thank their colleagues at Sinai Health System, Canadian Frailty Network, Canadian Foundation for Healthcare Improvement and University Health Network, with special thanks extended to the 18 teams involved in the CFHI–CFN ACE Collaborative.

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The Canadian Frailty Network (CFN) is Canada's exclusive network for frail older adults. Funded by the Government of Canada through the Networks of Centres of Excellence (NCE), we facilitate evidence-based research, knowledge sharing and clinical practices that improve healthcare outcomes for frail elderly Canadians, their families and caregivers. CFN takes a collaborative and patient-first approach – with our industry, academic, care-provider and patient-advocate partners, we lead Canadian research, knowledge mobilization and training focused on the urgent care needs of this vulnerable population. See more at: http://www.cfn-nce.ca/#sthash.ZPpmCEo4.dpuf.

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