REPORT TO THE TWENTY-EIGHTH LEGISLATURE
STATE OF HAWAII
2015

PURSUANT TO HCR 122, SESSION LAWS OF HAWAII 2014, URGING THE DIRECTOR OF HEALTH TO CONVENE A TASK FORCE TO ASSESS THE SCOPE AND FEASIBILITY OF ESTABLISHING AN EMERGENCY SERVICES PATIENT ADVOCATE PROGRAM

PREPARED BY:
STATE OF HAWAII
DEPARTMENT OF HEALTH
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INTRODUCTION

In House Concurrent Resolution 122 House Draft 1 Senate Draft 1, the 2014 Legislature found that patients and their family members can easily become overwhelmed within the medical system, especially when emergency medical attention is necessary. In this setting patients may be unaware of their rights regarding the treatment and care they receive from their emergency room physicians. And even when patients or family members may disagree with the diagnosis or treatment plan, they feel forced to accept the plan despite their concerns because they are unaware of how to effectively exercise their rights to secure appropriate and available emergency medical care.

In matters of life, death and serious bodily injury, visits to the emergency room can be incredibly overwhelming, emotionally charged, and physically taxing. At night when hospital staffing is at a minimum, with family emotion's running high, unintentional miscommunication occurs. Could the presence of a second pair of eyes, either hospital staff or external, help? Would having an active patient advocate program support the doctor-patient relationship? Are there other interventions, along these lines, that would add value to the current ED care model?

The Legislature found that a patient advocate (PA) is needed to assist in the effective case management of, and to enhance communication among patients, family members, and healthcare providers in emergency situations.

The Legislature asked the Director of Health to convene a task force (TF) to assess the scope and feasibility of establishing an emergency services patient advocate program to provide assistance to, and advocate on behalf of, patients receiving emergency medical care.

DIRECTIVES IN HCR 122 H.D.1, S.D.1:

(1) Assess and identify current practices in emergency service patient advocacy
(2) Assess and identify best practices in emergency service patient advocacy
(3) Make recommendations on whether a statewide emergency services patient advocate program is necessary
(4) Make recommendations on whether a statewide emergency services patient advocate program would be cost effective

BACKGROUND

Senate Bill 666

Legislation to establish an Emergency Room Patient Advocate (ER PA) program in Hawaii's hospitals was first introduced in the 2013 session of our legislature by the chair of the Senate Health Committee. SB 666 was heard by various Senate and House committees and

reported to the floor of both houses. Throughout this process it received unanimous support.

However, the bill approved by the House (which provided for a task force to review the matter) and the Senate contained different provisions and hence required a rewrite as a conference committee draft. A conference committee meeting was scheduled in 2013 but the bill was not called up before an agreed upon cutoff time deadline took effect. Efforts to hold an early conference in the 2014 session failed as no early conferences were authorized by leadership. Again, it is noteworthy that there was unanimous approval of the ER PA program.

Legislative/public support

Community support accords with the increased trend throughout our medical community and society in general that hospital safety be given greater attention and that patients be given a larger role in their own safety and their emergency care.

Forms of Patient Advocacy

Patient advocacy come in many different forms to meet different challenges. Earlier it was often an area of lay specialization in health care concerned with patient education about the use of health plans and how to obtain needed care. Many states have established an office of patient advocacy. The former head of the Office of Patient Advocacy of California provided briefings for public health officials in Honolulu on the subjects of responsibilities in 2013. The committee members learned that patient advocacy groups include government consumer agencies with services to the public at large, and private sectors for profit service providers, offer services to individual patients.

An individual patient advocate (PA) typically acts in a liaison capacity between the patient and their healthcare provider. More specifically, PA's often are case managers in social work whose expertise is navigating the complexities of health plans; or other medically trained health care professionals who have refocused on assisted living or nursing home. As time has passed PA's have assumed more advanced responsibilities and their qualifications have been raised to higher levels.

Patient Advocacy in the US

- 1972 Patient Bill of Rights was adopted by Joint Commission and is mandated.
- 1995 – National Patient Advocate Foundation – non-profit; has chapters nation-wide looking at legislation – how it is performed, supplied, who performs and pays. They do not have Patient Advocacy specific to emergency departments.
- 2007 – Alliance of Professional Health Advocates. Offers a certificate but is not nationally recognized.
- 2014 – There is no national certification or credentialing.

- Most PAs work for a hospital; they generally report to the legal or risk management department or quality improvement.
- New York and Florida are actively looking at legislation in PA in EDs, but they are financially focused, rather than clinically.
- American Nursing Association – Code of Ethics – a nurse's primary commitment is to the patient whether an individual, family group or community. The nurse promotes, advocates for and strives to protect the health, safety and rights of every patient.

The Primary Duties of the Patient Advocate in the ED are to:

- Act as a real time facilitator to assist communications between care providers and the patient and/or their families when patient concerns or disputes arise.
- The goal is to proactively prevent problems and improve patient satisfaction.
- Investigate and follow up on patient complaints.
- Provide support for service recovery when patient complaints have been received.
- Train ED staff in customer service and communication techniques.
- Examples of ED staff that often work to resolve conflicts and arrange for additional support or services needed are: ED nurses, case managers, ED social workers, and chaplains.
- Operationally, patient advocates are usually called in for ED "consults" by staff or patients/ families. Nursing supervisors most often fill the patient advocate role in the hospital at night or on weekends.
- Some hospital patient advocates also round in the ED to identify those in need of assistance.
- Hospital patient advocates are a profession in transition. The Society of Health Care Advocacy (the American Hospital Association's once designated professional association for advocates) has been dissolved and hospital advocates are transitioning to align more closely with hospital patient experience efforts. Certification and professional membership is now provided by The Beryl Institute, a patient experience organization.

Code of Ethics from the Professional patient advocate institute, WA –

- Represents patient and family first regardless of organization's interest.
- Full disclosure of services, fee and length of time.
- Accountable of work on behalf of patient.

2014 Joint Commission Hospital standards re: Advocacy

Definition of patient advocate: A person who represents the rights and interests of another individual as though those rights and interests were the person's own in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual's needs.

RI.01.07.03 The patient has the right to access protective and advocacy services.

- When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the patient's needs for such services.
- The hospital maintains a list of names, addresses, and telephone numbers of patient advocacy groups, such as a state authority or a protection and advocacy network.
- The hospital gives the list of patient advocacy groups to the patient when requested.

The Joint Commission does not have advocacy standards specifically directed at ED care. Their standards apply to all hospital departments. See Appendix A on the complete standards for this area.

American College of Emergency Physicians' Position

The American College of Emergency Physicians (ACEP) supports the use of patient advocates in the emergency department (ED). If EDs choose to use patient advocates, there are a number of ways in which patient advocates can contribute to patient comfort, satisfaction, education and safety, including the following:

- Patient experience and comfort
- Patient complaints and compliments/service recovery
- Patient protection and advocacy services
- Discharge planning/readmission reduction
- Community health and support services referrals
- Education, including disease-specific education

The ACEP recognizes that there are a variety of training programs, commensurate with responsibilities, to prepare individuals for patient advocacy services in the ED. At a minimum, patient advocates in the ED should receive training in customer service and be able to effectively communicate the ED mission and flow process, in addition to training for specific job functions.

A Neighbor Island Example

Maui Memorial Medical Center has a busy ED. MMMC has a fledgling patient advocate program. On Maui, 10% of the ED patients are non-resident visitors. Cruise passengers require extensive logistical support.

Another barrier to receiving care in the ED is language diversity of patients and their families who requires heavy use of interpreter resources.

Although all staff has a patient advocacy role and duty, at times patients in ER do experience more intense conflicts between staff, patient and their families. On these occasions MMMC deploys a patient advocacy team comprised of MMMC's patient

advocate, physicians, nurses, providers, ED case manager, ED social worker, and a member of the chaplaincy group.

MMMC has one fulltime patient advocate who has a non-clinical, social work background. She does not address medical needs or requests.

See Appendix B for information on PA programs in other Hawaii facilities.

THE HCR 122 PATIENT ADVOCACY CONCEPT

In this resolution the PA is an experienced and respected ED physician or nurse practitioner, hired by the State of Hawaii Department of Health to provide telephonic PA coverage statewide. An ED patient or family member would phone the PA, provides the clinical context, and outlines the area of conflict. When deemed appropriate, the PA would phone the ED in question and speak directly with the ED physician. The PA, in essence, would be providing a virtual second opinion.

PATIENT ADVOCATE TASKFORCE MEETINGS SUMMARY BRIEF

At Dept. of Health facilitated meetings of highly qualified and diverse emergency department experts and healthcare consumers, consensus was reached on recommendations for HCR 122. Nonetheless, with such a varied group of stakeholders, there were significantly contrasting perspectives for the statewide ED patient advocacy program – and as a credit to the taskforce participants, each contribution to the discussions was acknowledged with deep respect and professionalism. Although there are a few who maintained strong reservations for the taskforce's conclusions and recommendations, it is clear that every taskforce members' focus was on identifying potential opportunities to improve the patient experience in the Emergency Department setting. The team worked collaboratively to finalize this report to the Legislature and the Governor. Appendix C presents a contrary point of view.

TF CONSENSUS REGARDING HCR 122 PATIENT ADVOCACY

1. ED care in Hawaii, for the most part, is quite good. It would not be prudent to implement changes that have the potential to disrupt the system currently in place.

2. A nurse practitioner would probably not have sufficient stature to persuade an ED physician to reevaluate the management plan.

3. Many of the apparent conflicts between patients/families stem from inadequate communication.

4. Because the PA would not have the benefit of direct contact with the patient or the results of the clinical workup, the value of this "second opinion" would be limited.

5. On occasion, the management plan might be altered for the better, but the ED professionals on the TF could not offer a meaningful estimate of how often this would occur, except to say that it would probably be rare.

6. On the other hand, more tests would be ordered, more consultations would be obtained, and more patients would be placed in observation or admitted to the hospital. Costs would rise and patients would be subjected to increased risk of adverse reactions to tests and procedures.

7. To provide this service 24/7/365 using realistic salary estimates: $1,300,000 per year in salary alone. $850,000 per year in salary, if the service was provided only nights and weekends.

MOVING FORWARD,

The quality of ED care can always be improved, and it is the duty of hospitals and ED personnel to continue to strive to make things better.

An affirmative quest then becomes, *How do we improve services in the ED to patients and their families?*

Hawaii hospitals have implemented a number of strategies that have some relationship to patient advocacy. See Appendix B.

Current ED patient satisfaction surveys (mostly Press-Gainey) provide valuable information when used appropriately. Call-back programs and the review of revisit data have also been implemented in a number of facilities.

Highlight the “Patient Advocate” (or patient representative) paragraph in the admissions packet with a fuller description of the internal PA process.

Finally, the creation of a forum within the Healthcare Association of Hawaii would permit on-going sharing of best practices in patient advocacy, policy development, staff training needs, and the need for specific system changes.

Additional ideas, identified by the TF that appear to have merit but do not specifically relate to patient advocacy, are listed in Appendix D.

CONCLUSION AND RECOMMENDATIONS

1. Within a framework of a mandated statewide emergency room patient advocacy program the TF could suggest,

    a. Establish a centralized program that is managed by the State Department of Health.

    or

    b. Utilize existing hospital resources to support the objectives of a statewide patient advocacy program.

    The TF recommends deferring the implementation of a centralized DOH program and strongly supports the (b) option in expanding internal PA programs.

2. Hospitals can and should learn from each other. The TF asks the Healthcare Association of Hawaii to develop an appropriate, on-going forum that would facilitate the sharing of best practices and benchmarking data for patient advocacy in the ED setting.

3. The TF recommends highlighting the "Patient Advocate" (or patient representative) paragraph in the admissions packet with a fuller description of the internal PA process.

See Appendix D for additional ideas that appear to have merit but do not specifically relate to patient advocacy.

APPENDIX A

2014 Joint Commission Hospital standards re: advocacy

Definition of patient advocate: A person who represents the rights and interests of another individual as though those rights and interests were the person's own in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual's needs.

RI.01.07.03 The patient has the right to access protective and advocacy services

- When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the patient's needs for such services.
- The hospital maintains a list of names, addresses, and telephone numbers of patient advocacy groups, such as a state authority or a protection and advocacy network.
- The hospital gives the list of patient advocacy groups to the patient when requested.

Joint Commission Hospital standards re: family and patient rights

Definition of family: A person or persons who play a significant role in an individual's life. A family is a group of two or more persons united by blood or adoptive, marital, domestic partnership, or other legal ties. The family may also be a person or persons not legally related to the individual (such as a significant other, friend, or caregiver) whom the individual personally considers to be family. A family member may be the surrogate decision-maker if authorized to make care decisions for the individual should he or she lose decision-making capacity or choose to delegate decision making to another.

Role of family supported in patient rights standards:

Emotional support for patient, cannot be restricted by hospital, unless contraindicated

Surrogate decision maker

Patient Rights Standards re: decision-making

RI.01.02.01 The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services. Per CMS: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

- The hospital involves the patient in making decisions about his or her care, treatment, and services, including the right to have his or her family and physician promptly notified of his or her admission to the hospital.
- The hospital provides the patient with written information about the right to refuse care, treatment, and services.
- The hospital respects the patient’s right to refuse care, treatment, and services, in accordance with law and regulation.
- When a patient is unable to make decisions about his or her care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions.
- When a surrogate decision-maker is responsible for making care, treatment, and services decisions, the hospital respects the surrogate decision-maker’s right to refuse care, treatment, and services on the patient’s behalf, in accordance with law and regulation.
- The hospital involves the patient’s family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.
- The hospital provides the patient or surrogate decision-maker with the information about the outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.
- The hospital informs the patient or surrogate decision-maker about unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by The Joint Commission.

- The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his or her designee, informs the patient about unanticipated outcomes of care, treatment, and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed.
  Note: In settings where there is no licensed independent practitioner, the staff member responsible for managing the care of the patient is responsible for sharing information about such outcomes.

RI.02.01.01 The hospital informs the patient about his or her responsibilities related to his or her care, treatment, and services.

The hospital has a written policy that defines patient responsibilities, including but not limited to the following:
- Providing information that facilitates their care, treatment, and services
- Asking questions or acknowledging when he or she does not understand the treatment course or care decision
- Following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital
- Supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff and licensed independent practitioners
- Meeting financial commitments

<u>Provision of Care standards re: decision-making</u>

PC.02.01.19 The hospital recognizes and responds to changes in a patient’s condition.

- The hospital informs the patient and family how to seek assistance when they have concerns about a patient’s condition.

PC.02.02.13 The patient’s comfort and dignity receive priority in end-of-life care

- To the extent possible, the hospital provides care and services that accommodate the patient's and his or her family’s comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs.

PC.04.01.05 Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.

- When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care.
- Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need.
- Before the patient is discharged or transferred, the hospital provides the patient with information about why he or she is being discharged or transferred.
- Before the patient is transferred, the hospital provides the patient with information about any alternatives to the transfer.
- The hospital educates the patient, and also the patient's family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.
- The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand.

APPENDIX B

Summary of Survey of Hospital Patient Relations Departments
re: ER Advocacy
Presented to the Patient Advocate Task Force
July 24, 2014

The primary duties of the patient advocate in the ED are to:

- Act as a real time facilitator to assist communications between care providers and the patient and/or their families when patient concerns or disputes arise, proactively preventing problems and satisfying delivery of care needs.
- Investigate and follow up on all patient complaints.
- Provide support for service recovery when patient complaints have been received.
- Train ED staff in customer service and communication techniques.

Hospitals expect all staff to act in the best interest of the patient and to have a responsibility to protect the health, safety and rights of the patient.

Examples of ED staff that often work to resolve conflicts and arrange for additional support or services needed are: ED physicians, ED nurses, case managers, ED social workers, and chaplains.

Operationally, patient advocates are usually called in for ER “consults” by staff or patients/ families. Some hospital patient advocates also round in the ER to identify those in need of assistance. On off shifts, nursing supervisors most often fill the patient advocate role in the hospital.

Hospital patient advocates are a profession in transition. The Society of Health Care Advocacy (the American Hospital Association’s designated professional association for advocates) has been dissolved and hospital advocates are transitioning to align more closely with hospital patient experience efforts. Certification and professional membership is now provided by The Beryl Institute, a patient experience organization.

Emergency Department Patient Advocacy
Report to the Legislative Task Force

July 2014

Response from The Queen's Health System Hospitals

What is your ED currently doing for Patient Advocacy?

West Oahu

Patient experience, patient advocacy and service recovery are a priority for all West ED staff including Nurse Managers, Patient Relations, ED nurses, ED case managers, social workers and ED providers.

Since we are newly opened, we are still working to standardize our service behaviors in the ED. We doing bedside shift reports, leaders rounding with patients and their families, reception area hourly rounding, and consistent use of careboards in addition to other hospital wide patient experience initiatives.

Punchbowl

Our Social Workers and Case Managers work close with the nursing staff and providers, to advocate for our patients. Leaders round with patients to gather information about their experience. In addition, we have a Patient Liaison described below. We also conduct routine call backs to our patients connecting with approximately 65% of our patients to evaluate their experience with the ED. Both nurses and physicians do these call backs.

We have a Service Excellence Committee comprised of ED staff, Pt Liaison, SW, security, and physicians. We invite a patient or family member to our meetings to gain insight into the patient experience. We strive for consistency in our communication with patients, do bedside shift report, leadership patient rounding and document on communication boards in patient room to keep them informed of their care and care providers.

We work close with Patient Relations to perform service recovery and pass out service recovery coupons while rounding.

Molokai General Hospital

Patient advocacy is the responsibility of our social worker, patient navigator, and our nursing staff.

North Hawaii Community Hospital

What has the impact been on patient satisfaction?

West Oahu

During leader rounding, patients state they feel their needs are attended to and happy about patient care. West Oahu is in the process of getting set up for Press Ganey, so no Patient Satisfaction scores are available yet.

The patient experience and patient advocacy have been priorities since opening on May 20th. The administrators, providers and nurses are introducing new initiatives every couple of weeks as the ED adjusts to the high need.

Molokai General Hospital

Patient satisfaction in our ED runs at 95+ %.

Punchbowl

Time frame: several years, however inconsistent. Consistency is key driver.

Molokai General Hospital

We've had navigators for about 10 years and social workers for more than 25 years. The discharge and DME challenges and limitations the SW designee and the navigators must be creative in the solutions they find for the patient. It's a time consuming (but interesting) position.

North Hawaii Community Hospital

If there is a specific Pt Advocate position – what is the title and role summary?

West Oahu

Currently, there is not a designated patient liaison / advocate position but we are considering adding in the future.

Punchbowl

There is a Patient Liaison. The position was started in 2012. The Patient Liaison rounds routinely with patients. The Patient Liaison spends majority of the time in the waiting room, providing patients blankets and water for comfort during any wait times, and then assists patients and their family with communication with the provider and nursing staff.

Molokai General

We have patient navigators as identified above.

North Hawaii Community Hospital

Response from Maui Memorial Medical Center

MMMC's Emergency Department – General

- Maui Memorial has the second busiest ED in the state with approximately 40,000 ED visits per year.
- Approximately 10% of the ED patients are non-resident visitors. Assistance with general logistical support is part of patient advocacy for these patients. Cruise boat passengers require extensive logistical support.
- Many ED patients are more comfortable communicating in a language other than English. Providing translation/interpreting services are part of ED patient advocacy.
- As do all ED departments, the MMMC ED must deal with many drug, behavioral health and domestic violence cases. These cases often involve extensive and complicated patient advocacy and support.

ED Staff Patient Advocacy Duty – General

Maui Memorial considers all staff to have a duty to act in the best interest of the patient and to have a responsibility to protect the health, safety and rights of the patient. In effect all staff have a patient advocacy role and duty. This duty extends from the patient's first contact with the admitting department to post discharge billing and collection. That said, conflicts do arise between hospital staff and the patient and their families, or, patients require additional services and support beyond that provided in the ED. In those cases Maui Memorial has a patient advocacy team dedicated to resolving those conflicts and providing or arranging for the additional support or services needed. That team consists of MMMC's patient advocate, the ED case manager, the ED social worker, and the chaplaincy group. Patient advocacy often simply consists of effective patient pain management, frequent and effective communication and emotional support. ED nurses are often in the best position to provide this type of patient advocacy and therefore should be considered part of the team as well.

Patient Advocate

MMMC has one full time patient advocate. The patient advocate reports to the head of quality assurance. The patient advocate has a non-clinical social work background. Key to being an effective patient advocate are excellent every day language communication skills. Due to ED patient volume, about 30% - 40% of the patient advocate's time is spent on ED cases. The patient advocate does not address medical needs or requests.
The primary duties of the patient advocate in the ED are to:

- Act as a real time facilitator to assist communications between care providers and the patient or their families when patient concerns or disputes arise, proactively preventing problems and satisfying delivery of care needs.
- Investigate and follow up on all patient complaints.
- Provide support for service recovery when patient complaints have been received.
- Train ED staff in service customer service and communication techniques.

Social Work

MMMC has one social worker dedicated to the ED.

The primary duties of the ED social worker are to:

- Identify environmental and relationship issues associated with a patient's medical condition that may compromise a successful discharge.
- Connect the patient to appropriate services and support needed to address these issues in their home or community to avoid future hospitalization or ED visits.

Case Management

MMMMC has one case manager dedicated to the ED.

The primary duties of the ED case manager are to plan an effective discharge by:

- Arranging for patient post-discharge care needs in the most appropriate setting.
- Holding patients whose post-discharge care needs can only be met in a hospital setting.
- Reviewing with the patient and answering all questions regarding their medical condition, discharge instructions and drug regimen.
- Following-up with patients post-discharge to check their recovery, medication compliance and general health issues.
- Connect ED frequent fliers to health care services in order to prevent future ED visits.

Chaplaincy

MMMC has two full time and four part time Chaplains. Chaplaincy services are available at all times. A chaplain is proactively called to the ED whenever EMC notifies the ED that they are in route with a bad case where death is immanent or likely.

The primary purpose of the chaplain is to:

- Provide emotional and spiritual grief support to the family and the patient or to arrange for such support from a member of the patient's faith community.

Additional notes and observations

Patient complaints:

MMMC has established multiple ways for patients to voice concerns. They may call a 24 hour hotline, go to the MMMC web site, write a letter, or ask to speak to the medical director or another administrator.

Medical diagnosis and treatment complaints:

At MMMC medical diagnosis and treatment complaints are not dealt with by patient advocacy. They are processed through the chief medical officer and dealt with through the medical review process.

Physician complaints are rare.

Patient Families

Often the most difficult patient advocacy issues are not between the patient and the hospital staff but between the patient's family and the hospital staff. When using the term "patient advocacy" it needs to be understood that we are also including support for the patient's family.

Response from Wahiawa General Hospital

What is your ED currently doing for Patient Advocacy?

In the ED, all staff is the first line of patient advocacy. Specific patient complaints are handled primarily by the charge nurse in real time. He/She then can involve the house supervisor and/or the manager. We do leadership rounds several times daily where the nurse manager and CNO speak to patients randomly to find out how their experience has been and will attempt to answer questions and concerns. We have a chaplain on call who will come to the emergency department to help with spiritual needs. Our social worker covers the entire hospital and helps with financial needs, placement, psychiatric services. Physicians and nurses complete post-discharge callbacks to ensure the patient's needs have been met.

What has the impact been on patient satisfaction?

This is difficult to quantify, but anecdotally has been very successful. Wahiawa General Hospital Emergency Department patient satisfaction ranks in the 85th percentile nationally.

How long have you been doing it and what has the experience been?

Patient advocacy has been an important part of the Wahiawa General Hospital ED mission since the emergency department opened. Leadership rounds were initiated approximately one year ago and have been very well received.

If there is a specific Pt Advocate position – what is the title and role summary?

We do have a full time Patient Advocate - Her job is to do service recovery as well as discharge follow up. She is an advocate throughout the hospital including the emergency department. She rounds in the emergency department. She handles patient complaints and comments.

<u>Response from Castle Medical Center</u>

What is your ED currently doing for Patient Advocacy?

- Patients and families are considered active members of the care team and participate in discussions regarding treatment options/concerns and bedside shift reports.
- ED nursing leadership conducts purposeful patient rounds to ensure that we are listening to patient concerns, working with them to meet their needs, and to ensure that ED staff are performing specific expectations (i.e. assessing and treating pain, communicating the treatment plan, and providing approximate wait times).
- All staff and physicians are training in the five fundamentals of service using AIDET (Acknowledge, Introduce, Duration, Explain, and Thank).
- Physicians and staff conduct post discharge calls to patients who meet certain criteria, to ensure that they have made a smooth transition home and are following up on specific treatment recommendations.
- Staff are trained in the use of “Teach Back” to ensure that patients understand the information we have provided to them.
- The hospital Patient Advocate is available for patients who feel their needs are not being met.

What has the impact been on patient satisfaction?

Overall ED patient satisfaction ratings for the past 12 months is at the 87th percentile, and there have been many months when patient satisfaction results have been in the top 10% of the nation.

How long have you been doing it and what has the experience been?

- 2011: AIDET and Post Discharge Calls – immediate improvement in patient satisfaction scores
- 2012: Nurse leader rounds – improved patient engagement and staff accountability
- 2013: Bedside shift reports – enhanced patient engagement and satisfaction
- 2014: Color coded scrubs – patients are able to tell the difference between nurses and other ED staff making it easier for patients to know who they can ask what types of questions.

If there is a specific Pt Advocate position – what is the title and role summary?

Yes. Here is a brief summary of the Patient Advocate's role:

- Acts as a liaison between the patient and the hospital care team to enhance communication, collaboration, and teamwork.
- Encourages patients and their families to be active participants in their care by visiting patients to ensure they understand the information in their Patient Handbook including patient rights, patient safety recommendations, managing their pain, protecting their privacy, color coded scrubs legend, who to contact for questions or concerns, and planning for discharge.
- Responds to patient and family complaints and facilitates resolution with the rest of the hospital care team.

Response from Kahuku Medical Center

What is your ED currently doing for Patient Advocacy?

In the emergency department, patient advocacy is the responsibility of the emergency physician as well as the nurse. The relatively low volume of patients allows us to spend extra time with each patient in order to answer their questions and concerns. This also gives us the opportunity to connect patients with the appropriate resources to continue their care in or out of the hospital. If a patients' needs are not met in the emergency department, or if they require further assistance, the nurse manager will be involved and can dedicate as much time as needed to facilitate. Nurses and physicians complete patient callbacks to reevaluate the patient experience, do a clinical check and answer any new questions.

What has the impact been on patient satisfaction?

Patient satisfaction at KMC has been steadily improving. We have recently initiated the Studer/AIDET system for patient satisfaction. As this is relatively new, the data is not robust, but patient satisfaction has been trending upward for several months.

How long have you been doing it and what has the experience been?

Patient advocacy has always been an integral part of patient care at KMC. The experience has been positive for both staff and patients. Our patients feel that this hospital is their own and the staff is part of their extended family. The staff appreciates the extra time they have with the patients and always have support from administration in handling complex cases.

If there is a specific Pt Advocate position – what is the title and role summary?

There is no specific patient advocate position at KMC.

Response from Hawaii Pacific Health

What is your ED currently doing for Patient Advocacy?

The hospitals of Hawaii Pacific Health, Pali Momi Medical Center, Straub Clinic and Hospital, Kapiolani Medical Center for Women and Children, as well as Wilcox Memorial hospital have a consistent and mirrored practice for patient advocacy in each of the respective facilities. Each and every staff member is encouraged to act in the event of patient and their family's needs.

In the Emergency Departments themselves, patient advocacy is most often performed by the attending emergency physicians, advanced practice providers, registered nurses, medical social workers, case management staff, the chaplaincy, and the patient relations staff. It should be noted that, the while there are physicians and nurses in the ED 24 hours a day, social work and the chaplaincy are available off hours on call. Monday through Friday during normal business hours there is a dedicated patient relations coordinator at each of our facilities to address patient or family needs, concerns, or complaints. Direct contact information for the CEO/COO of each hospital is provided in the admission paperwork and is displayed around each facility campus.

All staff are trained in AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank) practices and it is a corporate-wide expectation. Nursing in particular is expected to complete hourly rounds to assess patient/family needs. ED physicians round with patients prior to discharge by ED nurses. Discharge instructions by the nursing staff include the practice of asking if there are any questions or concerns before discharge. Any staff member can initiate a chain of command process in the event of a patient or family concern. If necessary, the House Supervisor, or ED management team may be engaged in a patient advocacy scenario.

Approximately 2 – 3 days after discharge, follow-up calls are made with the attempt to contact each and every patient with scripted dialogue that inquires about their satisfaction as well as any questions or concerns that they might have.

What has the impact been on patient satisfaction?

While not directly quantifiable, the patient and family responses have been very positive. The emergency departments of HPH enjoy Press Ganey satisfaction scores as high as 99% nationally.

How long have you been doing it and what has the experience been?

Each of the HPH facilities surveyed report patient advocacy being a part of their respective practices since inception. Patient relations coordinators have existed at each of the facilities for as long as anyone could recall. Anecdotally, the experience has been overwhelmingly positive for patients, families, and hospital staff.

Is there a specific Patient Advocate position – what is the title and role summary?

Each of the HPH facilities has a patient relations coordinator whose role is to facilitate communication between the patients and families and the involved facility parties in the event of complaints or concerns regarding their respective care. They round throughout the hospital, including the emergency department, and provide real-time and post-hoc information to providers and administration related to the patient and family experience. They act to empower patients and families to actively participate in their experience and healthcare decision making. The patient relations coordinators also perform service recovery duties and as such are an important part of our service excellence endeavors at each of the Hawaii Pacific Health hospitals.

FAIL SAFE POLICY

The Fail Safe policy is an Emergency Medicine Physicians national group policy, which requires the treating ED physician to call an on-call senior emergency medicine physician for cases where they are not following a clinical practice policy. This provides the opportunity to have a real-time conversation with a senior emergency medicine physician in a high-risk clinical scenario. The responsibility and authority for medical decision making remains with the on-duty doctor at all times, even if the on-call physician disagrees with the treating physician.

An example of a clinical policy covered by this is a patient with asymptomatic hypertension. The policy states that these patients should not have their blood pressure lowered, to eliminate adverse effects of lowering asymptomatic blood pressure elevation. If the treating physician is going to lower a patient's blood pressure in the emergency department, the Fail Safe policy dictates that the treating physician would call the EMP on-call physician to discuss this.

APPENDIX C

Statement to Task Force on HCR 122
October 23, 2014
By former State Senator Fred Rohlfing

THE PEBBLE AND THE PROGRAM

> Drop a pebble in the water: just a splash and it is gone. But there's half-a-hundred ripples circling on and on and on, spreading, spreading from the center, flowing on out to sea… And there is no way of telling where the end is going to be…

As the task force develops its recommendations, let us not forget why we are here. What happened that caused us to propose an ER/PA program in the first place – or is it more important to remember what didn't happen? I never had heard the term "patient advocate" until weeks had passed after my wife died. And there was no such thing at the hospital that night or since. The physician assigned to my wife never spoke to me directly about my wife's status – all that I learned came from the nurses. The head nurse issued the instructions that Patty was to be released around 1:30 – 2:00 a.m. I confronted her stating that Patty was too drugged with morphine to be released. (Relate story of moving Patty to hotel at 4:30 then to an outpatient clinic and to a second hospital where she died after surgery for what was hoped to be a twisted colon.)

When the Patty Rohlfing ER PA Committee introduced SB 666, we had decided to seek a legislative answer rather than file a law suit. Though experiencing several formats, the bill was approved by several committees in both houses of the 2014 legislature. But it was not brought to a vote in conference committee due to an arbitrary time deadline. In its place, the House sent HCR 122 across the aisle, like the ripples in my poem. Now it is time to send back our task force reply.

Before doing so, we wish to remind ourselves and readers that early on, at the first Senate hearing we heard testimony from an RN's daughter favoring provision for a state PA ER program that hit the nail on the head. A brief portion follows:

> "Especially in matters of life, death, and serious bodily injury, visits to the emergency room can be incredibly overwhelming, emotionally charged, and physically and mentally taxing. Often times especially late at night when emergency rooms are staffed at their minimum, sleep-deprived patients and their families are left unattended and uninformed for hours.
>
> "Moreover, those on emergency room staff are not in the role of patient counselor or confidante. Instead, they are more focused on providing prompt necessary care – as it

should be. Hospital staff must make their priority the provision of critical patient care and often do not have the luxury of time to explain in satisfying detail the various treatment options and risk."

PATIENT FRIENDLY CARE

Throughout the country a movement has taken hold which has the objective of personalizing, humanizing and demystifying the hospital journey for patients. Some hospitals have separated out geriatric ERs to give greater focus to the needs of the ever increasing number of elderly patients. We encourage Hawaii's hospitals to consider such emphasis after due study.

HONOLULU EMERGENCY CARE CALL CENTER

We also favor further consideration of the establishment on Oahu of an electronic emergency call center manned by highly trained personnel during nighttime hours and available to neighbor island emergency facilities for advice and assistance in difficult situations. We believe this facility should be operated as a public/private partnership with a revolving leadership from Oahu hospitals. Hawaii's poor grade in the American College of Emergency Physicians annual report supports this need. The report states: However a severe gap in hospital capacity impedes the state's ability to respond to both everyday emergency care needs and potential disasters or mass casualty events." The report notes that our state has one of the highest per capita rates of ER physicians but few ER departments, (9.3 per one million people). Our hospitals are nearly at capacity (2nd in the nation). Such a facility could be manned by senior physicians during night shifts only and would employ a "skype" type technology to communicate. I would suggest this call center be named 'The Patty Rohlfing Memorial Emergency Care Communications Center'.

MISCELLANEOUS

The Institute of Medicine is among institutions identifying patient centered care as one of the 6 major aims of quality health care although it conceded it difficult to achieve. Interviews showed that patients believed that physicians should assume more responsibility for imagining disposition planning when either discharging or admitting thereby creating a home safety concern.

The ACEP report also recommends adoption of medical liability reforms e.g., reducing the medical liability on noneconomic damages to $250,000, and others which can reduce the incidence of defensive medicine.

All it takes is a few quiet minutes to relive the experience of those three horrible days of Christmas 2011 and the loss of my beautiful wife. I think about it daily and would forfeit all I possess to get her back.

It is time for us to lead in establishing a program of patient advocates in the ERs of our state and provide an Emergency Call Center.

While we who represent the community on this Task Force will continue to press our proposals for a statewide system of ER PAs and implementation of a call center to be cooperatively operated by Honolulu hospitals, we believe these are but several of the ways to improve emergency care offered at our hospitals. We do not want to discourage other voluntary steps to resolve problems and improve communications between physicians, ER staff and patients. We urge our hospital members to think constructively about ways to bring patients into the care giving process.

Maybe we can catch that ripple on its way out to sea…

APPENDIX D

Additional ideas were identified by the TF as having merit but do not relate directly to patient advocacy. Nevertheless, they have major importance and should be pursued in a collaborative way. The TF recommends that the forum created by the HAH accept responsibility for moving these ideas into fruition.

- Creating a system to share patient records from different EDs for the same episode of care was identified as having particular value. The Hawaii Health Information Exchange is actively working on developing this capability.

- Better reimbursement for Observation Status would allow this option to be used more broadly when appropriate.

- Collaborative policy development would bring about more uniformity of care for challenging patient groups, such as behavioral health and geriatric patients.