



2020

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Nicolas Hernandez
Northwell Health-Hofstra University

Alice Fornari
Northwell Health, Zucker School of Medicine at Hofstra/Northwell

Sage Rose
Hofstra University

Leanne Tortez
Hofstra University

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Recommended Citation

Hernandez N, Fornari A, Rose S, Tortez L. Implementing inter-professional patient-family centered plan of care meetings on an inpatient hospital unit. *Patient Experience Journal*. 2020; 7(1):84-91. doi: 10.35680/2372-0247.1379.

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Implementing inter-professional patient-family centered plan of care meetings on an inpatient hospital unit

Nicolas Hernandez, *Northwell Health-Hofstra University, nhernandez@northwell.edu*

Alice Fornari, *Northwell Health, Zucker School of Medicine at Hofstra, afornari@northwell.edu*

Sage Rose, *Hofstra University, Sage.Rose@hofstra.edu*

Leanne Tortez, *Hofstra University, ltortez@gmail.com*

Abstract

Inpatient plan of care meetings support efforts to encourage collaborative practice and patient-family centered care and result in an effective strategy to enhance communication and patient satisfaction. Clinical team members participated in patient/family centered plan of care meetings at a community hospital in a selected inpatient unit with full time hospitalist physicians. Quantitative data were gathered pre/post implementation from the external Hospital Consumer Assessment of Health Care Providers (HCAHPS) survey. HCAHPS data were collected independently, specifically for questions related to communication between patients, family members/guardians and the medical team and also the effects of care transition. There was a slow but steady upward trend in selected domains that reflected the standpoint of patients/families specific to patient communication and patient experience in care transition(s) during hospitalization. A greater upward trend was noted in the domain of communication with doctors. Qualitative data analysis revealed positive attitudes towards the plan of care meetings, and team members expressed concern regarding redundancy of information. Sharing amongst providers throughout the day identified a need for clearer criteria in patient selection for these meetings to maximize efforts and resources. A major concern was lack of direct feedback from the patient and family, the end users of the meetings. From this study, inter-professional collaboration in patient family centered care can be viewed as a positive aspect of efficient and innovative care delivery. More evidence-based research is needed to guide how inpatient hospital clinical care planning can be standardized to optimize the way in which patient family centered care can be supported by a collaborative coordinated effort among clinical team members.

Keywords

Collaborative practice, patient centered, patient-family centered, inter-professional, communication, inpatient care, HCAHPS, care transition in care and discharge planning

Introduction

Standardization of care in hospital medicine and patient-family collaboration in care planning are the aims of high-quality delivery of care from an inter-professional and collaborative practice standpoint. In 2001, the Institute of Medicine¹ promoted patient-centered care approach that respects patient values and preferences. Collaborative efforts in an inter-professional approach along with a patient-family centered partnership can achieve such a high value of effective medical care.

The American College of Physicians (ACP) has supported and advocated for patient and family centered models of care delivery. The ACP's Patient Partnership in Healthcare committee developed a set of principles that form a foundation for authentic patient and family partnership in care.¹ Of these principles, "*Patients and families should be active partners in all aspects of their care, and under this principle, patients and families should use decision aids, mutually*

agree on treatment goals, develop a shared agenda for visits and promote patient self-management."

In an era of an advancing age population, especially where many patients suffer from a multitude of co-morbid conditions which can complicate acute or chronic conditions, family members or advocates are essential to disposition planning and effective follow up to assure positive outcomes during their hospital course and upon discharge. 21st century models of delivery of health care, requires care models with a collaborative care practice mindset to ensure effective highest quality of care delivery.²

Patient centered care is acknowledged as an effective approach for providing high quality care across of a multitude of care settings.³ Inpatients' knowledge of their hospitalization is poor with respect to medications, diagnoses and plan of care according to available literature.⁴ Collaborative care with not only medical staff

but patient's loved ones could make a multifactorial impact on care transition and planning. Inter-professional concerted patient-family centered plan of care meetings allow opportunity for patients and/or family members to be active participants in treatment planning and goals. Chronic care, geriatrics, mental health and palliative care are areas where needs are complex, inter-professional teams have become necessary to provide full spectrum of care.⁵

Increased patient voice and engagement have been identified as an important approach to overcome barriers to patient safety, with patients and family members serving as valuable allies in the journey toward safe care.⁶ The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS, also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.⁷

The community-based hospital where this case study was conducted saw an urgent need for improved communication and patient care transitions based on external data and reports of past low HCAHPS scores specific to patient satisfaction.

A goal of the planned intervention was a new plan of care meeting that was implemented on a medical surgical floor designed to promote an improved model of communication among physicians, nurses and social workers with patients and families/advocates. The additional plan of care meeting included a "special" inter-professional team and addressed patient-family centered care plan delivery in preparation for discharge. Such meetings, using protected time and a location off the clinical care area, gives the patient, family member and/or clinical team member an opportunity to sit down and discuss the patient's current clinical status and next steps in care transition. Efforts focused on improving two deficiencies, patient/family communication with doctors and the transitions of care team.

The model of education supports an experiential learning component, described in the literature as "learning by doing."⁸ All the patient plan of care encounters experienced by the learners (medical students and resident physicians) who attended these meetings were followed by a brief reflection using problem centered approaches, which led to identifying what happened in the meeting and what could happen differently in future meetings. This resulted in collective learning among the team, which is congruent with the inter-professional stance and dynamics seen within collaborative practice and promotes socio-cultural learning in the experiential learning realm.⁸ This

framework positively supports clinicians and ultimately the patients and families.

Piloting and implementing the plan of care meeting-logistics

Setting

The community based 219 bed acute care inpatient facility where the pilot was initiated in a 24-bed medical surgical oncological inpatient unit. The project was supported by administration and the patient experience team. The chosen inpatient floor clerk, a consistent staff person, would offer the plan of care meeting to all patients and families/advocates on the inpatient hospital floor. Meetings occurred daily over a 3-month period. Patient and/or families would be invited to participate in a 15-30-minute session plan of care meeting, to increase communication about current clinical course, care plans and timely care transition/disposition planning. The meeting would be led by the attending hospitalist physician or nurse manager. The pilot was implemented in the 4th quarter of 2018, 1st and 2nd quarter of 2019, which included the months of October through May. The piloted inpatient floor had an average of 180 patients, of which 90 patients' care was provided by the health system's employed hospital medicine physicians. An average of 36 meetings a month were conducted, at 3 meetings per day with 3 meeting days a week. Present at the meeting were the patient, family member or advocates requested by patient, assigned hospitalist physician, senior resident physician, social work, nurse manager and case management RN along with family members/advocates as per patients' preference. If the patient was demented or unable to speak for themselves, his/her assigned health care proxy or guardian were present to represent the patient's best interest in plan of care. Reflective narrative data were obtained from members of the plan of care meetings to obtain their introspection with respect to the plan of care meetings noted in Appendix B.

Materials needed for the meeting

Participants met preferably in a private space such as family lounge that would be reserved for these plan of care meetings, or if necessary, at the bedside. A computer was used to access the EMR for any questions relevant to the patients' medical care up to that point. Sometimes a phone with speaker function would be used to call, at the request of a patient, for participants who could not physically attend these meetings. Some participants, such as social work or case managers, used notepads to write down notes from the conversation.

Outcomes for the Patient-Family Centered Plan of Care Meetings

For the quantitative analysis of this report we looked at the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)⁹ scores in relation to the 9-month

pilot intervention (quarterly assessment) to review pre-post data. From this data we could analyze which focused areas improved versus those that stayed the same or worsened prior to implementation of the plan of care meetings. The areas focused on for reporting of pre/post data were the care transition and physician communication areas based on external standardized hospital inpatient survey data (figure 3). In Figure 3, the horizontal axis represents quarters of the year in which Press Ganey was obtained and reviewed, the vertical axis represents the percent of participants that answered “always” in their survey responses for related measures, which included areas of care transition and communication with doctors domains. A gradual upward trend is seen in both physician communication and care transitions domains in the post data, as seen in figures 1 and 2 respectively especially in quarter 4 (Q4). In each of the figures (1&2), when comparing to the 2017 data, the 2018 data demonstrated an increased improvement percentile in these areas, which may reflect a positive impact from the implementation of these meetings (figure 3). As an example, in the doctors domain in figure 2, Q4 in 2017 has about 66% of respondents as compared to Q4 in 2018 when approximately 71% answered “always”, reflecting an improvement in doctor communication by nearly 5 percent in one year. Table 3 and Figure 3 have a more comprehensive view that looks at the overall data from

2017 through 2019; **pre data 1:** 1/1/2017 through 12/31/2017, **pre data 2:** 1/1/2018-09/30/18; and **post data** 10/1/2018 through 5/31/2019 when the plan of care meetings is piloted. Table 3 shows the statistical significance of both domains and their relative improved scores from the year prior.

For the qualitative portion, a multi-question semi-structured interview was made for the physician hospitalist, social worker and case managers who were involved in these plan of care meetings. Interviews were obtained in a narrative manner due to time and scheduling challenges, except one which was voice recorded and transcribed. Demographic data were also obtained (Appendix A) for 5 total interviewed participants. A summary of participant demographics may be found in Table 1. All participants interviewed, stated they were comfortable leading the plan of care meetings, which resulted in an average of 6.5 out of 7 on a Likert scale from 0, being not comfortable to 7, being very comfortable. Reflective narrative data were obtained from both surveys (Appendix A and B). Qualitative data were analyzed by the first author using a content analysis method that involved manual coding of the data to identify patterns. During the analysis, categories were identified, and a constant comparison method was used to refine the categories as needed. Categories that appeared across the majority of

Figure 1. Care transition data
(*Bold line data is 2018; thin line data is 2017*)

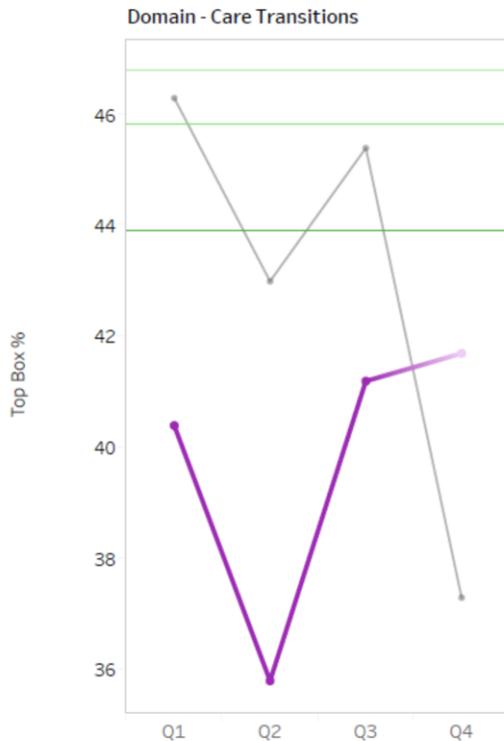


Figure 2. Communication with doctors
(*Bold line data is 2018; thin line data is 2017*)

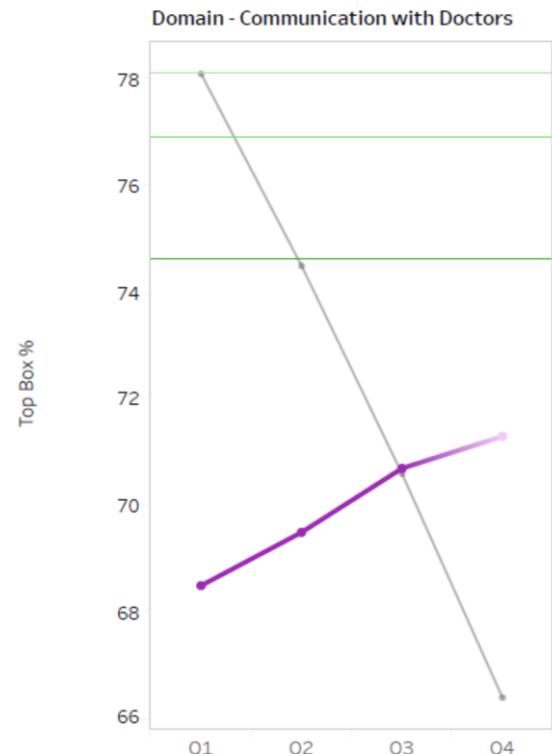
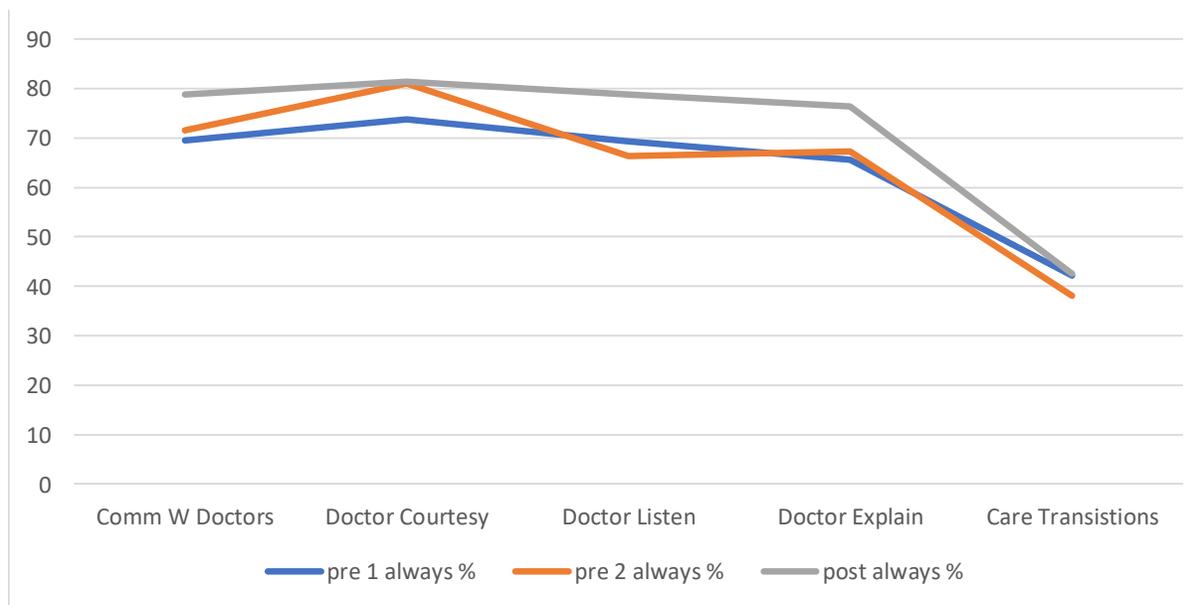


Figure 3. Domains graphed Pre 1, Pre 2, and Post - Percent of Always responses on doctor domains and care transitions



participants (e.g., 3 out of 5) were extracted as themes. The resulting themes were reviewed by the second and third authors. Table 2 presents a summary of major themes extracted from clinician responses who conducted plan of care meetings. Themes noted from responses to questions in Appendix B, specific to the patient family plan of care meetings, included: 1) positive experience for patients and families/guardians specific to care planning, which reflected a subtheme of an environment where a medical collaborative presence between patients and clinicians was supported. A second theme reported was redundancy in care planning amongst the team members, given this could be the third sit down meeting of the day amongst care collaborators and patient/families; therefore, a lot of what is being discussed can have multiple reiterations. Based on these comments a sub-theme of plan of care item repetition was time constraints and this additional meeting for clinical collaborators led to perspective of inefficient use of time. A third theme was criteria selection for patients and families requiring plan of care meetings. Subthemes included a need for a better selection process for patients/families and consideration of proper time investment and efficiency with respect to plan of care team members' time. Finally, the fourth theme of inadequate direct feedback on the plan of care meetings was addressed by some team members. Some respondents also expressed a lack of formal direct feedback by patients/families to team members on these meetings to help guide improvement of the meeting dynamics.

Discussion

Formalized clinician and patient and family plan of care meetings helps facilitate the need for timely and efficient care and disposition planning in the in-patient setting. A formal process as described in this intervention supports the ACP's position paper's committee recommendation that "Patients and families should be active partners in all aspects of their care," and under this principle, patients and families should use decision aids, mutually agree on treatment goals, develop a shared agenda for visits and promote patient self-management." Education opportunities could be sought to assure patients' diagnosis and management plan are understood by both the patient and extended family, friends or legal advocates. The positive outcome for patients and families must be valued by the clinical team.

The impact with respect to communication and generalized understanding of the care delivered can promote a sense of unity in the outcomes patient and family strive in their healing process. Communication and the patient experience, with the increased awareness in care planning and coordination, helps patients and their families better prepare for ongoing goals of care in care transition as seen in figure 1. High quality information sharing in terms of honesty, clearness and understandability, which is generally conveyed in ICU type settings¹⁰, can fulfill a need for a for an individual or loved one caring for the individual to feel cared for as the patient

Table 1. Demographics – Qualitative research participants (n = 5)

Variable	N (%)
Gender	
Female	4 (60%)
Male	1 (20%)
Ethnicity	
Caucasian	4 (80%)
Palestinian American	1 (20%)
Position	
Nurse	2 (40%)
Post graduate resident physician	1 (20%)
Attending hospitalist physician	1 (20%)
Social worker	1 (20%)
Work experience	Range = 3-20 years

and/or family member. This information sharing needs to go beyond the ICU setting to the general hospital inpatient units to enhance the overall patient and family experience. Whereas comparatively incomplete or low-quality information sharing, such as rushed, not empathetic or incomplete conversations can lead to higher risk of readmission, mortality and overall dissatisfaction with care and possibly overall poor outcomes.¹⁰ The population that was cared for in this case study were largely octogenarians with oncological and mental health needs as part of their complex diagnoses. Chronic care, geriatrics, mental health and palliative care are areas where patients' needs are so complex, inter-professional teams are necessary for the full spectrum of care.⁵ As noted above in the qualitative portion most members of the team felt positive towards collaborative communication with the patient and families' during these meetings.

Physician communication could also be seen as an improved domain with implementation of the pilot, which is supported in figure 2 and 3. However, attention to redundancy of plan of care discussions should be more organized and perhaps each meeting focus on a different aspect of care delivery and disposition planning can avoid direct overlap. Quality rounds and length of stay rounds that elicit similar conversations amongst staff were discovered in the qualitative comments but are these really patient and family focused or are these meetings more institutional mission focused? This targeted intervention is totally patient/family focused, away from the patient's room and with a smaller team than the clinical rounding team providing direct patient care. This intervention supports the stance of "nothing about me without me", which reflects the need for transparency and involvement of patient and family members in clinical decisions. In the design of the care process, supported with this intervention and clinical services, we must seek to directly involve the patient/family in the care delivery agenda with active participation.¹¹ Our study environment and sample was not the traditional clinical care units where structured

patient/family meetings naturally occur (critical care or palliative care units) and demonstrates that such meetings can enhance the patient/family care experience during a stressful time in an acute care setting.

As demonstrated in the reported HCAHPS scores pre data points from 1/2017 through 09/2018 compared to post data 10/2018 through 5/2019, an improvement can be seen specific to care transitions and communication with doctors' domains (figure 3).

The intervention of an inter-professional collaboration specifically in care of plan meetings in the inpatient care setting improves the clinical outcome and satisfaction of patients. Also, improved communication may result in lower medical costs² with respect to better care transitions and patient/family engagement in their care.¹² In previous studies it has been noted that a significant improvement in respect, collaboration, support and overall scores on family centered care and fundamental care to the patients can be seen within a 48 hour window.¹³ Timely engagement with patients and families in plan coordination demonstrates the improved satisfaction with care transition as well as communication as seen in figures 1 - 3.

Limitations to this study include inability to describe patients and families who participated and the opportunity to survey patients and their families on their thoughts due to time constraints and not wanting to interfere with their anonymous responses to post hospital discharge data as surveyed on the HCAHPS. The sample size and duration of the study would provide a better sense of particular areas that would require additional resources or improvement for this type of intervention. Participants spoke of redundancy in multiple meetings and overlap of communication amongst providers.

Lessening the number of meetings throughout the day required by the collaborators to minimize redundancy and maximize the patient experience would be beneficial. This

Table 2. Resulting themes and supporting quotes

Theme	Supporting Quote
Redundancy in share planning	“Patients verbally expressed they liked the meetings however no new information was shared during the meeting.”
Positive experience for patient and family	“I thought they (the meetings) were a good idea to demonstrate a physical presence to the patient and family that we were united as a team.”
Selection of patients for care transition planning	“Would be more appropriate for someone with clinical background to pick families for us to meet with. Could maximize our effectiveness by hand-picking cases with more discharge planning issues so that other disciplines (besides medicine) can take a role in this practice.”
Inadequate direct feedback on the plan of care meetings	“generally positive, no formal feedback” “Patients verbally expressed that they liked the meetings however no new information was shared during the meetings.” “I never heard of or gotten any direct feedback. I would think they (patients) were all appreciative of it (meetings) but I’ve never received any direct feedback.”

Table 3. Paired samples T Test statistics

Doctor Domains and Care Transitions		Percent Level	Select Always/Strongly Agree	
		Means	Std. Deviation	T Value
Pair 1	Pre 1 Percent	64.06	12.55	
	Post Percent	71.56	16.34	-4.04*
Pair 2	Pre 2 Percent	64.82	16.08	
	Post Percent	71.56	16.34	-3.31*

* is significant at the p < .05 level

all requires care team coordination. Lack of referral criteria for plan of care meetings could be improved to assure more efficient use of the time to meet with patient/family in care planning. Lack of a secure space to conduct meetings and allow a user-friendly environment for uninterrupted meetings was also a limiting factor. Engagement of leadership from an administrative standpoint and perhaps check in meetings with the collaborative team may be of use in strengthening the dynamics of the collaborative team’s perspective on the meetings.

Conclusion

Patient and family centered plan of care meetings result in a trend that has a positive impact on care coordination and patient/family experiences. More research is still needed on what may be the most efficient approach to embrace the culture and timing of these meetings in an adult acute

care inpatient unit. The overall impact of this time limited pilot intervention exemplified using existing clinical resources to create a positive clinical environment among the collaborators and assure everyone in the room with patient and their families are focused on communicating coordinating the best possible care outcomes for patients and families. An opportunity for future research could include scaling up the sample size across multiple floors. In addition, expand the data collection to include quantitative metrics of mortality, morbidity and readmission and assess if these patient/family meetings influenced both clinical and quality of life outcomes for the end users, our patients.

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Appendices

Appendix A. Participant demographics

- 1) What is your official title?
- 2) How long have you been doing this role?
- 3) Were you in any professional role before this one?
- 4) What is your age and gender?
- 5) What is your ethnicity?

Appendix B. Reflective Narrative interview questions

- 1) When you first heard about the plan of care meetings, did you have any preconceived thoughts about the outcome of these type of meetings?
- 2) Describe your experiences with the plan of care meetings.
- 3) Describe something that sticks out to you as a clinician as a positive or surprising experience from the plan of care meeting.
- 4) Describe something you would improve for the plan of care meetings.
- 5) Were there any negative experiences noted in these plan of care meetings? If so, please describe.
- 6) Were there any logistical challenges with these plan of care meetings?
- 7) Is there any patient and/or family feedback from these meetings that were received?