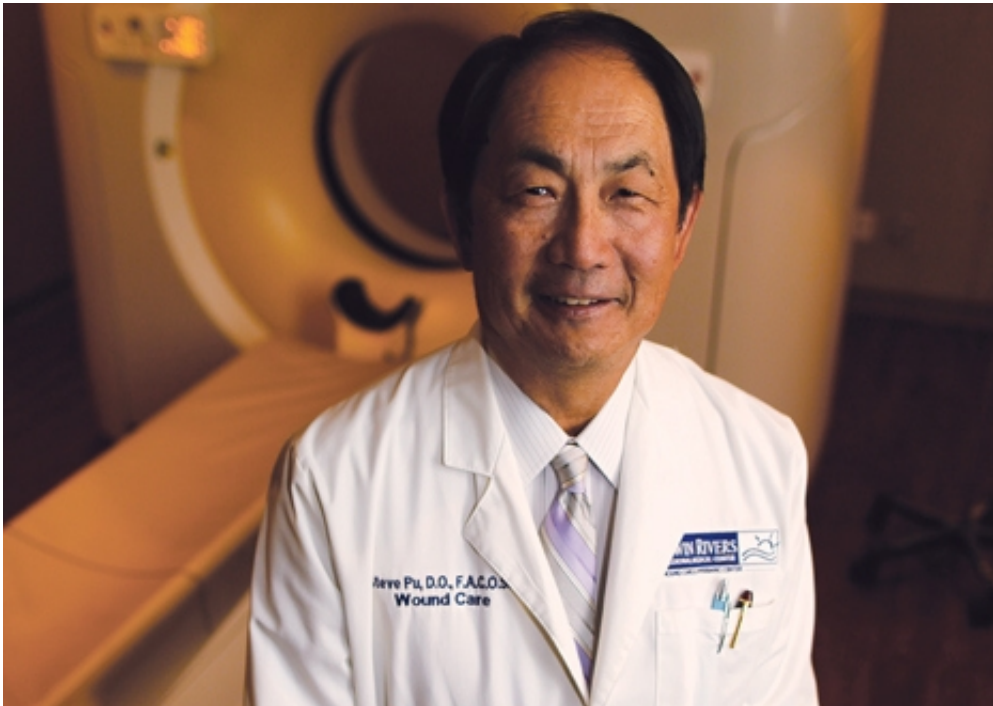


## PROFESSION



Efforts to improve patients' experience of care must “be framed in the context of quality and patient safety” to be successful, says Steve Pu, DO, medical director at Twin Rivers Regional Medical Center in Kennett, Mo. Photo by Lance Murphey / AP  
Images for American Medical News

## Redesigning the patient experience for safer care

■ Implementing processes that improve how patients feel about the care they receive can have another upshot: better quality outcomes.

By KEVIN B. O'REILLY ([HTTP://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=KOREILLY](http://www.amednews.com/apps/pbcs.dll/personalia?id=koreilly)) amednews staff — Posted June 24, 2013

Amid growing financial pressure to improve scores on patient satisfaction surveys, some hospitals are looking beyond the potential ding associated with low grades. They are working to redraft their approach to care in an effort to ensure that patients not only have a positive experience but also get the right care at the right time while being spared from harm.

This involves a variety of approaches, from relatively ambitious moves such as creating a senior-level position charged with improving patient experience to something as seemingly simple as asking patients about their biggest hopes, fears or concerns about their care.

“Patient experience is not about hotel service,” says M. Bridget Duffy, MD, who gained notoriety when Cleveland Clinic named her the nation's first “chief experience officer” in 2008.

“We're focused on the human experience of care, and when you focus on that and map the gaps in human experience while matching the gaps in efficiency, you'll find key points in the patients' journey where there are breakdowns in communications where you're at risk for adverse events in quality and safety,” Dr. Duffy says. She now is chief medical officer at San Francisco-based Vocera Communications, which offers patient experience consulting services as well as technology designed to improve the discharge process.

There appears to be a growing awareness that efforts to improve patients' subjective experiences of care should not be segregated from efforts to prevent medical harm and achieve better clinical outcomes. Dr. Duffy says about 30 people, mostly physicians, now have a senior title in a hospital or health system that combines responsibilities for quality improvement, patient safety and patient satisfaction. More than two dozen chief experience officers participate in roundtable meetings twice a year to share best practices in a process convened by Dr. Duffy. They also have access to periodic Web seminars that yield checklists and other tools.

### **“Sacred moment” checklist created**

One example of the kind of innovation hospitals use to link patient experience and patient safety can be found in practice at Twin Rivers Regional Medical Center. Twin Rivers is a 116-bed hospital in Kennett, Mo., about 100 miles north of Memphis, Tenn. The hospital's patient satisfaction scores were a matter of deep concern less than two years ago. In November 2011, only a third of patients surveyed gave the hospital a “top box” score, meaning they would definitely recommend it to a friend or loved one.

In October 2012, the Centers for Medicare & Medicaid Services began holding back 1% in pay to hospitals, and the agency now is using that money to provide incentives to those with the highest performance-measure scores. Patient-satisfaction metrics account for 30% of the score. The percentage of pay withheld will rise to 2% in 2017.

Although Twin Rivers took several steps to attack the problem, the one that stands out is its creation of a “sacred moment” checklist. The idea is that patients' arrival to the inpatient room marks an opportunity for health professionals to make a strong connection with patients and families, cover key questions and convey critical safety information. Among other things, the primary nurse will ask about patients' pain and dietary and spiritual needs, and explain how the call light works and how medications will be adjusted.

“This was something that people could do in a relatively short period of time and hit all the things we thought were important for patients in that moment,” says Edmund Landry, MD, an orthopedic surgeon who works at Twin Rivers. He says many of the questions were drawn from his patients' experiences.

“My patients tend to have pain medication issues,” he says. “There are also people admitted from the office or the emergency room and they haven't had something to eat for hours, or they have missed medication doses because of prolonged waiting times.”

Nurses also collect family contact information and ask about patients' immediate needs as well as what their hopes or concerns are about their stay. The sacred moment conversation helps patients and families understand what is happening and how to stay safe in the hospital while it helps nurses gather key information about patients, Dr. Landry says.

“The sacred moment is for the employee and for the patient,” he says. “The other great thing is that it doesn't cost a dime.”

As of May 2013, 70% of Twin Rivers patients now give the hospital a top-box satisfaction score and would definitely recommend it to friends and loved ones. The checklist idea has spread to three other hospitals that are part of the same health system.

The sacred-moment process can help create a relationship among patients, families and the people caring for them, says Steve Pu, DO, medical director at Twin Rivers.



**Selena Gorman, RN, spends a “sacred moment” with a patient at Twin Rivers. The process is designed to cover critical safety information and address the immediate concerns of patients and families upon admission.** Photo by Lance Murphey / AP Images for American Medical News

“Once you make that connection with them, it's like talking to another friend you've just met instead of just another patient and 'I've got to get out of here,' ” he says. “That's the culture you want, that patients look at these people as humans who are actually caring for them again. I think all those other metrics can improve if we look at it from that perspective.”

### **Engagement tools for safety**

Bassett Medical Center in Cooperstown, N.Y., also uses patient admission as an opportunity to have critical conversations with patients that can improve their experiences.

A nurse discusses with each new patient a document called “Partnership for Patient Safety.” Patients are encouraged to take an active role to prevent wrong patient, wrong procedure, wrong test and medication errors. They are told to expect that staff will double-check their wristbands before administering medication, drawing blood and taking them for procedures. If the health professional does not check, patients are encouraged to hold up their arm as a reminder.

Patients receive similar encouragement on hand hygiene — staff wear lapel buttons reading, “Please ask me if I've washed my hands” — and medication reconciliation. They also are told that staff must wait by the bedside until a patient has ingested all medicine. “Leaving a cup of medications at the bedside is prohibited,” the document says.

Studies show that when medications are left at the bedside, about half the time patients do not take them, says Ronette Wiley, RN, Bassett Medical Center's vice president of performance improvement and care coordination. Regular use of the compact, implemented in 2007, has coincided with hospitalwide improvements in key areas. For example, hand-hygiene compliance improved 30%, while *Clostridium difficile* rates fell by half, methicillin-resistant *Staphylococcus aureus* dropped 28% and wrong-patient medication errors were slashed by 90%.

The “Partnership for Patient Safety” document and discussion encourages patients and family members to speak up when health professionals forget or take shortcuts, and serves as a not-so-subtle reminder to nurses and others about what is expected.

Wiley and her colleagues opted for this patient engagement approach to improve patient safety after struggles with several other approaches.

“No one cares about the patient's care like the patient,” Wiley says. Along with the other physicians and health professionals in this article, she discussed her 180-bed hospital's experience at the National Patient Safety Foundation's 15th Patient Safety Congress, held in May in New Orleans.

### **Inside episodes of care**

Although some hospitals are homing in on admission as a critical juncture in care, the University of Pittsburgh Medical Center's approach relies on shadowing patients and families at every step in the episode of care to find out what can be improved. The project started in the hospital's total joint replacement program and has expanded to bariatric surgery, women's cancer services, home health care, rehabilitation, emergency services, transplantation and more.

An example of an episode of care that is shadowed is the Level I trauma care experience, which starts when emergency medical services respond to a patient needing transportation and ends when the patient is admitted to a rehabilitation facility. Health professions students, volunteers and new staffers all can serve as shadows, says Pamela K. Greenhouse, executive director of UPMC's Patient and Family Centered Care Methodology and Practice. The more uninformed the person doing the shadowing, the better, as they are more able to see things through the patient's eyes and empathize with their experience.

Transportation, triage, communication with nurses and physicians, testing and discharge all are scrutinized to see if they fall short of “ideal care,” Greenhouse says.

“What shadowing does is that it offers repeated, real-time observation of every segment of the care experience,” she adds. “It provides the emotional connection that creates the urgency to drive change. When any of us in health care sees something with patients and families that could be better in real time, we'd like to fix it and improve it.”

Shadowing is repeated on a periodic basis to see if the implemented fixes are working. The first care area to implement the idea in 2006, total joint replacement, has seen impressive results, with average lengths of stay half as long as the national average. More than 90% of UPMC's total-joint replacement patients are discharged directly to home, compared with the national average of about 25%. The service ranks in the 99th percentile nationally on patient satisfaction surveys.

For any of these or similar efforts to be successful, they must be integrated into the clinical mainstream of hospital operations, Dr. Duffy says.

“The reason why patient experience and quality should be linked is that they're both about culture,” she says. “They're about how people show up, how they treat each other with mutual respect, about good communication. That's the core of creating a culture of safety and a culture where patients feel a sense of confidence about their care.”

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## ADDITIONAL INFORMATION

### How a hospital creates patient connections

At one Missouri hospital, the patient's arrival to the inpatient room is a “sacred moment” to create a caring relationship and cover information that is critical to safe, satisfactory care. The primary nurse is expected to do the following with the patient and family within 30 minutes:

- Introduce the care team with pictures posted in the room and business cards. Health professionals should explain their roles and share some interesting personal facts.
- Make it clear to ask for the nurse by name when something is needed.
- Identify patients' understanding of why they are in the hospital; use layman's terms and clarify as needed.
- Ask patients about their immediate hopes and what can be done now, in their first 20 minutes in the unit, to help them.
- Identify the patient's fears and concerns and manage the patient's expectations. Ask: “What do you want to talk to me about right now?”
- Identify the patient's usual doctor and explain the role of the hospitalist, on-call doctors and more.
- Assess the patient's spiritual needs; offer a pastoral-care professional.
- Reassure patients that they will get their usual medications as modified for the current medical situation.
- Identify the patient's support contact to call with updates on care plans and progress.
- Give patients the hospital phone number to call with complaints and concerns.
- Check for patient pain and review the pain scale.
- Address dietary concerns.
- Determine whether patients are comfortable with the room's temperature and ask whether they tend to run hot or cold.
- Identify patients' personal-care rituals and when they like to bathe.
- Give patients an information kit about the hospital.
- Hand out a frequently-asked-questions document for family and visitors.

Source: Twin Rivers Regional Medical Center, Kennett, Mo.

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## Do's and don'ts for encouraging patient engagement

Patients who take an active role in their care are likelier to be satisfied with their care and have better health outcomes. Physicians and patient advocates say doctors can take steps to foster patient engagement.

**Do:**

- Provide pens and pads in the waiting room to encourage note taking during the visit.
- Sit down and look patients eye to eye.
- Set the agenda by asking, “What is the biggest fear, hope or concern about your care that you would like to address today?”
- To show you want to continue the conversation, ask, “What questions do you have?”
- Answer questions in plain English; explain medical jargon.
- Use the teach-back method to ensure that patients understand the information you have conveyed.

**Don't:**

- Let the computer interfere with a meaningful patient interaction.
- Ask, “Do you have any questions?” because patients might feel pressured to say no.
- Glance at the clock, stand or give other indications that you are eager to leave.

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**EXTERNAL LINKS**

Shadowing Resources, Patient and Family Centered Care Methodology and Practice, University of Pittsburgh Medical Center ([link: http://www.pfcc.org/shadowing-resources/](http://www.pfcc.org/shadowing-resources/) )

Agency for Healthcare Research and Quality tips and tools to improve patient engagement, including notepads that prompt patients to ask questions ([link: http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/tips-and-tools/index.html](http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/tips-and-tools/index.html) )

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