Identification and Dissemination of Best Practices for Patient-Centered Care

Final Report

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ABSTRACT

Purpose

Patient-centered care (PCC) can improve outcomes, reduce costs, improve satisfaction, and reduce medical malpractice. The public reporting of the Hospital Consumer Assessment of Health Providers and Systems Survey (HCAHPS) results have focused attention on the patient's hospital experience. It is unclear, however, how hospitals can ensure translation of the HCAHPS target behaviors at the bedside.

Scope

In this project, we identified United States hospitals that performed highly on HCAHPS, surveyed key hospital informants and invited them to share their best practices at a national conference.

Methods

High-performing hospitals were identified via analysis of publicly reported HCAHPS data for reporting period of March 2011 to March 2012. One hundred seventy-six hospitals met study selection criteria, and 52 hospitals participated. Hospital key informants were asked to respond to an online survey and submit up to three conference abstracts describing their improvement efforts. Thematic analysis was used to analyze survey responses. Abstracts were scored by blinded reviewers using a predetermined rubric. A post-conference evaluation survey was administered.

Results

One hundred thirty-eight informants responded to the survey, and 57 abstracts were submitted and reviewed. Survey responses and conference presentations revealed that the high-performing hospitals are employing multiple concurrent strategies and similar interventions to achieve improvement. Conference attendees provided highly positive ratings for the conference.

Discussion

This project helped surface and disseminate best practices for improving the patients' experiences of care within the hospital. It also introduced a new evidence-based approach for learning about successful improvement strategies in this area.

Keywords

Patient-centered care, hospital best practices, patient experience of care, HCAHPS, communication, pain management, staff responsiveness, hospital discharge

PURPOSE

Our overall objective in this project is to identify and disseminate healthcare innovations and promising practices for translating the Hospital Consumer Assessment of Health Providers and Systems Survey (HCAHPS) behaviors to the bedside. We proposed to do this via the following four-staged approach:

1. Identification of high-performing US hospitals based on objective criteria of performance excellence and invitation to submit an application for presentation at a national conference
2. Review of applications and scoring using a peer reviewed process and predetermined rubric
3. Holding a 2-day conference at which best practices are shared and peer recognition awards are distributed
4. Dissemination of best practices and facilitation of future networking via publication of conference proceedings and presenters' contact information

SCOPE

Patient-centered care can improve clinical outcomes, reduce healthcare costs, improve patient satisfaction, and reduce medical malpractice. [1-7] Ten years ago, the Institute of Medicine recommended patient-centered care (PCC) as one of six quality improvement aims, stating that "patients have expressed frustration with their inability to participate in decision making, to obtain information they need, to be heard, and to participate in systems of care that are responsive to their needs." [1] Hospital care often falls short of delivering patient-centered care. In surveys administered to hospitalized adults in multiple western nations, significant deficits in PCC delivery were reported in multiple areas, including information sharing and education, involvement in treatment decisions, and transitions of care. [8,9] There are challenges, however, to delivering PCC in the hospital setting. Hospitalized patients must stay in an unfamiliar place, trust physicians they do not know, and tolerate a continuous stream of medical interventions, some with substantial physical discomfort and risk. Patients also have to take instructions from many healthcare professionals – the majority of whom they only see once, many of whom give conflicting information – and rely on them for medical care, food, clothing, and shelter. Consequently, patients feel vulnerable and oftentimes overwhelmed. They need physical and emotional support. Patients also need to know what is wrong with them, what their treatment options are, what is being done, what to anticipate, and what they can do to get better. They need to have their questions answered, their concerns heard, and their opinions considered. Published reports of patient stories and recent results from national surveys of patient experiences in the hospital continue to confirm the pressing need to address these issues. [8-13]

The public reporting of results from HCAHPS and the recent authorization of financial incentives for survey performance by the Patient Protection and Affordable Care Act have

focused attention in the United States on the patient's hospital experience and the need to deliver PCC. The HCAHPS survey was developed to provide consumers with information about hospital quality by eliciting the patient's perspective regarding their hospital experience. The survey includes general satisfaction (rating of hospital quality and willingness to recommend hospital), six specific domains (communication with nurses and with doctors, responsiveness of hospital staff, pain management, communication about medications, and discharge information), and two single-item questions about the hospital environment. [14-16] With the exception of the hospital environment items, <u>the HCAHPS survey measures behaviors that clinicians need to demonstrate for patients to have a positive hospitalization experience.</u> [16] The behaviors were informed by formative research with patients on important aspects of healthcare quality from their perspective. Those behaviors are consistent with the described dimensions of patient centered care in the medical literature and are supported by both theoretical and empirical evidence in regard to their relationship with healthcare quality and improved outcomes. The behaviors measured by HCAHPS are broad in scope and span areas that can influence both safety and overall quality of care. For example, HCAHPS measures communication behaviors of clinicians (such as how often they listen and explain in terms that the patient can understand, how often they tell patients about reason for new medications, and what symptoms to watch for post discharge from hospital) and responsiveness of staff (how often they responded to call bells and met the patient's toileting needs). Communication is largely blamed for adverse events and preventable readmissions to the hospital, and about 50% of inpatient hospital falls occur during patients' attempts to meet their toileting needs. [17, 18] Higher HCAHPS scores are associated with better performance on quality metrics, such as delivery of evidence-based process of care measures for acute myocardial infarction and pneumonia and lower rates of pressure ulcers. [19, 20] A small increase in HCAHPS scores has been reported in the US. [21] Large variation in performance exist among hospitals and across states. [22, 23]

An analysis that we have conducted, including 2010 and 2011 nationally reported data for all measures of HCAHPS, revealed that hospitals maintained similar performance on HCAHPS measures and that large variation persisted between hospitals. Furthermore, in a multilevel analysis of variation of HCAHPS data within five hospitals, significant variation existed both between and within hospitals, with higher intraclass correlation coefficients at the hospital unit than at the hospital level. This means that both high- and low-performing units can be found within the same hospital. This finding was demonstrated across all HCAHPS domains. [24]

Hospital improvement teams currently struggle with how they can ensure the translation of the HCAHPS target behaviors at the bedside in a predictable and consistent manner. Successful translation, however, is critical for achieving higher HCAHPS scores and for realizing subsequent gains in healthcare safety and quality. This project aims to help identify and disseminate current best practices in this area via identification of hospitals that meet objective criteria for high performance on HCAHPS and exploration of what helped these hospitals achieve this status.

METHODS

The project included the following stages:

1. Identification of high-performing US hospitals and invitation to participate in project

To identify high-performing hospitals, we conducted a secondary data analysis on publicly reported HCAHPS data for reporting period of March 2011 to March 2012. We used the Hospital Compare database (downloaded from medicare.gov website), and all hospitals submitting at least 300 HCAHPS surveys for that reporting period were included. High performance was defined as achieving the highest ranks during that reporting period or making substantial improvements compared to the prior reporting period. Six HCAHPS domains were considered: Communication with Nurses, Communication with Doctors, Staff Responsiveness, Pain Management, Communication about Medicines, and Discharge Information. For more information about HCAHPS, please refer to http://www.hcahpsonline.org/.

Hospitals were classified based on bed count into three size categories: small, medium, and large. Bed count data were retrieved from the American Hospital Association database. Hospitals with up to 200 beds were categorized as small (n=1,927), hospitals with 201 to 499 beds were considered medium-sized (n=797), and hospitals with 500 beds or more were considered large (n=276). We identified the top 10 scores on each of the six HCAHPS domains (Staff Responsiveness, Nurse Communication, Doctor Communication, Pain Management, Communication about Medicines, Discharge Information) for each of the hospital size categories. Hospitals achieving those scores were identified as 'top-ranking' hospitals. We also identified as 'most improved' any hospitals that have made an increase of 12 points from the prior reporting period on any of the six domains.

Once a hospital was identified as 'high performing' (i.e., meeting 'top ranking' or 'most improved' criteria), a letter was sent to the hospital's Chief Executive Officer (CEO), congratulating him/her and the hospital's leadership team on their success and inviting them to participate in this project. Each CEO was asked to name key informants within their hospital (e.g., nursing director, director of service excellence, medical director, and director of quality). Key informants were asked to 1) respond to an anonymous online survey regarding the structures and processes in place that they believe attributed to their hospital's success and 2) provide specific examples of their current interventions, challenges met, and how they were addressed. We also invited key informants to submit up to three abstracts on their work for presentation at a national conference. (See abstract application in Appendix I and online survey questions in Appendix II.)

2. Review of applications and identification of evidence-based practices

We assembled a multidisciplinary conference scientific committee composed of researchers, clinicians, and other subject matter experts. An abstract scoring rubric was agreed upon by the committee members using a group consensus process. Scoring criteria included scientific content/merit, success of implementation, results over time, innovation, cost consciousness, replicability, and scalability. All submitted abstracts were reviewed and scored by two scientific committee members. The reviewers were blinded to the name of the abstract author and their organization. The highest-scoring abstract applications were selected for a 20-minute podium presentation. All applicants had the opportunity to share their best practices in either an oral or poster presentation session.

3. Conference Implementation

The conference sessions occurred during 2 full days and included a welcome address, the opening of the poster presentations area for viewing, formal learning sessions, lunch/networking breaks, reception and poster presentations, and recognition awards distribution.

The format for day one included opening plenary sessions in the morning followed by three 90-minute 'best practice' presentation sessions. The format for day two included an opening plenary sessions in the morning followed by one 'best practice' presentation session and one roundtable discussion. There was a lunch/networking break after the first 'best practice' session each day. Following lunch the first day, there were two additional 'best practice' sessions, and the day ended with poster presentations. Following lunch the second day, there was a roundtable discussion session. All high-performing hospital presenters (both oral and poster) were presented with recognition awards to recognize their outstanding performance on the relevant HCAHPS domain(s).

We limited the number of plenary presenters purposefully to maximize hospitals' presentation time on 'best practices.' The 'best practices' sessions were organized into the following themes: responsiveness to patients' needs; addressing patients' pain; preparing patients for discharge; and improving communications and overall patient experience. In each 'best practice' session, presenters from three hospitals presented about their work for 20 minutes each, followed by a question and answer period and a plenary discussion period. Presenters were asked to present on specific interventions that were successfully implemented, describe the challenges they have met, and explain how they overcame those.

To evaluate the conference, we administered a 12-item post-conference survey composed of five open-ended questions and seven four-point Likert statements and conducted quantitative and qualitative analyses of survey results.

4. Dissemination of best practices and facilitation of future networking via publication of conference proceedings and presenter/hospital contact information

We prepared a conference binder with session slides, links to abstracts submitted by high-performing hospitals, and contact information of conference participants. A web page was set up on the website of the Armstrong Institute for Safety and Quality at Johns Hopkins University to host the conference materials and presentations. Scribes were asked to take notes at the conference for the compilation of conference proceedings, which will be made available through electronic media and be widely distributed via email to key organizations.

RESULTS

Identification of high-performing US hospitals and best practices

One hundred seventy-six hospitals met the study selection criteria, and 52 hospital CEOs agreed to participate. Key informants from the 52 hospitals were invited to respond to an online survey and submit up to three abstracts describing their hospitals' patient-centered care efforts at the conference.

Table 1 below depicts participating hospitals distribution by bed size and teaching status.

Hospital size / Hospital type	Large (>=500 beds)	Medium (201-499 beds)	Small (<=200 beds)	**Total**
Non-Teaching	2	10	16	**28**
Teaching	15	6	2	**23**
Total	**17**	**16**	**19**	**52**

Table 2 below depicts participating hospital distribution by high-performance domain on HCAHPS.

	# Hospitals
Communication about Medications	16
Doctor Communications	15
Discharge Instructions	23
Nurse Communications	16
Pain Management	17
Staff Responsiveness	19

One hundred thirty-eight leaders/key informants at high-performing hospitals responded to the anonymous online survey. Preliminary analysis of survey results revealed that the vast majority of high-performing hospitals are employing common strategies to achieve improvement, including setting a clear strategy at the hospital board level, communicating specific improvement targets for HCAHPS scores, extensive use of data feedback, hospital-wide campaigns or initiatives, proactive nursing rounds, and unit-based interventions.

When asked 'what do you think has helped your hospital achieve a 'high-performer' status on the Patient Experiences of Care Survey (HCAHPS)' and prompted to provide specific examples on this, key informants responses revealed the following overarching themes: 'Valuing the patient experience', 'focus on employee engagement, development and accountability', 'focus on leadership engagement, development and accountability', 'improvement approach and data management/feedback', 'specific strategies/interventions', and 'striving for excellence.'

Specific strategies and interventions included the following:

1. Routine rounding to identify and address employee and patient concerns (done by nurses, multidisciplinary teams, charge nurses, senior leaders).
2. Use of communication tools (acronyms, white boards in rooms, sharing daily goals, discharge folders, skills training).
3. Developing new roles on team (such as unit-based pharmacists, unit nurse attending, patient educators, directors of patient experience).
4. Post-discharge calls and follow up.
5. Enhancing teamwork and coordination of care services via huddles, multidisciplinary rounds, and discharge planning services.

Main challenges met by hospitals include consistency of practice, managing change and ensuring buy in, and limited time and resources. We are conducting an in-depth qualitative data analysis to analyze these themes as well as specific strategies and challenges.

Conference implementation, findings, and evaluation

Fifty-seven abstracts were submitted by the identified high-performing hospitals to the conference. Based on the scientific review scoring, 12 abstracts were selected for oral presentations, and the remaining abstracts were invited for poster presentations.

One hundred fifty-five participants attended the national Best Practices in Patient-Centered Care Conference held in Baltimore, Maryland, on September 26-27, 2013. Participants included healthcare executives, quality improvement and service excellence professionals, frontline clinicians, and patient-family advocates. Conference presentations included six plenary sessions, 12 oral presentations, 31 poster presentations, and a roundtable discussion session.

The first day opened with a welcome plenary session from Dr. Peter Provonost, highlighting the importance of patient-centered care and its contribution to patient safety and quality. Dr. Hanan Aboumatar provided an overview of patient-centered care dimensions and presented new research findings on variation in patient experience data and how it can inform intervention design and hospital improvement efforts. Dr. Dominick Frosch presented on shared decision making as a key strategy for patient engagement. The second day started with an opening presentation on pain management and the importance of using multimodal pain treatment methods by Dr. Marie Hanna. Dr. Judith Hibbard introduced patient engagement as meeting patients where they are and discussed the need to understand how ready and able patients are to participate in their own care. Dr. Mary Catherine Beach presented on patient-centered communication.

The 'best practices' oral presentations were organized into four sessions on 'meeting patients' needs', 'addressing patients' pain', 'preparing patients for discharge', and 'improving communications and the patient experience.' Each session included three presentations from high-performing hospitals, followed by aquestion and answer section and a panel discussion. The best practice sessions revealed that the high-performing hospitals are employing multiple concurrent strategies and similar interventions to achieve improvement. The table below depicts a description of common interventions and the names of hospitals who shared those in their presentation.

Table 3 Common interventions presented by high-performing hospitals

Common Interventions	Intervention Description
Post-discharge phone calls	• Castle Medical Center: Calls are conducted registered nurses (RNs); nursing managers/directors have to make at least five calls per week; and emergency department (ED) physicians make the calls to patients post-ED visits. Surfaced patient concerns are addressed in real time by notifying a member of leadership team of the unit/department in which a concern is expressed. Leaders contact the patient immediately to address questions/concerns. Pharmacists respond to patients with medication related questions/concerns. In addition, for hospitalist service, the caller asks patient if they have any questions for their physician, and if so, the hospitalist contacts the patient within 24 hours. • Massachusetts General Hospital: Nurses call patients within 48 hours to check on their status and answer questions about discharge instructions and self-care. • OSS Orthopedic Hospital: RN calls patient within 48-72 hours post discharge. Satisfaction surveys are mailed to all patients post discharge.

Common Interventions	Intervention Description
Post-discharge phone calls	• Prairie du Chien Memorial Hospital: Calls at 24-48 hours post-discharge with an additional 5, 10, and 14 day post-discharge calls for high risk patients. Patients are called by the RN who performed their discharge. RN is responsible for addressing any patient concerns.
Communication/care boards in patient rooms	• Castle Medical Center: Boards were redesigned for use by nurses, support staff, patient, and family members. Common elements of the care board include room number, physician and nurse phone numbers, medications, tests and procedures, mobility, and special needs, 'what excellent care means to the patient.' Care board provides a list of new and existing medications requiring communication with the patient and/or family. All staff are trained how to update the care board, and nurses review the board during each bedside shift report. • Sarah Bush Lincoln Health Center: The communication board lists pocket phone number of the nurse and care partner assigned to the patient each shift. The patient can call them directly. When patients presses 'call light,' the pocket phone rings. • Prairie du Chien Memorial Hospital: Care board includes patient discharge goal
Bedside shift report	• Castle Medical Center: Shift report includes existing and new medications review with the patient and/or family. The teach-back method is utilized during report to ensure that patient understood the reason for each medication. • Sarah Bush Lincoln Health Center: Brief bedside shift report involves the nurses, care partners and the patient and/or family. The patient is informed about the plan for the day during report.
Discharge folder	• Castle Medical Center: A discharge folder was developed that is provided at admission and hangs on the wall next to the patient's care board. Front of folder includes the words: "What I need to know when I get home" and a checklist with following items: o Help I will need o How to care for myself o Purpose of my medications o Symptoms to look out for o When to see my doctor o My responsibilities o Any worries or concerns Staff are trained to review patient education/instructional materials with patient then place in folder. Items on the checklist are checked once discussed with patient/family. Staff write on inside flap of folder a "thanks and best wishes" note for the patient upon discharge.

Common Interventions	Intervention Description
Discharge folder	• Prairie du Chien Memorial Hospital: Healthcare handbags are used to hold paperwork and medications so that patient can bring with them to follow-up appointments.
New team member roles	• Massachusetts General Hospital: Created an 'attending nurse role'. This person is responsible for following plan of care for patient from admission to discharge. The attending nurse writes and updates patient care goals based on input from the patient's care team on daily basis. S/he coordinates patient care amongst clinicians and is responsible for communication with patient and family. In that role, they keep the patient/family informed about care plans, progress, and discharge plans. • Sarah Bush Lincoln Health Center: Created an ADT (admission, discharge, transfer) nurse position which is filled for day and evening shifts on large units. This has helped in responding to patient needs/expectations in regard to admission and discharge.
Multidisciplinary Rounds	• Prairie du Chien Memorial Hospital: Rounds focus on improving communication between patient, nurse and provider • Massachusetts General Hospital: Conducts these rounds routinely to plan discharges
Hourly Rounds	• Sarah Bush Lincoln Health Center: Hourly rounding is conducted by nurses and care partners (CNAs) to address pain, bathroom needs/potty, positioning, and to make sure personal items are within reach (4Ps). • Massachusetts General Hospital: Uses the four Ps
Standards of Performance	• Sarah Bush Lincoln Health Center: Developed 'Standards of Performance'. Also created three 'universal scripts' for use by all employees: e.g., "is there anything else I can do for you? I have the time" One standard of performance is for all employees to quickly respond to patients. Service recovery standards were put to place and 'relationship-based care principles' were applied. The latter stresses that staff 'actions and words reassure, empathize, listen, answer questions, take action and express appreciation (mnemonic: RELATE.).' • San Jacinto Methodist Hospital: Uses the motto – IACT, IASK, ICARE – "IACT is an abbreviated form of recognizing the need to respond to a patient needs and when failing to do so, Acknowledging/Apologizing, Correcting, and Thanking the patient for bringing the concern forward. IASK was developed as a means to constantly ASK and involve the patient in his/her care. ICARE was in response to ensuring that our ICARE values (Integrity, Compassion, Accountability, Respect, & Excellence) were always at the forefront of our actions and behaviors." Additionally AIDET is used and that stands for "A: Acknowledge I: Introduce D: Duration T: Thank "Mr. Smith, your registration is complete. I will now get your chart ready for Dr. Jones. Dr. Jones should be with you anywhere from 30 to 40 minutes. If anything changes I will let you know." Also uses BLAST: "- Be aware of concerns - Listen, actively - Apologize, blamelessly - State the concern, resolve and act -Thank the customer."

The roundtable discussions session used a small-group format in which each group focused on one of five topics: data feedback, rounding interventions, leadership and culture, technology

support, and clinician engagement. Each group had an assigned facilitator and a discussion guide to facilitate rich conversations.

Recognition awards were presented to all participating high-performing hospital presenters.

A post-conference survey was administered and collected at the end of conference. The response rate for the post-conference survey was 43%. Respondents reported highly positive ratings for the conference: 98% agreed that they received useful information; 100% agreed that they got specific ideas that they planned to apply at their hospital; and, 98% would recommend this conference be held on an annual basis. Ideas that respondents intended to apply related to discharge strategies, rounding strategies, bedside reporting, communication tools, new team structure models, and patient activation approaches. Participants reported being inspired by the success stories and highly valued the 'networking' opportunities with peers at high-performing hospitals that this conference allowed for.

Dissemination of best practices and facilitation of future networking

All conference attendees received a conference binder with names of high-performing hospital representatives, their contact information, and handouts of the presentations. All conference oral presentations and poster abstracts were posted on the conference website at the time as well. Conference proceedings have been developed and are under final review by proceedings contributors/conference presenters. They will be made available through electronic media and will be shared via email with key organizations and AHRQ grantors.

Multiple manuscripts are being prepared and will be submitted to peer- reviewed journals. Peer-reviewed journals under consideration for submission include Health Affairs, Health Services Research Journal, Medical Care Research and Review, and Joint Commission Journal.

Manuscripts under development include:

1. Paper on this project's approach to identification and dissemination of best practices. The paper focuses on the conference, the use of objective criteria for presenters' selection, and participant engagement through peer learning. The paper includes a description of the conference planning process and evaluation results.
2. Main manuscript reporting on project methods for identification of best practices and key findings from the key informants' survey.
3. Tool tutorials on specific interventions that are frequently employed to improve the patient experience. A first tutorial paper on 'Proactive Rounding Interventions' is under development.

Conclusions

This conference helped surface and disseminate evidence-based practices to improve the patients' experiences of care within the hospital. It also introduced a new approach to learning about successful improvement strategies in this area. This approach centers on use of objective criteria for best practice identification and disseminating those via peer learning methods. Conference participants reported that the conference helped inspire them and offered practical ideas that they intended to apply at their own organizations. Learnings from this conference will be widely shared with a broad national and international audience through widespread circulation of electronic conference proceedings, conference presentations, and peer-reviewed publications.

LIST OF PUBLICATIONS AND PRODUCTS

Proceedings and manuscripts are under development (please refer to above section).

REFERENCES

1. Institute of Medicine. Crossing the Quality Chasm: A new Health System for the 21st Century. Washington, DC: National Academy Press 2001:pp.49.
2. Epstein RM, Fiscella K, Lesser CS, et al. Why The Nation Needs A Policy Push On Patient-Centered Health Care. Health Affairs. 2010;29(8):1489-1495
3. Coleman EA, Parry C, Chalmers S, et al. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006;166(17):1822-8.
4. Meterko M, Wright S, Lin H, et al. Mortality among patients with acute myocardial infarction: the influences of patient-centered care and evidence-based medicine. Health Serv Res. 2010;45(5 Pt 1):1188-204.
5. Fremont AM, Cleary PD, Hargraves JL, et al. Patient-centered processes of care and long-term outcomes of myocardial infarction. J Gen Intern Med. 2001;16(12):800-8
6. Ratanawongsa N, Federowicz MA, Christmas C, et al. Effects of a Focused Patient-Centered Care Curriculum on the Experiences of Internal Medicine Residents and their Patients. J Gen Intern Med. 2011 Sep 27. [Epub ahead of print]
7. Kaplan SH, Greenfield S, Ware JE, Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Med Care 1989;27:S110-27.
8. Davis K, Schoen C, Schoenbaum SC, et al. The Commonwealth Fund. Mirror, Mirror on the Wall: An update on the quality of American Healthcare through the patient's Lens. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf . Accessed on October 28, 2011.
9. Coulter A, Cleary PD. Patients' experiences with hospital care in five countries. Health Aff (Millwood). 2001;20(3):244-52.
10. Villette, M.. For want of a four-cent pull chain. BMJ Qual Saf. Published online first: September 15, 2011. doi:10.1136/bmjqs-2011-000221
11. Levinson W., Shojania KG. Bad experiences in the hospital: the stories keep coming. BMJ Qual Saf. Published Online First: October 4, 2011. doi:10.1136/bmjqs-2011-000474
12. McCullough M. An ethicist's journey as a patient: are we sliding down the slippery slope to sloppy healthcare? BMJ Qual Saf . Published Online First: September 15, 2011. doi:10.1136/bmjqs-2011-000235
13. Elliott MN, Lehrman WG, Goldstein EH, et al. Hospital survey shows improvements in patient experience. Health Aff (Millwood). 2010;29(11):2061-7.
14. Goldstein E, Farquhar M, Crofton C, et al. Measuring Hospital Care from the Patients' Perspective: An Overview of the CAHPSs Hospital Survey Development Process. Health Research and Educational Trust. 2005;40(6 Pt 2):1977-95.
15. Sofaer S, Crofton C, Goldstein E, et al. What Do Consumers Want to Know about the Quality of Care in Hospitals? Health Serv Res. 2005; 40(6 Pt 2):2018–2036.
16. Crofton C, Darby C, Farquhar M, et al. The CAHPS Hospital Survey: development, testing, and use. Jt Comm J Qual Patient Saf. 2005;31(11):655-9,601
17. Hitcho et. al. Characteristics and Circumstances of Falls in a Hospital Setting. J GEN INTERN MED 2004;19:732–739.
18. Tzeng, HM, Hu, HM, Yin, CY, Johnson, D. Link Between Patients' Perceptions of Their Acute Care Hospital Experience and Institutions' Injurious Fall Rates. J Nurs Care Qual. 2011,Vol. 26, No. 2, pp. 151–160
19. Isaac T, Zaslavsky AM, Cleary PD, et al. The Relationship between Patients' Perception of Care and Measures of Hospital Quality and Safety. Health Services Research 2010;45(4):1024-40
20. Jha AK, Orav EJ, Zheng J, et al. Patients' Perception of Hospital Care in the United States. N Engl J Med 2008;359:1921-31.

21. Elliott MN, Lehrman WG, Goldstein EH, et al. Hospital Survey Shows Improvements In Patient Experience. Health Affairs, 2010;29:2061-2067.
22. US department of Health and Human Services. Hospital compare. http://www.hospitalcompare.hhs.gov/hospital-search.aspx. Accessed on Dec 3, 2011.
23. Agency for Healthcare Research and quality. The CAHPS database. https://www.cahps.ahrq.gov/cahpsidb/default.aspx. Accessed on Dec 3, 2011.
24. Aboumatar et al. Feb 2012. A multilevel analysis of patient experience measures variation among 5 hospitals. (Recent unpublished data)

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Appendices

Appendix I: Abstract application

Appendix II: Online survey

For conference proceedings, see https://www.hopkinsmedicine.org/-/media/armstrong-institute/documents/_documents/best_practices_in_patient_centered_care_proceedings.pdf

Appendix I

Best Practices in Patient-Centered Care Conference

Abstract Submission Form

(Deadline – July 15, 2013)

Title:

This abstract describes work that was developed to improve patient-centered care delivery for the following types of units and providers: (Please check **all** that apply)

Critical care unit ☐ Adult med-surg units ☐ Pediatrics ☐ Other ☐(Please Specify):

Physicians ☐ Nurses ☐ Clerical staff ☐ Other ☐(Please Specify):

Your Hospital's Name:

Contact person: Title:

E-mail: Phone:

Please provide the following information:

Problem

What problem did you address? Why did you choose to address this problem?

Approach to problem solving

How did you approach this problem? What methods did you use to help you understand it better and identify ways to address it?

Intervention/s

What intervention/s did you implement to address problem? How did you implement those?

Results

What were the results of your intervention/s? Have those intervention/s been sustained? If so, what do you think helped sustain them?

Please return this completed form AND any examples or supportive documents *via email to: bestpractices@jhmi.edu*

Please direct any questions to Dr. Hanan Aboumatar via telephone at 410-637-4361 or email at bestpractices@jhmi.edu

Best Practices in Patient Centered Care

Dear Hospital leader,

Congratulations! Your hospital has been identified as a top performing hospital on the Patient Experiences of Care Survey (also known as HCAHPS- Hospital Consumer Assessment of Health Providers and Systems Survey).

We are conducting a study to uncover best practices for improving the patients' hospital experiences that will culminate in a national conference on September 26-27, 2013 where leaders from top performing hospitals will be invited to present and be recognized for their work. Select hospitals will be given awards for their achievements and identified best practices will be published (with proper credits to the hospitals who have shared them), so we may increase our collective knowledge of how to improve in this important aspect of healthcare.

We are asking you to contribute to this study by taking a few minutes to share your knowledge of what you think has earned you high scores on patient experiences of care. The information you share is very valuable to this study. Your participation is completely voluntary. Your completion of this survey will serve as your consent to be in this research study.

Please do not share your name or other personal identifiers. We only ask that you provide your hospital name so we may acknowledge your hospital.

Please contact the study principle investigator Dr. Hanan Aboumatar at E-mail habouma1@jhmi.edu or Tel # 410-637-4361 with any questions.

Many thanks for your help.

1. Hospital Name?

2. What do you think has helped your hospital achieve a 'high performer' status on the Patient Experiences of Care Survey (HCAHPS)?

3. Provide specific examples of current activities/ interventions at your hospital that you believe help you achieve high performer status.

a. Describe interventions

b. What evidence do you have that these interventions are effective in improving your scores?

c. What challenges have you met in implementing those interventions and how did you address those?

Best Practices in Patient Centered Care

4. Additional information and comments on activities/ interventions at your hospital

5. Check all strategies/ actions that you have utilized to improve your patients' hospital experiences and provide examples in the comments box * below:

	Yes	No
Set strategy to improve patient experiences of care at the hospital board or CEO level.	○	○
Set specific improvement goals/targets for HCAHPS scores.	○	○
Used data feedback to drive improvement. Please comment on type of data; frequency of feedback; to whom; and, at what level do you summarize it (i.e. hospital, department, or unit level data)	○	○
Started hospital- wide campaigns or initiatives.	○	○
Implemented hospital- wide education.	○	○
Hired consultants to help improve HCAHPS/ satisfaction scores.	○	○
Started regular nursing rounds. Please comment below on who performs this (e.g. primary nurse, charge nurse, or others), round frequency, and any standard communication scripts or checklists	○	○
Developed new policies.	○	○
Developed new human resources regulations/ hiring policies.	○	○
Implemented unit-based interventions.	○	○
Recognized top performing teams within the hospital.	○	○
Offered incentives for high performance. Please comment describing the type of incentives and who receives them.	○	○

* Additional information and comments:

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6. Provide examples of any processes, policies, or procedures that you have in place to ensure that all patients have an excellent hospital experience

(HINT- Those may relate to leadership support, staff engagement, accountability, team and individual recognition, HCAHPS and satisfaction data feedback, education on patient centered care and related behaviors, staffing policies, criteria for annual reviews, etc...)

* If you like to submit additional files, information, or graphs about your/your hospital's work, please email the information with your abstract submission form to bestpractices@jhmi.edu