



**BEST PRACTICES IN
PATIENT-CENTERED CARE
CONFERENCE PROCEEDINGS**

**ARMSTRONG INSTITUTE
FOR PATIENT SAFETY AND QUALITY**

Best Practices in Patient-Centered Care

Conference Proceedings

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FORWARD

We are pleased to put together these proceedings from the Best Practices in Patient-Centered Care (PCC) Conference that we held in September 2013 in Baltimore, Maryland. This conference was hosted by the Armstrong Institute for Patient Safety and Quality and generously funded by Agency for Healthcare Research and Quality and the Gordon and Betty Moore Foundation. Submissions to present on best practices in PCC at this conference were restricted to a select group of organizations that have demonstrated very high performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey nationally. The presenters were subsequently asked to submit abstracts of their work that were reviewed by the conference's Scientific Committee. All abstracts were reviewed by two committee members who were blinded to the names and organization of the abstract's authors. The authors were then invited for an oral or poster presentation based on the abstract review scores. Several roundtable discussions were held as well.

Five hundred and fifty five people, from the US and internationally, attended the conference . Conference attendees included healthcare executives, quality improvement and service excellence experts, frontline clinicians, and patient-family advocates. The conference activities included six plenary sessions, twelve oral presentations on best practices, thirty-one poster presentations, and several roundtable discussions.

The purpose of these proceedings is to facilitate wide sharing of the information presented at the conference with interested organizations and individuals in the US and worldwide.

The proceedings have been brought together with the assistance of our editorial team composed of Ms. Bickey Chang, Dr. Marie Hanna, and Dr. Zishan.Siddiqui. A special acknowledgement is warranted for the conference scientific committee for their work on reviewing the submitted abstracts and facilitating conference events.

Sincerely,



Hanan Aboumatar, MD, MPH
Best Practices Project Director

Core Faculty, Armstrong Institute for Safety and Quality, Johns Hopkins Medicine
Assistant Professor of Medicine and Public Health, Johns Hopkins University

CONFERENCE WELCOME

September 26, 2013

Dear Colleagues,

Welcome to the Best Practices in Patient-Centered Care Conference. In this conference, we bring together hospital leaders, clinicians, policy makers, and patient-family advocates to share best practices in patient-centered care, discuss challenges, and collectively explore how those challenges can be successfully addressed.

We all yearn for a healthcare system that delivers safe, high quality, and patient-centered care. However, the pathway for achieving this is far from clear. Our hope is that this conference will offer an important step in that direction. Using the comparative database of the Hospital Consumer Assessment of Health Providers and Systems Survey (HCAHPS), we identified hospitals of various sizes in the United States that have achieved top ranking or made remarkable improvements in the HCAHPS domains of communication, staff responsiveness, discharge planning, and pain management. We invited leaders from these top-performing hospitals to present their work in this conference.

Our goal is that this conference will not only facilitate knowledge transfer but also enable networking and ongoing experiential learning in various areas of HCAHPS. We also hope that the conference will offer many moments of inspiration and encouragement for all of us who work towards achieving patient-centeredness in acute care settings; while this is often difficult, demonstrable progress is achievable.

We look forward to meeting all of you from across the country to take part in our rich conversations during the two-day conference, and to participate in collective learning that we hope will emerge from this confluence of perspectives and experiences. Together, we can move mountains!

Sincerely,

Hanan and Peter



Hanan J. Aboumatar, MD, MPH
Best Practices Project Director
Research and Education Associate
Armstrong Institute for Patient Safety and Quality
Johns Hopkins Medicine



Peter J. Pronovost, MD, PhD
Director, Armstrong Institute for Patient Safety and Quality
Sr. Vice President for Patient Safety and Quality
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CONFERENCE AGENDA

Thursday, September 26, 2013

7:30 AM - 8:00 AM	Registration
8:00 AM - 8:15 AM	Welcome and Conference Goals
8:15 AM - 8:55 AM	Safety, Quality, and Patient-Centered Care Keynote: <u>Peter Pronovost</u> Johns Hopkins University
8:55 AM - 9:35 AM	Making Hospital Care Patient-Centered Keynote: <u>Hanan Aboumatar</u> Johns Hopkins University
9:35 AM - 10:15 AM	Shared Decision-Making Keynote: <u>Dominick Frosch</u> Gordon and Betty Moore Foundation
10:15 AM - 10:30 AM	Break

Best Practices Session I: Meeting Patients' Needs

Moderator: Deborah Baker, Johns Hopkins Health System

10:30 AM - 12:00 PM	Excellence: A Way of Life - Responsiveness <u>Sandra Miller</u> Sarah Bush Lincoln Health Center
	Housekeeping Service Card <u>Kelly King</u> Sioux Falls Specialty Hospital
	Responsiveness of Hospital Team <u>Jane DeStefano</u> San Jacinto Methodist Hospital
12:00 PM - 1:00 PM	Lunch

Best Practices Session II: Addressing Patients' Pain

Moderator: Marie Hanna, Johns Hopkins University

1:00 PM - 3:00 PM	Driving Improvements in Pain Management and Communications with Patients Regarding Medications as part of Institutional Culture of Safety and Process Redesign Programs <u>Karen Olsen</u> and <u>Christina McQuiston</u> Memorial Mission Hospital and Asheville Surgery Center
	Monongahela Valley Hospital's Journey to Excellence (J2E) – Pain Management <u>Lynda Nester</u> Monongahela Valley Hospital
	Orthopaedic Patient Education: Utilizing an Orthopaedic Patient Educator to Improve Our Patients' Experience <u>Tina Cartwright</u> and <u>Rosheen LaValley</u> Concord Hospital
3:00 PM - 3:15 PM	Break

Best Practices Session III: Preparing Patients for Discharge

Moderator: Daniel Brotman, Johns Hopkins University

3:15 PM - 4:45 PM	Discharge Planning Process at OSS Orthopaedic Hospital <u>Eleanor Keller</u> and <u>Crystal Stiffler</u> OSS Orthopaedic Hospital
	Our Journey to Patient-Centered Discharge Process <u>Julia Nelson</u> Prairie du Chien Memorial Hospital
	Patient-Centered Transition of Care <u>Jay Pomerantz</u> and <u>Suzanne Herman</u> University of North Carolina Hospitals
6:00 PM - 8:00 PM	Evening Reception and Poster Presentations

8:00 AM - 8:40 AM	Pain Management in the Hospital Setting Keynote: <u>Marie Hanna</u> Johns Hopkins University
8:40 AM - 9:20 AM	Patient Engagement and Activation Keynote: <u>Judith Hibbard</u> University of Oregon
9:20 AM - 10:00 AM	Patient-Provider Communication Keynote: <u>Mary Catherine Beach</u> Johns Hopkins University
10:00 AM - 10:30 AM	Break

Best Practices Session IV: Improving Communications and the Patient Experience

Moderators: Emily Boss, Johns Hopkins University
Zishan Siddiqui, Johns Hopkins University

10:30 AM - 12:00 PM	Achieving Top Performance in HCAHPS Communication about Medications <u>Jerry Stockstill</u> and <u>Kathryn Raethel</u> Castle Medical Center
	Innovation Units at Massachusetts General Hospital – Transforming Care Delivery, Achieving Efficiency, Improving Quality and Providing a Superior Patient Experience <u>Rick Evans</u> Massachusetts General Hospital
	Nursing Communication: It Really Isn't All About The Nurses <u>Nancy Hesse</u> Abington Health Lansdale Hospital
12:00 PM - 1:00 PM	Lunch

12:30 PM - 2:00 PM

Roundtable Discussions

Topics:

Data Feedback

Rounding Interventions

Leadership and Culture

Technology Support

Clinician Engagement

2:00 PM - 3:00 PM

Awards and Closing Remarks

TOP PERFORMING HOSPITALS

Abington Health Lansdale Hospital
Carolinas Medical Center - NorthEast
Castle Medical Center
Catholic Medical Center
Concord Hospital
Geisinger Medical Center
Intermountain Medical Center
Massachusetts General Hospital
Mayo Clinic Florida
Mayo Clinic Rochester
Memorial Healthcare System
Memorial Mission Hospital and Asheville Surgery Center
Methodist Hospital
Metro Health Hospital
Monongahela Valley Hospital
Nebraska Orthopaedic Hospital
OSS Orthopaedic Hospital
Our Lady of the Lake Regional Medical Center
Penn State Milton S. Hershey Medical Center
Prairie du Chien Memorial Hospital
Provident Hospital of Cook County
Regional Medical Center at Memphis
San Jacinto Methodist Hospital
Sarah Bush Lincoln Health Center
Sioux Falls Specialty Hospital
Siouxland Surgery Center
SSM St. Mary's Health Center
The Memorial Hospital of Salem County
Thomas Jefferson University Hospital
University of North Carolina Hospitals
University of Florida Health Shands Hospital
Via Christi Hospital on St. Teresa

* Top performing hospitals arranged in alphabetical order

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SAFETY, QUALITY AND PATIENT-CENTERED CARE

Peter Pronovost, MD, PhD, FCCM

Sr. Vice President for Patient Safety and Quality,

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Patient-centered care is associated with clinical outcomes, patient loyalty, employee satisfaction, and financial benefits. Poor communication is reported as the root cause in 70% of hospital sentinel events and in 40% of malpractice cases due to medical errors. These highlights the importance of understanding and implementing best practices in patient-centered care. Much can be learned from ongoing work in improvement science to support work in patient-centered care.

In 2001, after the tragic death of eighteen-month old Josie King due to a hospital-acquired infection, Johns Hopkins Hospital (JHH) undertook a monumental effort to improve patient safety and quality of care. We developed a model for improving care which combined adaptive and technical aspects of improvement work. We used the Translating Evidence into Practice (TRiP) framework to summarize evidence and measure performance. In addition, JHH designed a Comprehensive Unit-based Safety Program (CUSP) to tap into the wisdom of the unit staff and to empower staff to take ownership for improvement work. A Central Line-associated Blood Stream Infection (CLABSI) checklist was developed based on evidence-based practices and implemented using this model. Subsequently, the statewide implementation of these evidence-based practices in hospitals across Michigan resulted in a significant decrease in mortality, and these strategies have spread nationally and internationally to over 1500 hospitals.

Important success factors in our CLABSI improvement work included defining and communicating clear goals and measures and transparently reporting results for feedback and accountability. The creation of ownership by local teams and communities to support process improvement were also critical.

In order to implement change in the organization, it is essential to examine the paradigm that guides our work and to identify key behaviors and enablers that could support our progress. There is an urgent need to develop a framework with clearly communicated goals and measures, which would help create an accountability mechanism, a sustainability plan and a transparent reporting system. The hospital policies need to be crystal clear for everyone to perform his/her day-to-day activities. The hospital leaders need to frequently reevaluate and improve the health system.

Patient harm does not only include biological harm, but also caring aspects such as disrespect. The improvement model could be applied to improve patient-entered care and the patient experience.

MAKING HOSPITAL CARE PATIENT-CENTERED

Hanan Aboumatar, MD, MPH

*Project Director, Best Practices in Patient-Centered Care Study and Conference
Core Faculty, Armstrong Institute for Safety and Quality, Johns Hopkins Medicine
Assistant Professor of Medicine and Public Health, Johns Hopkins University*

Patient-centeredness in the hospital involves providing care that is respectful of and responsive to individual patient needs, preferences, and values. Patient-centeredness improves patient outcomes and satisfaction, as well as quality of services, safety, and employee retention.

From the patient's perspective, hospitalization is a challenging life experience. Patients are acutely ill and surrounded by new healthcare providers who deliver multiple medical interventions, some with substantial degree of discomfort and risk. In order to understand what patients care about in the hospital, we analyzed open comments from satisfaction surveys administered to patients post their hospital discharge. Following a thematic analysis approach, we identified central areas that patients focused on. Those included perceptions of healthcare providers' attitudes and technical skills, as well as communication skills. Other areas of focus included addressing patients needs, maintaining physical comfort (e.g. pain control), being informed about and engaged in their care, and being ready for discharge. A helpful action framework to improve patient-centered care delivery in the hospital, involves focusing on 3 areas: Meeting patients' needs, involving patients (and their family caregivers) in their care, and preparing them to manage their health conditions upon discharge.

Patient experiences in healthcare vary a great deal between hospitals and between patients within the same hospital. We conducted a multilevel analysis of data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for 5 hospitals within the Johns Hopkins Health System. The study revealed that patient experiences are highly variable among hospital units. The 'doctor and nurse communication' domains were the least variable, whereas the 'staff responsiveness' domain- which measures staff responsiveness to 'call bells' and to patients' toileting needs- showed the most variation. These results raise patient safety concerns given that about 50% of inpatient falls are related to toileting activities. Hospital-based interventions need to reduce variation and improve reliability of delivering patient-centered practices.

The *Best Practices in Patient-Centered Care* study and conference aims to identify healthcare innovations and promising practices for advancing PCC delivery. We identified high performing hospitals in the United States via analysis of publicly reported HCAHPS data and invited them to take part in this study. Fifty-two hospitals participated and key informants from these hospitals were surveyed. The hospitals included 23 academic and 28 community hospitals of varying hospital sizes. To allow for in-depth conversations and wide spread sharing of best practices we organized this national conference and invited representatives from the high performing hospitals to share their best practices via oral and poster presentations. We also organized a series of roundtable discussions on topics that are central to achieving improvement in this area.

SHARED DECISION-MAKING

Dominick Frosch, PhD

Patient Care Program

Gordon and Betty Moore Foundation

Patient and family engagement is defined as a process by which the patients, their families, their representatives, and all health professionals work in active partnership at various levels across the health care system towards improving direct patient care, the care delivery process, and governance and policy-making.

Shared decision-making is a key strategy for patient engagement that is relevant for making healthcare choices, especially when multiple options are available and there is no clear best choice. These decisions are often described as preference-sensitive because the different options entail varying trade-offs between risks and benefits. With shared decision-making, the physician brings the medical knowledge to address the challenges at hand, while the patient bring forth their preferences, what they are willing to know, and what they are willing to try.

Studies have shown that 96% of patients want to know information about their diagnosis and therapeutic options. Therefore, it is essential to involve patients in preference-sensitive decision-making, which decision support interventions can facilitate. Numerous studies have shown that patients are more satisfied with the process of care, are more knowledgeable about their options, and have more realistic expectations of what care can and cannot accomplish when they receive and use decision support interventions.

The Partners in Medical Decision-Making project was initiated to make the provision of decision support to eligible patients routine, habitual, meaningful, and accessible to as many patients as possible. The study found that engaging patients in shared decision-making will require significant culture change because the traditional understanding of clinicians' and patients' roles is that clinicians do things "to patients" rather than "with patients". However, a change of culture is a challenging process because the idea of patients and clinicians working together as equal partners is still a novel concept. This will require concerted and sustained strategic efforts to succeed.

Providing decision support to patients as a default for providing care is the first step that can help us move forward in patient-centered care. It is essential to help patients become more active and encourage them to express their concerns if a recommendation does not make sense or fit with their goals, preferences and values. Finally, it is essential to measure the extent to which healthcare providers engage the patients that consult them.

PAIN MANAGEMENT IN THE HOSPITAL SETTING

Marie Hanna, MD

Associate Professor

Johns Hopkins University School of Medicine

Pain is a universal phenomenon and affects everyone at some point. For many, pain becomes chronic, a scourge that impacts every aspect of life- work, family relations, finances, mood, and even the very essence of identity. According to the National Institutes of Health (NIH), pain is considered to be a silent epidemic and an important public health problem. Studies have proved that pain is not treated well, pain level before and after hospital discharge is often similar, and a large proportion of patients go home with extreme pain. This ineffective management of pain results in an escalating cascade of health care issues.

Acute pain that is not treated adequately and promptly may result in persistent pain that eventually causes irreversible changes in the nervous system. This translates into progressive biopsychosocial epiphenomena resulting in further pain and disability. Ineffective pain management can be attributed to inadequate assessment of pain, use of inadequate interventions for pain control, inadequate knowledge of pharmacology, fear of side effects of opioid, and fear of addiction.

In the face of adequate medical science, technical skills, and resources, the reality of delayed and inadequate pain care is paradoxical. Improved pain management has been shown to improve patient outcome especially morbidity. Asking about pain needs to be an important part of all assessments. It is important that everyone caring for the patients know how to assess and report pain. Assessments to identify and treat pain must be an ongoing process especially for elderly patients. Even the top institutions in our country fail to produce good results in-terms of managing pain.

The concept of a multimodal strategy, including regional analgesia, was introduced more than two decades ago to allow early ambulation, promote better rehabilitation, accelerate recovery, and reduce hospital stay. In the ambulatory surgery setting, evidence has shown great promise for the use of local anesthetics, acetaminophen, and nonsteroidal anti-inflammatory drugs (NSAIDs). The combination of several non-opioid analgesics with opioids delivered by patient-controlled analgesia offers advantages over opioids alone. Pain management is an art; a clinician must balance the risks and benefits of each modality to customize treatment based on a patient's specific needs. Pain management is important to the overall patient experience and has a strong influence on overall patient satisfaction.

We can consider several viable avenues to achieve our goal of attaining excellence in the delivery of high quality, cost-effective pain care to the patients we serve. We should aim to understand the scope and body of knowledge encompassed by the field of Pain Medicine. We need to assess the adequacy of undergraduate, graduate, and postgraduate education in the principles and practices of pain management. It is also critical to understand the nations demand to improve pain management. By applying evidence-based practices and utilizing the growing expertise in the field of pain management, we can tackle the challenges associated with pain management and in turn improve the overall quality of care.

PATIENT ENGAGEMENT MEANS MEETING PATIENTS WHERE THEY ARE

Judith Hibbard, DrPH

Senior Researcher and Professor Emerita

University of Oregon

Patient engagement means meeting patients where they are. To meet patients in this way, we need to understand how ready and able they are to participate in their care. By measuring their knowledge, skill, and confidence for managing their health, we can better understand patient needs and work more effectively with them. The Patient Activation Measure (PAM) gives the clinician actionable information for working collaboratively with patients.

An activated consumer is someone who has the knowledge, skill, and confidence to take on the role of managing their health. Reviewed findings from various studies have shown that activation is linked with better care experiences and better health outcomes. Higher activated individuals are more likely to engage in positive health behaviors and to have better health outcomes. Activation level is predictive of behaviors and people who are more activated are more likely to engage in preventive behaviors, healthy behaviors, disease specific self-management behaviors, and information seeking behaviors. Activation can predict utilization and health outcomes two years into the future for various diseases while less activated patients are more likely to have poorer health outcomes and to incur higher costs. As provider payments become more closely linked with patient outcomes, understanding how to increase patient activation will become a priority for payers and providers

Engagement is important in any situation where the patient has a significant role to play. We are counting on the patient to do their part of the care process, and we know that not all patients are equally ready for this. Health care delivery systems are using PAM to help tailor their care to the patients' level of activation. The idea is to set patients up for success by encouraging behaviors they are likely to succeed at. This means encouraging smaller steps for those less activated. Health systems are also using the information to rethink how they allocate resources. For example, less activated patients are almost twice as likely to be re-admitted to the hospital in the 30 days after discharge. Hospitals are using this information to give more follow-up support to patients who score low on the PAM. They are re-allocating resources to give more to these higher risk, low activated patients, and less support to patients who have more self-management competencies.

IMPROVING COMMUNICATION FOR BETTER PATIENT OUTCOMES

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Associate Professor

Johns Hopkins University School of Medicine

Communication plays a significant role in delivering high-quality health care. Most of the patient dissatisfaction and complaints are associated with breakdown in the doctor-patient relationship. The ultimate objective of any doctor-patient communication is to improve the patients' health and medical care. Good communication leads to positive effects on patient satisfaction and helps with recall of information, understanding and perceived control over illness, adherence to therapy, and other health outcomes.

The main goals of doctor-patient communication is to create a good interpersonal relationship, facilitating exchange of information, and including patients in decision-making. In order to improve the communication clarity, clinicians should set explicit agenda for the patients' visit and explore the patients' perspectives. Clinicians should also express empathy, listen reflectively and resist the "righting reflex", which is the tendency to "correct" the patient when they are engaged in unhealthy behaviors. Studies have shown positive patient responses when clinicians demonstrate an accurate understanding of patients' needs and are receptive of their feelings or concerns.

By empowering the patient and assessing comprehension, the clinicians allow their patients to take control of their biomedical information, identify and build on their strengths, and also help patients gain control over how they can make a difference in their own health. Studies have shown that 40-80% of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect. In order to tackle the loss of information, the 'teach back' method is currently utilized and has been associated with improved patient outcomes.

Every doctor has their own innate style and skills when interacting with patients, but regardless of how skilled they may be, instinctively, there are skills to learn that might seem counter-intuitive. Patients want doctors who can skillfully diagnose and treat their sicknesses as well as communicate with them effectively. Doctors with better communication and interpersonal skills are able to detect problems earlier, prevent medical crises and expensive intervention, and provide better support to their patients. Better communication may lead to higher-quality outcomes and better satisfaction, lower costs of care, greater patient understanding of health issues, and better adherence to the treatment process. Therefore, it is essential to nurture the physician and patients' partnership in every hospital to achieve the agreed upon goals and the attainment of quality of life.

BEST PRACTICES SESSION I: MEETING PATIENTS' NEEDS

Moderator: Deborah Baker, Johns Hopkins Health System

PRESENTATION 1: EXCELLENCE A WAY OF LIFE – RESPONSIVENESS

Presenter:

Sandra Miller, Sarah Bush Lincoln Health Center

Introduction

Sarah Bush Lincoln Health Center worked for several years to improve patient satisfaction scores with little success. As a health system, a large-scale initiative was needed to create a new culture of excellence. In 2007, they created “Excellence a Way of Life” initiative to train all employees across the health system.

Interventions

Different teams were created that focused on the following areas:

1. Communication - Communication was considered as a key intervention component. Hence, communication boards were created in every department to help all employees understand what is happening within the system and what they needed to do to reach their strategic objectives. The boards were updated monthly.
2. Employee engagement, leadership, physician liaison, and patient experience team, aimed to give a ‘wow’ experience to patients. This was an important focus of the intervention.
3. Measurement and Standards: The measurement team looked at data, and a standards team looked at standards of performance, including attitude, appearance, communication, commitment, responsiveness, and privacy.

Interventions in the following areas were implemented:

1. Service Recovery: Staff was trained in service recovery using blameless apologies and offering small tokens if necessary. Universal scripts with language such as: “I am sorry you had that experience. Is there anything I can do to make it better for you?” were used by support staff in service recovery.

2. Nursing Care: Over the years, nurses were felt to have gotten so caught up in technology that it was easy for them to forget about the patients and communicate with them well. Therefore, the nursing staff were encouraged to develop a relationship with the patients. As a result, nurses now spent five minutes at the beginning of each shift with each patient, where they would sit down, establish eye contact with the patient, explain the plan of care for the day, listen for questions and concerns, and respond to those.
3. Hourly rounding: Hourly nursing rounds were divided between nurses and care partners (such as nursing technicians) on odd and even hours. The staff would ask every hour about patients' pain, need to go to the restroom, need to reposition, and if everything they needed was within their reach. Hourly rounding provided the staff a chance to anticipate patients' needs and meet them before the patients needed to ask.
4. Bedside shift report: Bedside shift report was provided from nurse to nurse and from care partner to care partner at the start of each shift. During report, the outgoing nurse /care partner would introduce the new staff member on the team to the patients, orient them to what is happening, involve the patients in the discussion, and give the patients the opportunity to say "don't forget about this". This allowed nurses to be responsive from the beginning.
5. Admission, Discharge, and Transfer special nurse (ADT nurse): Given that paper work was very time consuming, patients wanted to go home quickly, and nurses were not always available to address their needs in a timely manner, the ADT nurse role was added to the unit team. This was met with opposition from staff at first. However, having a dedicated ADT nurse worked well and became a great satisfier.

Lessons Learned and Sustainability

Resistance to change was the main challenge:

- Scripting – Staff resisted this, stating, "I don't need you to tell me what to say. It makes me feel like a robot". However, the patients were very impressed when every single caregiver asked if there was anything he/she could do to help.
- Bedside shift report – Nurses were resistant to talking in front of the patients initially.
- Hourly rounding – There was a need for continuous monitoring to make sure hourly rounding was being done. The recommendation to nurses was to try to take care of everything while they were in the room to save time and ensure patients are happy.
- Motto – Every patient, every time, everywhere. Holding each other accountable was a challenge.

For sustainability:

- Daily charge – Information was consistently communicated across the entire health system, including standards of performance, which needed to be put out in front of the staff regularly.

- Stories – Nothing was more motivating for the staff than to be mentioned positively by the patients.
- Staff recognition -These included mutual recognition and compliments from leadership. Nursing compliments to care partners also had a positive effect.
- Employee recognition – When a patient recognized someone, it was posted; recognition posts were updated every week. Even now after six years, staff still looked forward to this and worked hard to make the list.
- Supervisor rounding – This helped ensure hourly rounding was adhered to. Supervisors looked at quality of care, not just customer service, ensured high fall risk patients had bed alarms, and facilitated early discontinuation of foley catheters.
- Director rounding – Staff knew the director would be out and about; this helped them to step up.
- Patient feedback and follow up – Sarah Bush Lincoln Health Center tracked progress and focused efforts based on patient feedback.
- Annual performance review – The annual performance review needed to include all standards of performance and helped to hold staff accountable.

For more information on Sarah Bush Lincoln Health Center’s best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

An Angel at the Hospital

Abby is a nurse at Sarah Bush Lincoln Health Center. One morning, she came to work and was assigned to an elderly, confused, and paranoid gentleman. He was used to people in the hospital dismissing him, saying, “oh, he’s confused” and “you’re in the hospital” and moving on.

Abby listened to his fears and realized she could not say he was just confused. More than anything, he was afraid of this scary place called the hospital. She asked him to take a walk with her around the hospital, showing him how many patients were around him and how many staff members were available to help him. He bonded with Abby.

He was in the hospital several times, and he always requested to have Abby by his side. In his last days, his family took picture of him with Abby. “There’s his little angel.”

When he passed away, his family called the unit to invite Abby to join the visitation. His picture with Abby was included because that was the last time they saw him smile.

Responsiveness is not about getting patients to the bathroom or answering the call line quickly. It is about responding to their fears and needs.

PRESENTATION 2: HOUSEKEEPING SERVICE CARD

Presenter:

Kelly King, Sioux Falls Specialty Hospital

Introduction

Sioux Falls Specialty Hospital identified an area of concern related to the HCAHPS question, “How often was your room and bathroom kept clean?” With an average of 87.6% of HCAHPS respondents responding “Always” to that question, they were determined to develop and implement a thoughtful intervention to increase their score.

Prior implementation of the housekeeping competency in 2011 did not lead to sustained improvement in patient satisfaction. They found that although the housekeeping competency may have enhanced cleaning efforts and housekeeping staff efficiency, it did not improve the patients’ views on how clean their room was.

Interventions

Sioux Falls Specialty Hospital’s approach to problem solving was as follows:

1. Data sharing: Everyone within the organization, including the inpatient department, reviewed the HCAHPS scores on a monthly basis so that everyone shared the same expectations. Graphs and charts were shared to facilitate brainstorming sessions for ideas to improve scores.
2. Teamwork: Collaborative teams were formed, with participation from staff who were at the bedside performing direct patient care. Nurses, nursing assistants, dietary staff, and housekeeping staff all worked together to think about the problem from the patients’ perspective.
3. Patient perspective: From the patients’ perspective, when they woke up after being on pain medications, it was rather difficult to know who had been in or out of the room. It was also difficult to know if the room had been cleaned or not.
4. Communication: It seemed the common denominator was communication. This led to the development of the Housekeeping Service Card.

On the Housekeeping Service Card, the housekeeper filled out:

- Housekeeper’s name: I have been here to clean your room today.
- Contact phone number: Here’s my number, if you have concerns, feel free to call me.

This card was strategically placed on patients’ over-bed table where patients could easily view it.

It was not just housekeeping who was responsible:

- Dietary staff was also included. When they brought meal trays, they wiped the over-bed table.

- Nursing staff were challenged to keep patient rooms de-cluttered. Storage spaces, such as cabinets and closets on the unit, were identified to store equipment that was not in use.

Lessons Learned and Sustainability

This was a grassroots team effort:

- Team effort - From nursing to dietary to housekeeping, this was a team effort. Everyone helped to make a difference in improving patient care.
- Employee ownership - This was not a top-down administrative directive. The staff played an integral role in developing an action plan which aligned with the organizational Standards of Performance. Upper management recognized that the key for leading change would be staff involvement in both identifying and implementing solutions.

To sustain the results, they had to close the loop:

- Accountability - Once an intervention was developed and implemented, holding people accountable to the organizational Standards of Performance was essential. This intervention was tied to high-level organization goals, to department goals, and to individual goals reflected in staff performance appraisals.
- Monitoring – Daily nurse rounding was implemented to ensure the tent cards were being used. An adenosine triphosphate (ATP) monitor was also utilized to validate the cleanliness of surfaces around the patients' environment.
- Communication – Continual conversations with people involved in the team, including housekeepers and other key players, was important.
- Celebration – They were good at celebrating success. One of the corporate values is to have fun, so this fit into the organizational culture.

For more information on Sioux Falls Specialty Hospital's best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

PRESENTATION 3: RESPONSIVENESS OF HOSPITAL TEAM

Presenter:

Jane DeStefano, San Jacinto Methodist Hospital

Introduction

Houston Methodist San Jacinto Hospital was once the only hospital in town. In the beginning, its patient satisfaction scores were at the bottom tenth percentile, which was surely among the lowest of the low. The driving forces on Houston Methodist San Jacinto Hospital's road to improvement were organizational values of Integrity, Compassion, Accountability, Respect, and Excellence (ICARE), a commitment to quality, safety, and service, and a dedication to patient and family centered care.

Interventions

A system-wide branding initiative was launched to create the "Methodist Experience", an experience that made patients want to return to this health system when they needed care. Key strategies and intervention for improvement included:

1. Technology: The use of communication devices could help or hinder responsiveness towards patients and needed to be considered with thoughtfulness. At San Jacinto, a patient call system sent an alert to front line staff equipped with a Vocera communication device when the patient activates the call system. The message was communicated directly to the caregiver, who could not continue his/her current activities unless he/she entered the patient room to respond to the patient's needs and deactivate the call. The Patient Interactive System, with health education videos, discharge information, and the latest movies, provided a way to engage patients and family members in their care.
2. Hourly rounding – Hourly rounding could help identify and address patient concerns in a timely fashion, but monitoring actual implementation consistency was a challenge. A light outside the patient room provided a solution: it turned yellow at 45 minutes and red at the hour mark. This created a no pass zone, where if a caregiver passed a room with a red light, he/she had to check on the patient before continuing on.
3. Senior leadership rounding – The senior leadership team members were assigned to a number of rooms every month and would sit and talk to each assigned patient to understand his/her concerns.
4. Service recovery – Staff could apologize to the patient about his/her experience and leave him/her with a service coupon. Service standards (such as smiling and greeting people) might seem basic but were not simple in practice. Reaching out to patients from the moment they reached the hospital was an important part of the 'Methodist' experience.

5. Patient satisfaction teams – These teams held weekly meetings that focused on three questions which were top priority areas from the Press Ganey survey: 1) how well they responded to patients’ concerns and complaints; 2) how well they included patients’ in decisions about care, treatment, and service; 3) how well they addressed patients’ emotional needs. Staff-driven IACT (Acknowledge and Apologize, Correct, and Thank), IASK (ask the patient for permission and probe for understanding), and ICARE (sit and listen) teams addressed each of these concerns.
6. Courtesy cards – These were business cards left with patients to help them identify members of their care team.
7. Culture – Houston Methodist San Jacinto Hospital has a culture of safety with personalized service and a commitment to deliver “wow” service for patients. Consistent messaging to staff on who they are and what they stand for was important: “You’re always on stage”, “Take five minutes to go above and beyond”, and “Try to look at problems from the patient perspective”.
8. Recognition – Staff nominated peers who went above and beyond for “The Sacred Works Award”.
9. Patient and family centered advisory council – The patient and family centered advisory council showcased leadership commitment to culture change. It was important to view the patient experience through the patients’ eyes and provide them the opportunity to contribute. Currently, everything from the patient hospital guide to the boards in patient rooms goes through this council.
10. Daily line up – Started by CEO, this line up provided staff 5 minutes to regroup and connect each day. Quick updates were shared on what’s happening within the organization that week, and a daily trivia passage was included, too.

Lessons Learned and Sustainability

It was not always easy to identify which interventions to pursue. At Houston Methodist San Jacinto Hospital, sometimes they tried some interventions and then aborted them if they did not work.

The key to sustainability:

- Reinforce the patient as the center of care –Efforts to reinforce patients as the center of care included director rounding, caring ambassadors, and including employee recognition plans, as well as distribute badges of IACT.
- Open dialogue, transparency – Communication efforts included posting satisfaction scores and holding weekly patient satisfaction meetings.

For more information on San Jacinto Methodist Hospital's best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

The Sacred Works Award

Clinical staff: A nurse in the emergency department met a gentleman who came from India and needed surgery. There was no way for him to reach the care team, so she gave him her cellphone. In surgery, she sat by him. After the surgery, she and her husband sat with him. Her husband also came to walk with him as he began rehabilitation.

Non-clinical staff: A guard saw a family struggling to get a patient to the rest room. The patient was already embarrassed. The guard went with him, stayed with him, and cleaned him up.

Presented by Jane DeStefano, San Jacinto Methodist Hospital

Commitment to Excellence Statement

Excellence demands that we constantly challenge perceptions and the status quo. Excellence demands that we commit to the health and well-being of our community. Excellence demands that we work together as a team to provide outstanding care for the physical, spiritual, emotional, and cultural needs of our patients, generation after generation. Excellence demands that we value innovation.

We are committed to igniting the passion of excellence that burns within each of us. We will proactively focus on safety, quality, and service. We will live by our values. We will be good stewards of our financial and human resources. We will recognize and respect the uniqueness and worth of each person. We will take pride in our work, foster a sense of ownership, and celebrate our success. We will provide a warm and inviting environment. We will stand proudly as a leader in our community. We will be a place to heal, learn, and transform.

We will not rest.

Presented by Jane DeStefano, San Jacinto Methodist Hospital

BEST PRACTICES SESSION II: ADDRESSING PATIENTS' PAIN

Moderator: Marie Hanna, Johns Hopkins University

PRESENTATION 1: PAIN MANAGEMENT AND COMMUNICATION WITH PATIENTS REGARDING MEDICATION

Presenters:

Karen Olsen, Memorial Mission Hospital and Asheville Surgery Center

Christina McQuiston, Memorial Mission Hospital and Asheville Surgery Center

Kathy Smith, Memorial Mission Hospital and Asheville Surgery Center

Introduction

Memorial Mission Hospital and Asheville Surgery Center are dedicated to providing the best patient care without harm while creating an exceptional patient experience. Their HCAHPS survey results showed that patient perception of pain management was at the 48th percentile, and explanation of new medicine was at the 31st percentile. These baseline numbers provided an opportunity for improvement.

Interventions

Leaders in the hospital thought it was very important to include front-line physicians and other health care providers who spent a large amount of time with patients on the improvement team. Value stream mapping showed a multidisciplinary team was necessary to improve patient perception of pain management and overall patients care. Key interventions included the following:

1. Training – A course called “Communication in Healthcare” provided skills for healthcare providers to communicate efficiently with patients and bring medical knowledge and terms down to a level that patients could understand.
2. Bedside shift reporting – During shift reports, the two involved nurses handed off work at the bedside and engaged patients and their family in the plan of care.
3. SBAR (Situation, Background, Assessment and Recommendation) – SBAR provided a standardized communication process. Currently, the electronic medical record has an SBAR page, which pulls all the data in one concise page for easy access.
4. White boards – White boards were placed in patient rooms to provide a standardized method to communicate patients’ pain levels, as well as information on patient goals and schedules.

5. EMR redesign – They partnered with their Electronic Medical Record (EMR) vendor to streamline the processes for documentation and monitoring of pain assessment.
6. Geriatric pain management order set – A multidisciplinary team consisting of nurses, physicians, pharmacists, and orthopedic program coordinators developed an age-appropriate, evidence-based, and multi-modal pain management order set.
7. Pilot program in pain management– A pilot program was started with orthopedic patients and was later expanded to the general surgery population.
8. Patient engagement – Staff involved patients in their own pain management. Every patient had a target pain score, which took into account his/her own self-assessment and target for pain control.
9. Medication reconciliation – Physicians were expected to electronically enter all orders and complete medication reconciliation at patient admission and discharge. Nurses were responsible for obtaining the medication list. Facility-wide education reinforced the process and the role of each provider.
10. Quality board – Each unit had a quality board, which shared quality, patient safety, and patient satisfaction results with staff.
11. Leadership support - Senior executives went to a different unit each week, where customer service, unit staff, and nurse managers presented their opportunities for improvement and shared best practices.
12. Discharge toolkit – The discharge toolkit included a discharge instruction folder, which contained anything given to the patient during his/her visit. Discharge information and the patient’s medication list were printed on the same sheet. Each unit had a box with a communication checklist tool, which provided guidance for key tasks to be completed in the first 24 hours, the day before discharge, and the day of discharge to anticipate and address any patient needs before discharge.
13. Discharge phone call – High risk patients (no primary care physician, in the hospital for more than 1 year, on more than 7 medications) received a discharge phone call within 72 hours of discharge from a case manager.

14. Patient safety officers – Patient safety officers in each service line established a patient safety culture among physician and nurses to lead investigations and constantly look for opportunities to improve.

Lessons Learned and Sustainability

Key lessons learned include:

- Most processes are very complicated and require multiple efforts to improve situations.
- More physician engagement is important in care delivery.

The Memorial Mission Hospital and Asheville Surgery Center team say that they are not experts in patient-centered care but are on the journey with everyone else to learn from each other and to continually improve.

For more information on Memorial Mission Hospital and Asheville Surgery Center's best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

PRESENTATION 2: JOURNEY TO EXCELLENCE: PAIN MANAGEMENT

Presenter:

Lynda Nester, Monongahela Valley Hospital

Introduction

Monongahela Valley Hospital began its “Journey to Excellence” in 2006. Baseline statistics showed room for improvement. Their central mission as a community-based hospital could be summed up in six words: “What if it was your mother?” This was Monongahela Valley Hospital’s vision and the common driver to improve patient and employee satisfaction as well as community confidence.

Interventions

This journey to excellence included the following components:

1. Culture – We aimed to create a culture which retained great employees, continuously developed leaders, supported employees, and looked at both service and cost.
2. Leadership engagement – Leaders were vital in driving improvement. The CEO was the captain of the ship, while the leaders engaged staff to get on the boat, grab an oar, and start rowing.
3. Communication – Posters of Press Ganey and HCAHPS scores allowed staff, patients, and family to see the data. They believed in transparently sharing this data with patients since the data came from patients. Patient communication boards and huddles were also used.
4. Employee engagement – Employees came first, and patients came second. Employee engagement led to quality patient care. The leaders learned from employees what they valued and what rewards they appreciated the most (ex. gas cards). Reward and recognition were important.
5. Multidisciplinary teamwork – The Service Excellence Team and Standards Performance Group included multidisciplinary members, such as housekeepers, escorts, and senior nurse leaders.
6. Employee education and leadership development – This program reached 1,000 employees. About one-tenth of employees have participated in leadership development.
7. Hire for attitude - Pre-employment surveys and behavioral and peer interviews helped employers determine if potential employees would fit the culture of the organization.
8. Rounding – Different forms of rounding were employed, including leadership rounding, department and team rounding, nurse leader rounding, and hourly rounding. The CEO rounded at 2am in the morning at times so that he could meet the night shift staff.

Lessons Learned and Sustainability

Key lessons learned include:

- Leadership commitment should be the driving force – leaders must walk the walk.
- The leadership team must have an objective desired state and learn information from patient surveys results, patient comments, observations, and ongoing QI projects.
- Leadership must also engage staff in problem solving by going to the unit and asking what they wanted to try.
- Communicate the current state and the *desired state*, as well as brainstorming with the staff on how to get to the desire state.
- Ensure that staff have the tools required to make the changes.
- Hardwire the practice – standardize, hardwire, hold people accountable, and coach effectively, and
- Always keep in mind: “Is this the care you want for your mother?”

For more information on Monogahela Valley Hospital’s best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

PRESENTATION 3: ORTHOPAEDIC PATIENT EDUCATION: UTILIZING AN ORTHOPAEDIC PATIENT EDUCATOR TO IMPROVE OUR PATIENTS' EXPERIENCE

Presenters:

Tina Cartwright, Concord Hospital
Rosheen LaValley, Concord Hospital

Introduction

In-depth analysis of Concord Hospital's Press Ganey scores showed opportunities for improvement during patient discharge, including the length of time it took for patients to leave the hospital after they were told they could go home, communication and education about medications, and pain management.

Interventions

An Orthopaedic Patient Educator (OPE) role was created to lead the following interventions:

1. LEAN – The LEAN methodology was used as a tool for quality improvement, and training was provided for staff to learn how to implement it in their practice.
2. Care plan pamphlets – At each change of shift, practitioners talked patients through what they could expect during each part of their hospital stay.
3. Rounding – Caregivers rounded on orthopedic patients throughout the hospital. We made sure nurses had what they needed to care for this patient population.
4. Discharge readiness sheet – A discharge readiness group designed this tool to guide conversations with patients to ensure necessary arrangements were made for discharge and to help patients understand the process. The tool addressed patient concerns and helped ascertain whether they are comfortable to go home. Patients were given the tool the day before discharge to give them the chance to record questions they would like to ask the nurse beforehand.
5. Patient education – The leadership restructured pre-operative class scheduling and standardized the patient education content and approach to improve class attendance.

Lessons Learned and Sustainability

Key lessons learned include:

- Direction - Know where they have been, where they are, and where they are going,
- Support - Know where to get more resources, and
- Back to the patient – Do not lose sight of the patient.

For more information on Concord Hospital's best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

Case Study: Mrs. M.

Mrs. M. was contacted by pre-surgical testing (PST) routine phone interview prior to joint replacement surgery. She expressed frustration and apprehension related to a recent Concord Hospital stay. She insisted on dispensing and taking her own medications on her own schedule.

- PST contacted risk management.
- Risk management called the patient at home.

Mrs. M. revealed that on a previous stay, her disability needs were not considered. She felt her care was constantly rushed, and her own personal routines were not respected.

- Risk management notified everyone on the Ortho unit leadership team as well as care coordination and social work.
- There was confusion on who was going to follow-up, resulting in an informal meeting.
- Ortho unit leadership called the patient at home to discuss concerns.
- An inpatient care plan was drafted.
- On day of surgery, Mrs. M. was visited in the Admitting Unit (AMU) by the charge nurse on duty to present the inpatient care plan.
- The patient was not satisfied with the plan, so the care plan was sent back.
- Resource Nurse reworked plan and met with patient again.
- Patient approved the plan and copies were made (1 to patient, 1 to chart, 1 to caregivers).

Outcome

S/P procedure Mrs. M. was admitted as an inpatient to our unit where she had been satisfied with an uneventful stay until she sustained an MI and required 2 other transfers before discharging home.

Presented by Tina Cartwright and Rosheen LaValley, Concord Hospital

Case Study: Mr. F.

Mr. F. is a 63 year old gentleman scheduled for joint replacement.

Past Medical & Surgical History: HTN, Hep A, 8th cranial nerve autoimmune abnormality leading to deafness, recent bilateral cochlear implants, oscillopsia, & cholecystectomy.

- Orthopaedic Patient Educator (OPE) was contacted by the surgeon's PA to communicate patient's mobility and hearing loss could affect his recovery. OPE was provided with the patient's contact information.
- OPE contacted the patient and his wife via telephone. It was determined that they would discuss the initiation of a care plan the following week at their scheduled joint replacement class. After the pre-operative class, OPE met with Mr. F. and his wife, and the inpatient care plan was developed.
- The OPE also contacted the Deaf and Hard of Hearing Coordinator to resource any other necessary assistive equipment that may be available for the patient.
- OPE contacted and shared the inpatient care plan with all applicable staff and departments that would be involved in Mr. F's care.
- On the morning of surgery, the OPE visited the patient and his wife in the admitting unit to review the inpatient care plan one more time and ease any anxieties. Mr. F and his wife verbalized they were pleased with both the inpatient care plan and the extra attention in meeting their needs.
- OPE ensured room was setup as planned prior to arrival on unit.

Outcome

Patient stay was uneventful and on track for discharge to home.

Presented by Tina Cartwright and Rosheen LaValley, Concord Hospital

BEST PRACTICES SESSION III: PREPARING PATIENTS FOR DISCHARGE

Moderator: Daniel Brotman, Johns Hopkins University

PRESENTATION 1: DISCHARGE PLANNING PROCESS AT OSS ORTHOPAEDIC HOSPITAL

Presenters:

Eleanor Keller, OSS Orthopaedic Hospital

Crystal Stiffler, OSS Orthopaedic Hospital

Introduction

At OSS Orthopaedic Hospital, review of Press Ganey scores and post-discharge calls pointed to an opportunity for improvement in the discharge process. Patients did not feel ready for discharge and often felt the discharge process took too long. With an average length of stay of 2.2 days, patients were also in and out of the hospital very quickly. As a result, education was often done at the last minute, and patient retention of important information for post-discharge care was inadequate.

Interventions

A multidisciplinary team was formed to understand how to keep patients in the center of the process. Key conversations and shadowing experiences with everyone involved in the process – including patients, nurses, case management, and physicians – led to the following interventions:

1. Patient education – The pre-surgical packet given to patients prior to surgery was revised to include a wealth of information such as: what to bring to the hospital the day they were going to have surgery, advance directives, living will, home health agencies, nursing home, and acute rehabilitation facilities. These helped prepare patients for discharge even before they have their surgery. Joint classes for spine, hip, and knee patients were offered, and attendance was highly encouraged. The discharge packet included a discharge checklist. Education for discharge started the day of surgery after admission to the inpatient unit and was ongoing during the patients' hospital stay.
2. Communication about medicines – A pharmacist met with every patient to go over his/her medications on post-op day number one instead of waiting until the day the patient went home.
3. Dietary and physical therapy – Dietary and physical therapy staff met with patients prior to discharge to discuss their home environment, fears and obstacles at home, and how to overcome them.
4. Discharge folder – A discharge folder was handed to patients the day after they have surgery so they could review the information contained prior to discharge. The folder also included a resource list for discharge planning and flowers from the surgeon.

5. Communication – Communication across the continuum of care was key. Patient information from the physician’s office was shared directly with the hospital, and the EMR also reflected some pre-hospital information.
6. Patient and family centered care –The patient’s room was equipped with a chair that can roll out into a bed, and families were encouraged to stay with patients 24/7. The team included the patients and families in the discharge planning by going in, sitting down at eye level, and asking patients simple scripted questions such as, “what is your discharge plan?” Patients were in charge of the time they went home.
7. Discharge planning – Discharge planning was streamlined and started before patients had surgery. High risk discharges were identified by the physician’s office, and the social worker or case manager pulled together the whole plan and relevant paperwork, reviewed medication reconciliation, and arranged medical equipment in a timely manner.
8. Interdisciplinary rounds – Every day at 10 a.m., dietary, pharmacy, the charge nurse, nursing staff, case management, and social work conducted a 30-minute run down of what was going on with all the patients in the unit and discussed any barriers.
9. Post-discharge call – 48 to 72 hours post-discharge, each patient received a follow up call from one of the nurses to ensure he/she understood the instructions and have had a chance to fill his/her prescriptions. The nurse also reviewed directions from the facility the patient was transferred to.

Lessons Learned and Sustainability

Key lessons learned include:

- Multidisciplinary teamwork and communication are critical to improving the discharge process.
- Start early – The discharge process should begin the moment the patient enters the hospital.

For more information on OSS Orthopaedic Hospital’s best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

PRESENTATION 2: OUR JOURNEY TO PATIENT-CENTERED DISCHARGE PROCESS

Presenters:

Julia Nelson, Prairie du Chien Memorial Hospital

Bethany Schiefelbein, Prairie du Chien Hospital

Introduction

Prairie du Chien Hospital serves a community with a high population of frail elderly patients with chronic illnesses. An ineffective discharge process contributed to patient and caregiver distress, duplication of services, inadequate follow-up to care, and higher readmissions rates.

Intervention

To address these challenges, the following interventions were implemented:

1. Culture – Culture transformation was necessary to promote and sustain change. Training, which included LEAN methodology and tools to implement change, was provided for all employees and was included in the employee onboarding process. Partnership with the Studer group and Wisconsin Hospital Association’s Transforming Care at the Bedside Initiative (TCAB) also helped shift culture.
2. Multidisciplinary rounding – Nurses and physicians rounded together, and teamwork and communication improved. Patients and families were included in discussions of the daily plan of care, medications, and discharge planning.
3. Patient education – Education was completed based on patient preference. The “Educate Before You Medicate” initiative was launched to support staff to communicate the side effects of medications with patients. Fact mats related to diagnoses, with large print and clear graphics, were developed by the staff to assist with patient and family education. The teachback methodology and whiteboards were also used.
4. Communication – Standardized nurse-to-nurse bedside shift report forms were developed for all inpatient units.
5. Post-discharge call – A nurse called every high-risk patient at 24 to 48 hours post-discharge to address concerns expressed by the patient, connect the patient to pharmacy and primary care, and set up follow up appointments for every patient.
6. Leadership support – Everyone from the leadership down was committed to being the best hospital in the nation. Prairie du Chien Memorial Hospital has a very dedicated Board of Directors that participates on many teams, including the Quality Improvement Team and the Safety Team. Hospital staff provided a 30-minute education session at monthly board meetings

to educate board members and to keep them apprised of how they were doing and where they were going.

Lessons Learned and Sustainability

Some challenges include:

- Multidisciplinary rounding – Synchronizing nurse and physician availability is sometimes a challenge. Multidisciplinary rounding is being considered, although it may be hard to organize due to busy schedules.
- Education – Incorporating the Teach back methodology has been challenging. For specific topics such as CHF, COPD, medications, antibiotics for UTI, written instructions and/or videos are available. Having standardized, easy-to-use education materials and emphasizing to staff that education is as important as administering medications are key.
- Patient-centered perspective – It is important to look at the process through the eyes of the patient instead of through the eyes of the staff. Front line staff from multiple departments were engaged to brainstorm and lead change. Patients and families were included in improvement projects to provide their perspectives.
- Enabling staff –The first question a leader asks when rounding on staff is, “do you have all the tools you need to do your job?” This is the responsibility of the manager.
- Change – Embracing change is not always easy, but a culture shift makes it possible.

Future initiatives include:

- Engaging pharmacists – Implement discharge medication education by pharmacists
- Medication reconciliation – Create a better process for patient-friendly discharge medication reconciliation
- Multidisciplinary rounding – Schedule rounding at the bedside and include additional team members, such as respiratory therapy

For more information on Prairie du Chien Memorial Hospital's best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

PRESENTATION 3: PATIENT-CENTERED TRANSITION OF CARE

Presenters:

Jay Pomerantz, University of North Carolina Hospitals

Suzanne Herman, University of North Carolina Hospitals

Introduction

In 2007, the University of North Carolina (UNC) Hospitals started a service framework based on the Swanson Caring Theory called “Commitment to Caring”. Partnering with patients and families was a central part of this framework, and the six pillars were: People, Service, Quality, Finance, Growth, and Innovation. In 2009, with the “Carolina Care” initiative, UNC Hospitals was challenged by its president to hardwire these practices and reach higher HCAHPS goals.

Interventions

Key elements in Carolina Care included:

1. Post-discharge call – Nurses at the centralized call center called patients 24 to 48 hours post discharge to review discharge instructions and discharge medications, assist with any patient needs, and provide a friendly reminder to return satisfaction surveys. Real-time feedback, which was reported to nurse managers and ancillary managers, was obtained for rapid cycle improvement, and trends were documented.
2. Personal touch – Flowers attached to a personal note from the president were given to patients when they were discharged. These housekeeper-initiated thoughtful gestures signified for patients and staff the start of a new program.
3. Leveraging resources – UNC Hospitals worked with senior leadership to identify deliverables and how to work around limited resources to implement the program.
4. Multidisciplinary team – A SWAT team consisting of two case managers and a pharmacist made scripted and focused calls to high-risk patients to understand if they received their medicines and to help schedule follow up visits. Focused calls by the call center were expanded to all patients except low-risk patients, who received a standard call.

Lessons Learned and Sustainability

Some challenges include:

- Resource management – Working within limited resources may be challenging but is still possible, especially if the budgetary offset can be presented to the leadership.

Looking towards the future:

- The goal is to ensure no patient leaves the hospital without an appointment.
- As the hospital transitions to EPIC, an additional goal is to ensure no patient leaves the hospital without medication reconciliation.

For more information on the University of North Carolina Hospitals' best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

Key components of a post-discharge call

- Caller introduces self
- Confirm that person on phone is the intended patient/caregiver and obtain their permission to proceed
- Inquire about patient's current condition
- Any new or worsening symptoms?
- Assess understanding of discharge instructions
- Ask whether prescriptions were filled as ordered
- Does patient understand prescription orders?
- Verify that follow-up appointment was scheduled
- Probe for additional questions or concerns
- Notify the patient that they might receive a survey and encourage them to complete and return it
- Thank the patient for their time and for choosing your facility

Presented by Jay Pomerantz and Suzanne Herman, University of North Carolina Hospitals

BEST PRACTICES SESSION IV: IMPROVING COMMUNICATIONS AND THE PATIENT EXPERIENCE

Moderators: Emily Boss, Johns Hopkins University
Zishan Siddiqui, Johns Hopkins University

PRESENTATION 1: ACHIEVING TOP PERFORMANCE IN HCAHPS COMMUNICATION ABOUT MEDICATIONS

Presenters:

Jerry Stockstill, Castle Medical Center
Kathryn Raethel, Castle Medical Center

Introduction

When Castle Medical Center saw a dip in its 2012 Communication about Medication HCAHPS scores, it identified an opportunity to improve.

Interventions

Several interventions were successfully implemented:

1. In-room care board – Based on conversations with patients and nurses, the in-room care board was redesigned to be user-friendly for patients and staff. This initiative changed the patients' perception from 'the boards were for nurses' to 'the boards were for the entire healthcare team including the patient and family'. One example of improvement was the creation of a checkbox for new medication. An unchecked box would indicate an opportunity to educate the patient that the nurse or pharmacist would follow up on.
2. Focus on Commitment – The "We Promise" poster, highlighting the organization's commitment to partner with patients to deliver patient-centered care, was reviewed with each patient upon admission. "We Promise" was developed with reference to HCAHPS questions. (Please see box below.)
3. Patient engagement – Castle Medical Center created a "SPEAK UP" culture to engage patients to communicate their concerns with the care team.
4. Beside shift report – Historically Castle Medical Center had utilized recorded shift reports so changing this to bedside in-person shift reports needed strong leadership support. Directors had to train staff and garner buy-in for this new best practice. Nurses were given scripted cheat sheets and were tested for competencies using simulation, with the nurse managers lying on the bed as patients.

5. Discharge folder – Castle Medical Center introduced this streamlined folder of information to patients and family members when the patients were admitted. There was a checklist which tracked topics patients were not ready to discuss or did not completely understand (please see box below). Inside the folder was a post-it from the care team to thank the patients for allowing the team to care for them.
6. Discharge phone calls – Patient call managers called patients 24 hours after discharge and continued to reach patients for another 3 to 5 days if they could not reach them right away. Scripting (ex. calling on the physician’s behalf, asking about medications) and teach back were incorporated (please see box below). Telecommuting nurses, unit managers, and physicians all participated in calls. The caller connected patients with resources to resolve their concerns or questions, including real-time contact with the hospitalist.
7. Pharmacy transitional care – This was started through pharmacy. A pharmacy technician saw every patient, completed medication reconciliation, and determined if medications were appropriate. Pharmacists worked with the care team to educate patients and family members on newly prescribed drugs.
8. Transparency – Now in its fifth year, Castle Medical Center’s annual quality report presents transparent data about hospital quality. The information was presented at board meetings, physician recruitments, on the website, and in the community.

Lessons Learned and Sustainability

Challenges include:

- Implementation of the care board for patient and care team
- Change from nursing shift report to bedside shift report
- Modification of the post-discharge call process and improving discharge communication

To sustain improvements:

- Ensure data and information are accessible throughout the hospital: in the break room, on the communication board, and on the web. There are also weekly spotlight reports by units and departments.
- Provide real time feedback as survey data comes in

For more information on Castle Medical Center’s best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

We Promise

During your stay we promise to:

- Tell you who we are and what we are doing
- Partner with you to plan your care
- Listen and respond to your needs
- Round on you hourly
- Safely control your pain
- Respond to your call button in a timely manner
- Wash our hands and check your ID band for your safety

Presented by Jerry Stockstill and Kathryn Raethel, Castle Medical Center

Ready to go home?

What I need to know when I get Home

Discussed:

- Help I will need
- How to care for myself
- Immunizations needed
- Purpose of my medication
- Symptoms to look out for
- When to see my doctor
- My responsibilities
- Any worries or concerns

Mahalo! Thank you for allowing me to care for you.

Presented by Jerry Stockstill and Kathryn Raethel, Castle Medical Center

PRESENTATION 2: INNOVATION UNITS AT MASSACHUSETTS GENERAL HOSPITAL – TRANSFORMING CARE DELIVERY, ACHIEVING EFFICIENCY, IMPROVING QUALITY AND PROVIDING A SUPERIOR PATIENT EXPERIENCE

Presenter:

Rick Evans, Massachusetts General Hospital

Introduction

Continually rising health care costs highlighted the need for innovative ways to bend the cost curve and become more efficient while also improving service, quality, and safety.

Interventions

Twelve pilot units agreed to start an innovation journey and designed and implemented the following bundle of interventions:

1. Relationship-based care (RBC): The RBC approach focused on relationships with patients, families, and with each other.
2. Attending Nurse (ARN): This involved the creation of a new role. The ARNs became the quarterbacks for patients from admission to discharge. Upon admission, ARNs met with the patient and accompanied them throughout their journey.
3. Discharge notebook/envelope –Staff were trained to remind patients to put all papers given throughout the hospital stay in the envelope. The envelope also had a “Going Home Checklist” to help patients and families prepare for discharge. The notebook had pages with prompt questions and themes to encourage the patients to think about questions they had for the care team. Family members could write questions in the notebook. To monitor usage, we looked at the discharge notebook reordering rate from each unit and asked patients if they have received it.
4. Rounding – Interdisciplinary team rounding, hourly rounding, and nurse leader rounding were implemented as part of the bundle of interventions.
5. Communication – We used SBAR, simple white boards in patient rooms, and smart phones to facilitate better communication.
6. Quiet times –Daily times for patients to rest, both in the afternoon and overnight, were identified. Sources of noise on the units were removed to enhance the healing environment. Staff were trained to support the designated quiet times.
7. Post-discharge calls – Nurses on the unit called the patients who they cared for once they were discharged home. The call focused on the patient experience and assessing adherence with

discharge instructions. Calls averaged 3 to 4 minutes, and 23% of these calls included clinical advising.

Lessons Learned and Sustainability

Some challenges include:

- Standardization – Standardization, instead of different units each adopting a unit-based approach, has been a challenge.
- Resource management – The creation of the ARN new role had to be carved out of existing FTEs. ARNs did 8 hour shifts 5 days a week which was a new lifestyle for nurses.
- Discharge planning - Delays in discharge happened often because the patients were not ready to go home. The discharge envelope/patient notebook helped patients prepare for discharge from the beginning. Seeing patients continue to bring these notebooks for subsequent admissions has been especially rewarding.
- Post-discharge call – Buy-in from staff and leadership to complete post-discharge calls has taken time. Sharing data that 23% of all post-discharge calls included clinical advising was convincing evidence of the importance of the calls.

Massachusetts General Hospital is now starting Phase II of the innovation unit pilot, with 27 additional units beginning the intervention bundle.

For more information on Massachusetts General Hospital's best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

PRESENTATION 3: NURSING COMMUNICATION: IT REALLY ISN'T ALL ABOUT THE NURSES

Presenter: Nancy Hesse, Abington Health Lansdale Hospital

Introduction

In 2008, Abington Health acquired the community hospital Lansdale Hospital. The hospital was underutilized by the area medical staff and staff engagement was low. Patient satisfaction was at 10%, and the community had not yet developed a trusting relationship with the hospital.

Interventions

Nurse communication was seen as a rising tide for other HCAHPS measures. As the overarching framework for improvement, the following interventions were implemented:

1. Performance standards - The “E3” (“engage every employee”) initiative was started and established performance standards. Beginning with new employee orientation, staff were immersed in the mission, vision, and values of the hospital. Introducing themselves to patients and asking patients if there was anything else they could do for them were established as non-negotiable behaviors. Care givers committed to sit at the bedside and conducted bedside shift reports.
2. Call bells - A no passing zone was created for call bells.
3. Dry erase board in patient rooms – Patient boards contributed to better clinician patient communication.
4. Nurse leader rounding – Everyday, all nurse leaders’ schedules from 9 to 11am were protected to enable them to complete nurse leader rounding on patients and staff on hospital units. No meetings could be scheduled at that time, and no one could email, beep, or interrupt them unless it was a 911 situation.
5. Hourly rounding – Classical music was broadcasted on the hour to remind nurses and nurse assistants to complete hourly rounding. Hourly rounding was redesigned to be meaningful. Non-clinical units also rounded. In the emergency department, physicians used this music as a prompt to gather and discuss collaboration needs.
6. Transparency – Patient satisfaction data and action plans were shared on a regular basis. Leaders or their designees from 25 departments completed a daily call to report census, patient safety scores, patient satisfaction scores, and action plans. The daily unit-based safety briefing, focusing on safety concerns, took 5 to 8 minutes each day. Weekly departmental patient safety scores were shared with department administrators, which were shared with the units to develop unit-based action plans.

7. Engaging pharmacists – Pharmacists went to the bedside and communicated with patients about their medications. A letter with the pharmacists’ number was included in the admission packet which the patient could use to reach the pharmacists after he/she left the hospital.
8. Patient daily care plan – Nurses went over printed computerized reports (included information on orders, allergies, medications, and consults) everyday with the patients.
9. Discharge envelope – Discharge envelopes were designed in bright red and included a thank you note. Patients were encouraged to bring the envelope to the next family physician visit.
10. Recognition - The department with the highest satisfaction scores was rewarded each month.

Lessons Learned and Sustainability

Lessons learned include:

- Consistent behavior – For desired behaviors to be repeated and hardwired, need to continually recognize those who do well.
- Accountability – Need to hold the team accountable to walk the walk and talk the talk. Every meeting started with a patient safety story and ended with a service excellence story.
- Nurse communication – Nurse communication can transform care and create a fabulous patient experience.
- What’s in it for me? - There was initially push back for physicians to commit to sit with patients, but after implementation, they found patients had fewer questions, and they received fewer nurse calls. This brought buy in and continued commitment.

For more information on Abington Health Lansdale Hospital’s best practices in patient-centered care and results, please refer to the presentation slides and abstract on the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study).

POSTER PRESENTATIONS

Hospital Name	Abstract Title
Carolinas Medical Center - NorthEast	Provider Communication
Carolinas Medical Center - NorthEast	Use of Integrative Therapies for Pain Management
Castle Medical Center	Achieving Top Performance in HCAHPS Pain Management
Castle Medical Center	Achieving Top Performance in HCAHPS Discharge
Catholic Medical Center	Improving the Assessment-Intervention- Reassessment of Patient Pain: One Hospital's Journey
Concord Hospital	"We're Expecting You..."
Concord Hospital	Nursing Bedside Shift Report
Intermountain Medical Center	Engaging patients at discharge: Using electronic physician discharge orders to improve satisfaction
Mayo Clinic Florida	HCAHPS- Pain Management
Mayo Clinic Rochester	Improving Hospital Discharge Processes and Information through Patient Centered Care Redesign
Memorial Healthcare System	Helping our Patients Effectively Manage Pain
Methodist Hospital	Methodist Hospital Physician's Best Practices in Patient-Centered Care (March 2011-March 2012)
Metro Health Hospital	HCAHPS Discharge Information Domain; Post Hospitalization Call is Essential
Monongahela Valley Hospital	Monongahela Valley Hospital's Journey to Excellence (J2E) - Communication with Nurses
Monongahela Valley Hospital	Monongahela Valley Hospital's Journey to Excellence (J2E) - Responsiveness of Hospital Staff
Nebraska Orthopaedic Hospital	Discharge Planning: Striving for Continuous Improvement
Our Lady of the Lake Regional Medical Center	Nurse Communication
Our Lady of the Lake Regional Medical Center	Hospitalists: Patient Satisfaction
Our Lady of the Lake Regional Medical Center	Quiet at Night – Chatter Matters
Penn State Milton S. Hershey Medical Center	Weekly Leadership Rounds Across the Hospital: Initial Impact
Provident Hospital of Cook County	Strategies to Improve the Patient Experience through Collaboration and Patient Engagement
Regional Medical Center at Memphis	Driving clinical outcomes through centralized discharge calls

Sarah Bush Lincoln Health Center	Excellence A Way of Life—Communication about Medications
Sarah Bush Lincoln Health Center	Excellence A Way of Life—Nurse Communication
Siouxland Surgery Center	Erasing Invisible Barriers to Patient-Centric Care. What Can Be Learned From Physician-Owned Hospitals (POH's)?
SSM St. Mary's Health Center	Nursing Communication – It's All in a Day's Work
The Memorial Hospital of Salem County	The Memorial Hospital of Salem County
Thomas Jefferson University Hospital	An Organization-wide Service Improvement Approach
Thomas Jefferson University Hospital	Physician CARE
UF Health Shands Hospital	Changing the Face of Pain through Standardization of Pain Scales throughout UF Health
Via Christi Hospital on St. Teresa	Empowering Patient-Centered Care

BIOGRAPHIES

Keynote Speakers



Peter Pronovost

Director

Johns Hopkins Armstrong Institute for Patient Safety and Quality

Peter J. Pronovost, MD, PhD, FCCM is a practicing anesthesiologist and critical care physician and a professor in the departments of Anesthesiology & Critical Care Medicine, Surgery and Health Policy and Management who is dedicated to finding ways to make hospitals and health care safer for patients.

In June 2011, he was named director of the new Armstrong Institute for Patient Safety and Quality at Johns Hopkins, as well as Johns Hopkins Medicine's senior vice president for patient safety and quality.

Pronovost has developed a scientifically proven method for reducing the deadly infections associated with central line catheters. His simple but effective checklist protocol virtually eliminated these infections, saving 1,500 lives and \$100 million annually across the State of Michigan. These results have been sustained for more than three years. Moreover, the checklist protocol is now being implemented across the United States, state by state, and several other countries. The New Yorker magazine says that Pronovost's "work has already saved more lives than that of any laboratory scientist in the past decade."

Pronovost has chronicled his work helping improve patient safety in his book, *Safe Patients, Smart Hospitals: How One Doctor's Checklist Can Help Us Change Health Care from the Inside Out*. In addition, he has written more than 400 articles and chapters related to patient safety and the measurement and evaluation of safety efforts. He serves in an advisory capacity to the World Health Organizations' World Alliance for Patient Safety.

The winner of several national awards, including the 2004 John Eisenberg Patient Safety Research Award and a coveted MacArthur Fellowship in 2008, known popularly as the "genius grant." Pronovost was named by Time magazine as one of the world's 100 "most influential people" in the world for his work in patient safety. He regularly addresses Congress on the importance of patient safety, prompting a report by the U.S. House of Representatives' Committee on Oversight and Government Reform strongly endorsing his ICU infection prevention program.

Pronovost, who earned his M.D. at the Johns Hopkins University School of Medicine and his Ph.D. from the Johns Hopkins University Bloomberg School of Public Health, previously headed Johns Hopkins' Quality and Safety Research Group and was medical director of Hopkins' Center for Innovation in Quality Patient Care. Both groups, as well as other partners throughout the university and health system, have been folded into the Armstrong Institute.



Hanan Aboumatar

Core Faculty

Johns Hopkins Armstrong Institute for Patient Safety and Quality

Hanan Aboumatar, MD, MPH is Education and Research Associate at the Armstrong Institute for Safety and Quality and Assistant Professor at the Johns Hopkins University School of Medicine. She is dually trained in Family Medicine and General Preventive Medicine and Public health with expertise in health care safety and quality, health communications, and teamwork. Aboumatar uses her background and experience to design, implement and evaluate system-based interventions that address safety and quality of care via improving transitions of care and communication among health care professionals, patients and family members.

Aboumatar’s research focus is in the area of health care improvement, patient-centered care and patient engagement. Examples of her current research work include development and evaluation of a simulation-based intervention to advance physicians’ patient-centered communication skills around medication adherence issues, an assessment of impact of a multimodal quality improvement intervention on patient activation and experiences in primary care setting, a mixed methods study on respect and dignity in the critical care setting, and a study on variation of patient experiences within the acute care setting. Aboumatar has recently received the Picker Institute/Gold Foundation Graduate Medical Education Challenge Grant Award for her study “Towards Clear and Caring Communication Always: Partnering with patients and families to develop and evaluate a simulation based program for training residents on ‘information sharing’ and ‘caring’ aspects of patient-centered communication.” She has also recently received an AHRQ award to identify and disseminate best practices for patient-centered care delivery in the acute care setting.

Aboumatar holds her MD from the American University of Beirut, and both her MPH and Health Finance and Management Certificate from the Johns Hopkins Bloomberg School of Public Health. She received her postgraduate training in Family Medicine at Case Western Reserve University, University Hospitals of Cleveland in Cleveland, Ohio and her General Preventive Medicine and Public Health training at Johns Hopkins University, Bloomberg School of Public Health in Baltimore, Md.



Dominick Frosch

Fellow

Gordon and Betty Moore Foundation

Dominick L. Frosch is a fellow in the Gordon and Betty Moore Foundation's Patient Care Program. He oversees the foundation's activities related to patient and family engagement in health care. Before joining the Foundation, Frosch served as associate investigator at the Palo Alto Medical Foundation Research Institute and associate professor of medicine at UCLA. For over a decade he conducted research on shared decision-making and developing, evaluating and implementing patient decision-support interventions.

Frosch has published over 60 peer-reviewed articles and chapters. He currently serves as deputy editor for the Journal of General Internal Medicine and previously served as Associate Editor for Health Psychology.

Frosch completed his Ph.D. in clinical health psychology at the University of California, San Diego and a fellowship as a Robert Wood Johnson Health & Society scholar at the University of Pennsylvania.



Marie Hanna

Associate Professor

Johns Hopkins University School of Medicine

Marie Hanna, MD is currently Associate Professor in the Department of Anesthesiology and Critical Care Medicine, Division of Obstetric/Regional Anesthesia and Acute Pain Management at the Johns Hopkins University School of Medicine. She is the Director of Regional Anesthesia and Acute Pain Service at The Johns Hopkins University. She is the Associate Residency Program Director and Program Leader of the Pain Task Force education committee. Hanna conducted her anesthesia residency at Loyola University in Chicago, Ill. Since completing her own training, has been instrumental in developing numerous regional anesthesia educational programs for anesthesia residents and fellows both in the U.S. and abroad. She currently leads the pain management education program for health care providers at Johns Hopkins and hopes to bring this model to the national and international levels. Hanna has published articles on pain management and regional anesthesia in journals that include Regional Anesthesia and Pain Medicine, Journal of Opioid Management, and Journal of Anesthesiology and Clinical Research. She has been an invited speaker of The American Society of Regional Anesthesia and Pain Medicine, of which she is a member. She has also been invited to speak at many national and international meetings, including the American Society of Anesthesiologists, the World Congress of Regional Anesthesia, the All African Anesthesia Congress, and the UAE pain international Conferences. She is currently a member of the scientific committee of AFSRA (African Society of Regional Anesthesia).



Judith Hibbard
Senior Researcher and Professor Emerita
University of Oregon

Judith Hibbard is a Senior Researcher and Professor Emerita at the University of Oregon. Over the last 30 years she has focused her research on consumer choices and behavior in health care. Hibbard is the lead author of the Patient Activation Measure (PAM). The PAM measures an individual's knowledge and skill for self-management. The measure is being used around the world by researchers and practitioners. Hibbard advises many health care organizations, foundations and initiatives. She has served on several advisory panels and commissions, including the National Advisory Counsel for AHRQ, the National Health Care Quality Forum, United Health Group Advisory Panel, and National Advisory Council for the Robert Wood Johnson Foundation's Aligning Forces for Quality Initiative.

She is the author of over 150 peer-reviewed publications. Her recent work appears in issues of Health Affairs, Medical Care, and Health Services Research. Hibbard holds a masters degree in public health from UCLA and her doctoral degree is from the School of Public Health at the University of California at Berkeley.



Mary Catherine Beach
Associate Professor
Johns Hopkins University School of Medicine

Mary Catherine Beach, M.D., M.P.H., is an Associate Professor in the Johns Hopkins University School of Medicine, with a joint appointment in the Department of Health, Behavior, and Society in the Bloomberg School of Public Health, at The Johns Hopkins University. Beach is a core faculty member of the Berman Bioethics Institute and Welch Center for Prevention, Epidemiology, and Clinical Research. She received her B.A. from Barnard College, her M.D. from The Mount Sinai School of Medicine, and her M.P.H. from Johns Hopkins. She has completed the Greenwall Fellowship in Bioethics and Health Policy, a fellowship in the Division of General Internal Medicine at Johns Hopkins, and was a Congressional Health Policy Fellow in the office of Senator Hillary Rodham Clinton.

Beach is a past recipient of a Robert Wood Johnson Generalist Physician Faculty Scholar Award and a K-08 Award from the Agency for Healthcare Research and Quality (AHRQ). She has since served as an Associate Editor of the Journal of General Internal Medicine (JGIM), was elected to the Editorial Board of Patient Education and Counseling, and now serves as Treasurer on the Board of Directors of the American Association of Communication in Healthcare. In 2010, she was awarded the Jozien Bensing Award for outstanding research contributing to effective health care communication, given by the European Association of Communication in Healthcare.

Beach's scholarship focuses on patient-physician communication, with a focus on improving health care quality for under-served populations particularly in under-resourced primary care settings, the treatment of HIV, and the treatment of sickle cell disease.

Best Practices Presenters



Sandra Miller
Director, Adult Care Unit West
Sarah Bush Lincoln Health Center

Sandra Miller is the director of a 33 bed medical-surgical-telemetry unit at Sarah Bush Lincoln Health Center, a 129 bed hospital in Mattoon, Illinois. She has 37 years of nursing experience and the last 17 years have been in managing a nursing unit. She has a passion for providing excellent service and quality of care. Over the last two years the organization adopted lean principles in performance improvement and Sandra helps facilitate performance excellence teams. She received her Masters of Science in Nursing from Southern Illinois University in Edwardsville. She is a member of Sigma Theta Tau and Illinois Organization of Nurse Leaders.



Kelly King
Director of Nursing
Sioux Falls Specialty Hospital

Kelly King is the Director of Nursing at the Sioux Falls Specialty Hospital. Her background includes 28 years of nursing experience in perioperative and medical/surgical nursing, with 20 of those years in a management role. In 1996, Kelly became the first manager of the Recovery Care department at the Sioux Falls Specialty Hospital in which she was responsible for hiring of staff, equipment acquisition, policy and procedure development, and implementation of patient safety measures. Kelly has had an integral part in the ongoing monitoring of HCAHPS scores for her facility. She received a bachelor's of science in Nursing from Mount Marty College in Yankton, SD, and is currently pursuing her MBA with a healthcare concentrate from the University of Sioux Falls.



Jane DeStefano
Chief Nursing Officer
San Jacinto Methodist Hospital

Jane DeStefano is Vice President and Chief Nursing Officer at Houston Methodist San Jacinto Hospital. Jane has over 30 years of healthcare experience. Jane earned a Master's Degree in Nursing from the University of Texas School of Nursing, a Bachelor's Degree in Nursing from the University of Texas Medical Branch and an Associate's Degree in Nursing from the Catholic Medical Center of Brooklyn and Queens. In her role as CNO, Jane is responsible for oversight of all nursing departments and nursing professional practice, imaging services, cardiovascular services and the education department. Jane is also responsible for leading the Houston Methodist System-wide Policy and Procedure Committee. Jane is active in the community and serves on the fundraising committee of the Bay Area Homeless Services.



Karen Olsen
Vice President and Chief Nursing Officer
Mission Hospital

Karen Olsen, MBA, BSN, RN is the Vice President and Chief Nursing Officer for Mission Hospital with over twenty two years of healthcare management and leadership that includes emergency services, home health, inpatient medical and endocrine nursing units. Previous to her role at Mission Hospital, she served as the Executive Director of Emergency Services at Forsyth Medical Center and Kernersville Medical Center, Novant Health System in Winston-Salem, NC. Karen also served twenty years in the United States Navy as a Nurse Corps Officer, Commander (ret.)

Karen has 32 years of nursing experience which includes emergency nursing, pediatrics, neonatal ICU, medical ICU, surgical ICU, medical-surgical nursing, home health, women's center referral & education center, inpatient diabetes care center, and medical-endocrine nursing unit.

Karen has specialty Education in, Pediatric Advanced Life support – Instructor status, Trauma Nurse Core Course, CBRNE (Chemical, Biological, Radiological, Nuclear Explosive) Clinicians Course – Navy Training, Incident Command Training – ICS 100, ICS 200, ICS 700. Karen is a member of the Emergency Nurses Association, North Carolina Nurses Association, American Nurses Association and American Organization of Nurse Executives.



Christina McQuiston
Medical Director for Senior Services
Mission Hospital

Dr McQuiston is currently Medical Director for Senior Services at Mission Health, Asheville NC and is a hospitalist with Asheville Hospitalist Group and chair of Mission Hospital Ethics Committee. She is a graduate of the Medical School of the University of Glasgow (Scotland) and completed her Internal Medicine residency at the New England Deaconess Hospital in Boston, MA. She has lived and worked in Western North Carolina for the past 27 years. She is a member of the Society of Hospital Medicine, the American Geriatric Society and a Practice Change Fellow (John A Harford/ Atlantic Philanthropies).

The current focus of her work is on improving the quality of care for elders at a system level. As a Practice Change Fellow she has been physician champion for a team which developed a co- management model of care for the geriatric hip fracture patient. This work has evolved into development of age appropriate pain and PRN order sets for surgical patients. She was an early adaptor of the Society of Hospital Medicine BOOST project which has led to improved care transitions at Mission Hospital. She is also working with teams to close the gap on bone health after fractures, peri procedural DNR, Advanced Care Planning and delirium prevention.. Dr McQuiston serves on the Quality and Safety Committee and Physician Executive Council and is a facilitator for courses on Communications in Healthcare and Relationship Centered Leadership.



Lynda Nester
Assistant Vice President, Nursing
Monongahela Valley Hospital

Lynda Nester, RN, BSN, MS is a graduate of Alderson Broaddus College and California University of Pennsylvania. She began her career at Monongahela Valley Hospital as a staff nurse in the Emergency Department. She served as Nurse Educator and Nursing Quality Assurance Instructor prior to assuming her current position as Assistant Vice President, Nursing. In these roles she has served as Team Facilitator for numerous Continuous Quality Improvement and Rapid Cycle Improvement Teams. Lynda is a member of the hospital's multidisciplinary Pain Management Committee. She completed the Nurse Navigator Fellowship Program sponsored by the Jewish Healthcare Foundation in co-operation with Robert Wood Johnson. She also completed the Pittsburgh Regional Healthcare Initiative sponsored Perfecting Patient Care System University. Lynda was the first leader of the hospital's Journey to Excellence Standards Team. She is currently on the board of the Southwestern Pennsylvania Organization of Nurse Leaders and has served on that organization's education committee.



Tina Cartwright
Director of Orthopaedic Specialties
Concord Hospital

Tina Cartwright, RN-BC, BSN, MBA is the Director of Orthopaedic Specialties at The Orthopaedic Institute at Concord Hospital in Concord, NH. Concord Hospital is a regional referral center and is designated by American College of Surgeons as a Level III trauma center. Concord Hospital is nationally recognized through Press Ganey as a top performing hospital. The Orthopaedic Institute specializes in joint replacement surgery, spine surgery and orthopaedic trauma performing over 2,000 inpatient surgeries per year. Tina has 14 years' experience as a Registered Nurse in a variety of roles with the last 7 years specializing in Nursing Leadership. Tina is board certified by the ANCC in medical-surgical nursing and has her BSN from Marymount University in Arlington, Virginia as well as a Master's Degree in Business Administration from The University of Houston in Houston, TX. She is passionate about nursing and continuously finding ways to improve quality and the patient experience through innovation and team collaboration.



Rosheen LaValley
Orthopaedic Patient Educator
Concord Hospital

Rosheen LaValley, RN, ONC is the Orthopaedic Patient Educator at the Orthopaedic Institute at Concord Hospital in Concord, New Hampshire. Rosheen has been a Registered Nurse for 6 years, specializing in the care of adult orthopaedic, neurosurgical and medical-surgical patients. Rosheen is a certified Orthopaedic Nurse and has been vital in the growth of patient education at The Orthopaedic Institute. She serves as both a resource and liaison for patients, families, and the Orthopaedic Care Team resulting in enhanced patient experiences, better coordinated care, and optimal recovery outcomes. Rosheen will complete her BSN next year with a focus on patient education



Eleanor Keller
Director of Inpatient Services
OSS Orthopaedic Hospital

Eleanor Keller received a Diploma in Nursing from Washington Hospital School of Nursing, a Bachelor of Science in Nursing from Immaculata University and a Masters of Science in Nursing with a Specialization in Leadership and Management from Walden University. She successfully completed the Orthopaedic Nurse Certification in 2012. She has worked in various nursing departments for over thirty-two years with eleven years of nursing management experience. Eleanor began her tenure as the Director of Inpatient Services at OSS Orthopaedic Hospital in York, PA in 2010, four months prior to the opening of the hospital.



Crystal Stiffler
Social Worker
OSS Orthopaedic Hospital

Three years ago, Crystal Stiffler left her secure job for the unknown. She left her job to open a new state-of-the-art orthopaedic hospital. After spending 9 years working as a social worker in a large community hospital, the idea of downsizing and tailoring surgical care appealed to her. Patient care is a focus of Crystal's and having the ability to offer such fantastic patient centered approach was a seller! Crystal has spoken at various professional conferences that focus on the patient as an individual as well as how that patient interacts within their own groups. She is a co-author on a paper entitled: An Education Program Changed Clinician's Attitudes About Caring for the Dying. Crystal is also featured in a documentary entitled: Love, Loss, Life. Crystal's hope is that from today's presentation you will take away a pearl that you can implement in your everyday use so that you can offer excellent patient centered care.



Julia Nelson
Chief Quality Officer
Prairie du Chien Memorial Hospital

Julia Nelson, RN is currently serving as the Chief Quality Officer/ Director of Education at the Prairie du Chien Memorial Hospital. As Chief Quality Officer she coordinates her organizations selection and use of clinical data for quality improvement, analysis, and implementation of efforts to improve patient care and outcomes. She oversees her organization's processes for listening to the patients to determine their satisfaction and dissatisfaction with care and utilizes the data to determine process improvement efforts to exceed the patient's expectations. Julia is responsible for organizing, planning, developing, and maintaining a progressive educational program utilizing Evidence Based Practice for continued growth and development of hospital personnel. She began her 20 year nursing career working as a Medical-Surgical and Obstetrical Nurse. Julia has been a member of the Wisconsin State Board of Nursing since 2008 and currently serves as the Board Chair. Julia is also a member of the Community Health Services Board of Directors providing oversight to two long term care facilities in Southwest Wisconsin. For the past 10 years she has been an adjunct faculty member at Southwest Technical College. Julia is passionate about rural nursing and committed to the quality and safety of care provided to every patient.



Jay Pomerantz
Clinical Associate Professor, Medicine and Geriatrics Medical Director
University of North Carolina Hospitals

Jay I. Pomerantz, MD, M.M.M., F.A.C.P., is Clinical Associate Professor of Medicine and Geriatrics and Medical Director for Clinical Care Management and HealthLink Clinical Call Center at the University of North Carolina Hospitals and School of Medicine.

Prior to joining UNC in February 2011, Dr. Pomerantz was senior vice president and chief medical officer of HealthNow New York's Healthcare Services department, leading Medical Management—including case and disease management, quality improvement and clinical pharmacy management—and Provider Relations, Provider Negotiations, Health Promotion, and Behavioral Health & Wellness. Before joining HealthNow in September 2006, Dr. Pomerantz was regional vice president and chief medical officer of Excellus Health Plan in Rochester and regional vice president and chief medical officer of its Univera Healthcare division. As senior vice president and chief medical officer for Holy Cross Hospital and Health Ministries in Ft. Lauderdale, FL, Dr. Pomerantz developed a disease-based improvement model for medical staff and redesigned outpatient services, scheduling and financial services and patient billing processes.

He earned his bachelor's of science degree at Union College in Schenectady, NY and his medical degree from the University of Florida College of Medicine. Dr. Pomerantz was a resident, then chief resident, of the University of Rochester Association Hospitals Program and is board-certified in internal medicine. He also has a master's degree in medical management from Carnegie Mellon University in Pittsburgh, PA.



Suzanne Herman

Director, External Affairs, Patient Experience, Clinical Contact Center
University of North Carolina Hospitals

Suzanne Herman, RN, MSN, is the system director of External Affairs, Patient Experience and the Clinical Contact Center at UNC Health Care. She is responsible for patient experience, community relations, volunteer services, interpretive services, marketing and communications supporting patient and referring physician loyalty, and health care call centers (including physician to physician referral and 24/7 nurse triage services).

In her role as director of Patient Experience, she leads patient centric experience efforts at all access points of the health care system via web, portals, telephone, and all inpatient and outpatient encounters.

Prior to joining UNC Health Care, Ms. Herman was a Clinical Assistant Professor at the University of North Carolina School of Nursing. She has also practiced as a nurse practitioner at Duke Medicine and UNC Hospitals. She holds a Bachelor of Science in Nursing from Duke University and a Master of Science in Nursing and Family Nurse Practitioner Certification from the University of North Carolina at Chapel Hill.



Jerry Stockstill

Director of Quality Resources and Risk Management
Castle Medical Center

Jerry Stockstill, M.B.A., R.N., is the Director of Quality Resources and Risk Management at Castle Medical Center, an Adventist Health Hospital in Kailua, Hawaii. He has worked for over a decade to improve patient outcomes, clinical operations effectiveness, and healthcare quality in a variety of settings, including: hospitals, outpatient settings, physician practices and managed care environments. Prior to entering the healthcare industry, Jerry enjoyed a successful executive leadership career in the investment banking industry, holding executive positions at ING Group, Fidelity Investments, and Capital One Financial. Jerry is a Registered Nurse with a Bachelor's Degree in Finance and a Master's Degree in Business Administration. He is currently working to complete his Masters of Nursing at the University of Hawaii. Jerry is actively involved with the Healthcare Association of Hawaii where he is a member of the Quality and Patient Safety Committee. He is also an active member of AONE, NAHQ, and ACHE.



Kathryn Raethel
President and CEO
Castle Medical Center

Kathryn Raethel, R.N., MPH, MHA, is President and CEO of Castle Medical Center, a 160-bed acute care hospital located in Kailua, Hawaii. Kathryn is passionate about the pursuit of excellence in patient care and seeks to lead Castle Medical Center's journey to top decile performance across clinical processes as well as patient, associate and physician perception scores. Kathryn's career has spanned almost 40 years, with experience in nursing education, quality, business development and administration. Kathryn is a registered nurse with a Bachelor's Degree in Education, a Master's Degree in Public Health and a Master's Degree in Health Administration. She is a Fellow in the American College of Health Care Executives. She also serves as the Chair Elect for the Board of the Healthcare Association of Hawaii.



Rick Evans
Senior Director for Service
Massachusetts General Hospital

Rick Evans is the Senior Director for Service at the Massachusetts General Hospital and Massachusetts General Physicians Organization in Boston, MA, where he coordinates the organization's effort to improve the patient experience. He also has responsibility for the organization's Referral Management Office, the Physician Leadership Program and the Visitor Education Program.

Prior to coming to MGH, Rick served as the Vice-President of Support Services and Patient Centered Care for New York-Presbyterian Hospital, where he oversaw support services functions including housekeeping, food service, patient escort and laundry departments and where he also led the organization's successful strategy to improve the patient experience called "We Put Patients First."

Prior to joining NYP, Rick served as the Vice-President of Mission Services for the Bon Secours and Canterbury Partnership for Care in Hudson County, New Jersey and also as the Director of the St. Francis Hospital Foundation in Wilmington, Delaware. He also served in leadership roles in local and national not-for-profit organizations before moving into healthcare.

Rick holds a Masters Degree in Theology from Christ the King Seminary in East Aurora, NY and a Bachelor's Degree in Philosophy from Wadhams Hall Seminary College in Ogdensburg, NY.



Nancy Hesse
Chief Nursing Officer
Abington Health Lansdale Hospital

Nancy G. Hesse, MSN, RN, CEN, received her Bachelor of Science in Nursing from Widener University and her Masters Degree in Nursing Leadership from the University of Pennsylvania. Prior to becoming CNO, she was the Director of a 100,000 visit Emergency Trauma Center at Abington Memorial Hospital for 17 years that sustained patient satisfaction scores greater than the 95% for the past 12 years . She has presented nationally for the Emergency Nurses Association, PICIS, VHA and the National Association of Orthopaedic Nurses. Under her leadership Lansdale Hospital achieved ANCC's Pathway to Excellence designation in 2.5 years. She has been instrumental in transforming the culture of Abington Health-Lansdale Hospital to one that permeates service and nursing excellence.

Scientific Committee



Daniel Brotman

Director, Hospitalist Program, Johns Hopkins Hospital

Associate Professor of Medicine

Johns Hopkins University School of Medicine

Dr. Daniel Brotman grew up in New England. He received his undergraduate degree at Harvard in 1992 and his medical degree from the University of Virginia in 1997. He completed Internal Medicine Residency at Johns Hopkins Hospital in 2000. He spent 5 years as a Hospitalist at the Cleveland Clinic Foundation, where he directed the Hospital Medicine Fellowship Program and was involved in research in perioperative medicine, thrombosis, and cardiovascular complications of hospitalization.

Dr. Brotman returned to Johns Hopkins in 2005 to direct the Hospitalist Program and has remained clinically active in Hospital Medicine and inpatient consultative medicine. He currently is an Associate Professor of Medicine (tenure-track) at Johns Hopkins University. He continues to do research focused on Hospital Medicine, with an emphasis on quality improvement, thrombosis, perioperative medicine, and cardiovascular disease. Dr. Brotman's current academic work is funded by the Agency for Healthcare Research and Quality (AHRQ), the Center for Medicare & Medicaid Services Innovation (CMMI), and by private foundations and corporate contracts. Dr. Brotman has dozens Medline-indexed publications, most as first or senior author, and is a sought-after peer reviewer for dozens of major medical journals. He is a Senior Deputy Editor of the *Journal of Hospital Medicine*, an Associate Editor of the *Cleveland Clinic Journal of Medicine* and an Editorial Consultant for *The Lancet*. He also maintains active involvement with the Society of Hospital Medicine where he chairs the Education Committee and the Annual Meeting Committee and serves on the Research Committee.



Deborah Baker

Director of Nursing in Surgery, Ophthalmology, Physical Medicine and Rehabilitation

Johns Hopkins Hospital

Deborah Baker, DNP, CRNP, is the Director of Nursing for the Departments of Surgery, Ophthalmology and Physical Medicine and Rehabilitation at the Johns Hopkins Hospital. The department of surgery consists of eight inpatient units, three ICU units and 12 satellite operating rooms including ophthalmology. She is a certified acute care nurse practitioner that served as the Assistant Director of Nursing for Advanced Practice in the Department of Surgery for four years before assuming the Director role. Deborah holds a Bachelor of Arts in psychology from Towson University. She earned a Bachelor of Science and Masters of Science in Nursing from Johns Hopkins University School of Nursing (JHU SON). She earned a Doctorate in Nursing Practice from the Johns Hopkins University in 2011. Deb is part of the steering committee led by the COO of Johns Hopkins Hospital, overseeing the Patient and Family Centered Care (PFCC) initiatives at the Johns Hopkins Hospital and affiliates. She is also a member of the JHM Strategic Planning work group.



Emily Boss

Assistant professor

Johns Hopkins University School of Medicine

Dr. Emily F. Boss, nee Rudnick, is an assistant professor with the Department of Otolaryngology—Head and Neck Surgery at the Johns Hopkins University School of Medicine. Her clinical interests include all aspects of pediatric otolaryngology, however she has particular interest in pediatric airway disorders, congenital and neoplastic head and neck tumors, speech and swallowing disorders in children, and pediatric sinusitis. An active participant in the interdisciplinary vascular anomalies team at Hopkins, Dr. Boss has a special interest in the diagnosis and treatment of head and neck hemangiomas and vascular malformations (including capillary, venous and lymphatic malformations) in children. She also has particular interest in medical and surgical therapy for velopharyngeal insufficiency in children. Her research interests involve healthcare disparities and outcomes in pediatric otolaryngology.

Dr. Boss is a member of the American Academy of Otolaryngology—Head and Neck Surgery and the Triological Society (American Laryngological, Rhinological, and Otolological Society). She is board-certified in Otolaryngology—Head and Neck Surgery.

Dr. Boss is part of the Resource Exchange International-Cuba, an organization dedicated to improving subspecialty medical education in Cuba.

Dr. Boss received her undergraduate degree from Northwestern University.



Hanan Aboumatar

Core Faculty

Johns Hopkins Armstrong Institute for Patient Safety and Quality



Jill Marsteller

Associate Professor

Johns Hopkins Bloomberg School of Public Health

Jill A. Marsteller, PhD, MPP has been involved in health services research for 17 years and is currently an Associate Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. She is jointly appointed in ACCM and is a member of the QSRG.

She specializes in organizational theory and behavior, specifically in estimating the influence of organizational variables on quality improvement activities with a focus on the determinants of successful implementation, dissemination, and sustainability of knowledge.

Jill has evaluated infection prevention, safety attitudes and patient safety interventions in the intensive care unit (ICU), cardiac operating room, and other settings. She was a co-principal investigator for a multisite clustered randomized trial of an intervention to reduce central-line associated blood stream infections in ICUs and led research efforts evaluating the effects of leadership, provider engagement and team activities on infections, length of stay and nursing outcome measures.

She presently coaches three states and the District of Columbia in the national On the CUSP: Stop BSI project. In addition, she is working with cardiac ORs, ICUs and floor units to help them implement CUSP and reduce infections. In that effort she will oversee data analysis and work with others to improve cross-unit/area relationships.



Lara Klick

Director of Service Excellence

Howard County General Hospital

In her position of Director of Service Excellence at Howard County General Hospital, Lara Klick, B.S., has created a strategic emphasis on a patient centered culture within the hospital setting. She is responsible for oversight of Press Ganey patient satisfaction surveys and the federal HCAHPS patient satisfaction survey, development and implementation of strategic initiatives designed to improve the patient experience and management of hospital complaint and grievance process. In addition he has operational responsibility for the effective management of Patient Relations, Front Desk, Gift Shop and Volunteer Services. She is an active volunteer in her community serving as a Girl Scout leader for Troop 1733, a committee member for Cub Scout Pack 2214, a member of the Cape St. Claire PTO and a member of the American Partnership for Eosinophilic Disorders a parent driven advocacy group supporting her son's rare medical disorder. She holds a Bachelor of Science degree in Secondary English Education from Duquesne University and is a 2011 graduate of Leadership Howard County and serves on the Board of Trustees for Leadership Howard County.



Marie Hanna
Associate Professor
Johns Hopkins University School of Medicine



Mary Catherine Beach
Associate Professor
Johns Hopkins University School of Medicine



Peter Pronovost
Director
Johns Hopkins Armstrong Institute for Patient Safety and Quality



Rebecca Zucarelli
Senior Director for Service Excellence
Johns Hopkins Health System

Rebecca Zucarelli is the Senior Director for Service Excellence for the Johns Hopkins Health System. In this role, which she has held since 2006, Rebecca is responsible for measuring and improving patient satisfaction and leading the effort to create a more patient and family centered environment throughout the Johns Hopkins Health System. During her tenure at Hopkins, inpatient satisfaction at The Johns Hopkins Hospital has improved from the bottom to the top quartile.

Before joining Hopkins, Rebecca served in various positions at OhioHealth in Columbus Ohio including, System Vice President of Customer Service and Vice President of Post Acute Services. Rebecca began her administrative career over 25 years ago at Summa Health System in Akron, Ohio in a role in quality management and medical staff services.

Rebecca received her Bachelor of Science degree in Physical Therapy and her Master of Public Health in Health Administration from the University of Pittsburgh in Pittsburgh, Pennsylvania. She has authored several publications regarding customer service and patient relations and has spoken at numerous conferences regarding improving patient satisfaction in hospitals.



Rhonda Wyskiel
Nurse Clinician
Johns Hopkins Hospital

Wyskiel is a Nurse Clinician in the Weinberg Surgical Intensive Care Unit at the Johns Hopkins Hospital and a Senior Research Coordinator with the Armstrong Institute for Patient Safety and Quality. Wyskiel's 16 years of bedside nursing experience have been an integral and critical force in the development, implementation, and spread of the comprehensive unit-based safety program (CUSP) to improve teamwork and safety culture at Johns Hopkins Hospital as well as nationally and internationally. She is also passionately involved in Patient- and Family-Centered Care initiatives. Combining her clinical knowledge with applied research, she has successfully begun identifying innovative methods to involve Patients and their families as integral members of the healthcare team and necessary participants in the treatment plan. Her role as a nurse leader and researcher are critical for the effective development, implementation, and evaluation of these efforts toward the improved delivery of Patient- and Family-Centered Care. Wyskiel continues to work on numerous quality improvement projects incorporating her expertise as a clinician and quality and safety improvement professional to the design, development, and integration of clinical systems.



Sosena Kebede
Assistant Professor
Johns Hopkins University School of Medicine

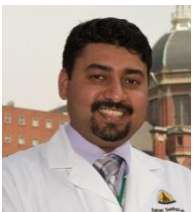
Sosena Kebede, MD, MPH, is an assistant professor of medicine and a full time faculty in the department of medicine at the Johns Hopkins University where she currently works as an academic hospitalist with a strong research focus in patient centered quality care and patient satisfaction. She is an associate faculty and a consultant for the Armstrong Institute for Patient Safety and Quality. She is involved in medical education and teaches on Social Determinants of Health and its application in health care. Sosena has an associate faculty appointment in the Bloomberg School of Public Health in the department of international health, from which she also holds an MPH with a concentration in health policy and health systems. She is active in global health work as well in national professional societies such as the Society of General Internal Medicine (SGIM). She is committed to improving the safety and quality of health care delivery to patients and to reducing health care disparities both locally and globally.



Zackary Berger
Assistant Professor

Johns Hopkins University School of Medicine

Zackary D. Berger, MD, PhD, is an internist and epidemiologist and an Assistant Professor in the Department of General Internal Medicine at Johns Hopkins School of Medicine, with joint appointments in the Department of Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health and in the Berman Institute for Bioethics at Johns Hopkins. His research interests include the patient-relevant effects of public reporting, patient-doctor communication, overuse, and the exercise of patient autonomy in the context of limited clinical information; among his clinical interests are the treatment of depression, anxiety, and low-risk prostate cancer. He is currently conducting a pioneering qualitative study of doctor-patient communication in the hospital, focusing on patients' dialogues with their physicians. In addition, he has published on the importance of doctor-patient communication to patient satisfaction and on physician professionalism as it interacts with patient choice, and conducted research on how doctors and patients collaboratively set an agenda during the primary care visit. Dr. Berger is also Core Faculty in the Johns Hopkins Evidence-Based Practice Center (EPC) and the Johns Hopkins Center for Health Sciences and Outcomes Research. He has focused on patient-reported outcomes as a co-investigator on numerous systematic reviews, including those of continuous glucose monitoring and of treatments for Crohn's disease. In addition, he was lead author of the chapter on patient and family engagement in a recent EPC critical analysis of patient safety practices. Dr. Berger maintains an internal medicine practice in the Johns Hopkins Outpatient Center and is a preceptor in the Adult Medicine housestaff clinic there. He is actively involved in applying methods of quality improvement to the outpatient setting.



Zishan Siddiqui
Instructor

Johns Hopkins University School of Medicine

Dr. Siddiqui is on the faculty in Department of Medicine at Johns Hopkins School of Medicine and has practiced hospital medicine at Johns Hopkins Hospital for the past seven years. Patient-centered care is his area of research interest. He was awarded Osler Center Faculty Scholarship grant for his research study titled "Influence of Hospital Environment, Provider and Patient Related Factors on Patient Satisfaction". He recently submitted research manuscripts titled "Influence of New clinical Building on Patient Satisfaction" and "Comparison of HCAHPS Patient Satisfaction Scores for Specialty Hospitals and General Medical Hospitals: Confounding Effect of Survey Response Rate". He collaborates with Johns Hopkins Service Excellence Department and is a member of Johns Hopkins Patient Experience Work Group.

APPENDICES

Please refer to the Best Practices in Patient-Centered Care website (www.hopkinsmedicine.org/armstrong/patient-centered-care-study.) for the following materials:

- Conference Presentation Slides
- Abstracts from Top-Performing Hospitals