What makes a positive patient experience?  
**IHI explores how to improve a patient’s time in the hospital**

Hospitals have been working toward better patient satisfaction for years. Now, with patient experience survey results posted publicly and a new national value-based purchasing system in place, it’s more important than ever to understand what positively and negatively affects a patient’s time spent in the hospital.

“Culture of safety and culture of a great patient experience are very, very closely tied together,” says Barbara Balik, RN, EdD, senior faculty at the Institute for Healthcare Improvement (IHI), principal at Common Fire Healthcare Consulting, and coauthor of the report *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care.* “If leaders are seeing those as two separate activities, they’re going to waste a lot of time and energy.”

Balik and the report’s team of authors found that there are five primary drivers of excellent patient care and experience (see “IHI patient and family experience driver diagram” on p. 4 for more information):

➤ Leadership
➤ Staff hearts and minds
➤ Respectful partnership
➤ Reliable care
➤ Evidence-based care

These drivers reinforce the idea that there is no silver bullet to achieve a better patient experience, says Balik.

“I think our original hope was we’d find a small bundle of things, kind of like a ventilator-associated pneumonia bundle, and we’d get this great patient experience,” Balik says.

“But what we learned from the exemplar hospitals is when we really pressed them about what they did specifically for patient experience, they could not separate that out from what they do for quality and safety.”

The team found that “random acts of goodness” alone will not create a positive patient experience.

“It’s not just rounding, after-discharge phone calls, scripting for nurses—those are great tools and tactics, but if it doesn’t fit together as part of an integrated system, you’re not going to make or sustain the headway you want,” Balik adds.

The study’s authors conducted an in-depth research review, studied exemplar organizations, and interviewed experts in the field to discover the primary and secondary drivers of exceptional patient and family experience, as defined by whether patients would be likely to recommend a hospital (measured by the HCAHPS...
“willingness to recommend” dimension). The IHI report is designed for “hospitals to use this framework to design their efforts to improve the patient and family experience—testing and implementing changes, weaving them into the fabric of daily work for everyone, and achieving outstanding results,” according to the report.

Leadership support

Like all good quality improvement initiatives, leadership support is vital for a positive patient experience, says Balik. With patient satisfaction tied to value-based purchasing for fiscal year 2013 (see “Payment and patient experience” on p. 5), leadership may want to look closely at what actions a hospital takes to improve experience..

“It’s part of our growing accountability as healthcare leaders,” says Balik. “I think in the past, perhaps executives didn’t realize how big a role they played in patient experience, and it’s more explicit now.”

But with more evidence showing that a positive patient experience is linked with whether a hospital operates efficiently, respectfully, and with good communication, that notion that leadership involvement isn’t vital should change.

Professional teamwork and efficient systems

Respectful listening, communication, and teamwork are essential to a good patient experience, says Balik.

“If nurses can’t partner well together, they certainly can’t with patient involvement,” she says. “Patients need to feel like there’s a whole team of people working together with them, not just isolated people who come and go.

“If we’re not respectful to one another, patients pick up on that,” adds Balik. “That’s fundamental.”

Also important to a patient’s perception of care are hospital systems and protocol. If they’re not effective, the patient will notice.

“If staff don’t have effective systems, they’re not going to be able to create a great experience with patients and families,” says Balik. “Unreliable systems for staff are unreliable for patients and a waste of resources.”

Ineffective systems mean frontline staff have less time to spend with patients—a commodity many patients highly value. If systems are inefficient, communication will also likely suffer.
Systems must also support patient engagement. Engagement makes the difference between doing something to the patient, for the patient, or with the patient, says Balik. “I really advocate that as a baseline we need to be doing with the patient.” For example, Balik says a hospital could allow visitors at any time, with the only restrictions placed by the patient regarding who can visit and when.

What happens if there’s a problem with this patient-centered allowance? Balik says it’s up to the hospital—not the staff—to have a policies that support patients and staff. For example, if security is a concern, there should be a name badge system, a visitor census, and more security if necessary. If patient visitors are causing a disturbance late at night, there should be a policy in place for such a scenario, with expectations for visitors set ahead of time.

Teaching patient experience from the beginning

One of the drivers, “staff hearts and minds,” may seem like something a hospital can’t really change or affect. But in fact, it’s a driver that can be controlled through hiring and training.

“A number of organizations, many outside of healthcare, do what we call ‘hire for values’ and then train for specific skills. Human resources must be involved in the patient experience, as they must hire individuals whose ideals align with the hospital’s,” says Balik.

Balik warns, however, that if you hire for values, you should ensure that the hospital actually displays those values in everyday care.

“You can’t recruit people for values and then throw them into an environment that negates everything that you’ve recruited them for,” she says. You should show potential candidates what the values look like in action.

Understanding the patient journey

To understand patient experience, go to the source: the patients.

“What I really recommend and what I’ve been teaching is how to observe and follow a patient across the experience of care,” says Balik. She admits that it can be hard to follow a patient throughout his or her entire stay, but even following a patient from the ED to the inpatient unit, or from prep to the operating room, can be a learning experience.

“Having staff who work in those areas actually follow a patient through the experience, taking notes, taking photos for learning, are the best sources of discovery and the best way to identify where we need to improve,” she says, adding that the process can be part of a mock Joint Commission regulatory patient tracer and thus make use of activities that already occur in your hospital.
IHI patient and family experience driver diagram

**Primary Drivers**

**Leadership**
Governance and executive leaders demonstrate that everything in the culture is focused on patient- and family-centered care, practiced everywhere in the hospital — at the individual patient level; at the microsystem level; and across the organization, including governance.

**Hearts and Minds**
The hearts and minds of staff and providers are fully engaged.

**Respectful Partnership**
Every care interaction is anchored in a respectful partnership, anticipating and responding to patient and family needs (e.g., physical comfort, emotional, informational, cultural, spiritual, and learning).

**Reliable Care**
Hospital systems deliver reliable, quality care 24/7.

**Evidence-Based Care**
The care team instills confidence by providing collaborative, evidence-based care.

**Secondary Drivers**

In words and actions, leaders communicate that the patient’s safety and well being are the critical considerations guiding all decision making.

Patients and families are treated as partners in care at every level, from decision-making bodies to team members delivering individual care.

Patient- and family-centered care is publicly verifiable, rewarded, and celebrated with a relentless focus on measurement, learning, and improvement with transparent patient feedback.

Sufficient staff are available with the tools and skills to deliver the care patients need when they need it.

Staff and providers are recruited for values and talent, supported for success, and held accountable for results individually and collectively.

Compassionate communication and teamwork are essential competencies.

Patients and families are part of the care team and participate at the level the patient chooses.

Care for each patient is based on a customized interdisciplinary shared care plan with patients educated, enabled, and confident to carry out their care plans.

Communication uses words and phrases that the patient understands and that meet their emotional needs.

The physical environment supports care and healing.

Patients are able to access care without long and unreasonable waits and delays.

Patients say, “Staff were available to give the care I needed.”

Care is safe, concerns are addressed, and, if things go wrong, there is open communication and apology.

Care is coordinated and integrated through use of a shared care plan and everyone on the patient’s care team, including the patient, has the information they need.

Patients get the outcomes of care they expect.

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Payment and patient experience
Understanding the payment point system

In spring 2011, CMS issued a final rule for value-based purchasing (VBP), for which more than 3,000 hospitals are eligible. The move creates the first ever national pay-for-performance system.

“It helps set the framework to fundamentally change how hospitals are paid for their services to Medicare beneficiaries,” said Jean Moody Williams, group director for the quality improvement group for the Office of Clinical Standards and Quality in a July 27, 2011 CMS Open Door Forum. “It’s moving from ‘How much did you do?’ to ‘How well did you do?’ And more importantly, ‘How well did the patient do?’”

Seventy percent of the VBP will be based on 12 clinical process measures; the other 30% is based on eight patient experience of care dimensions on the Hospital Consumer Assessment for Healthcare Providers and Systems (HCAHPS) patient survey, including:

➤ Nurse communication
➤ Doctor communication
➤ Hospital staff responsiveness
➤ Pain management
➤ Medicine communication
➤ Hospital cleanliness and quietness
➤ Discharge information
➤ Overall hospital rating

The score is based on both achievement—one hospital’s performance during the performance period (July 2011 through March 31, 2012) for fiscal year 2013 compared to all other hospitals during that period—and improvement, which is one hospital’s performance during the performance period compared to its own performance during the baseline period (July 2009 through June 2010).

For HCAHPS measures, hospitals have an opportunity to receive achievement or improvement points, plus consistency points. For each of the eight HCAHPS dimensions, hospitals will be rewarded either achievement or improvement points, whichever score is greater. Scores are determined for all dimensions and totaled (the highest possible score is 80, or 10 points for each dimension). This total is referred to as a hospital’s “base points.” In addition to base points, the hospital also has an opportunity to earn consistency points.

Consistency points are based on the lowest-scoring dimension (LSD). The LSD is compared to the 50th percentile of all hospitals in the baseline performance period; this is called the achievement threshold. The jackpot is an LSD that hits or surpasses the achievement threshold (i.e., all eight dimensions perform above the threshold)—this earns a hospital 20 consistency points.

At the other end of the spectrum, if an LSD is below the worst-performing hospital, otherwise known as the “floor” rate, that hospital earns 0 points.

If a hospital’s LSD lies between the floor and the achievement threshold, the hospital will be awarded somewhere between 0 and 20 points, based on a formula that takes into account the LSD score relative to its distance from the floor.

The purpose of consistency points is to “encourage higher performance across all HCAHPS dimensions and promote wider systems changes within hospitals to improve quality by offering hospitals additional incentives,” according to CMS.

A hospital’s base points and consistency points added together form its patient experience of care score—i.e., 30% of its total VBP score. In subsequent years, CMS plans to add additional domains and measures to provide a broader snapshot of quality improvement and efficiency of care delivery.

Editor’s note: For more information on VBP scoring, visit www.cms.gov/Hospital-Value-Based-Purchasing.

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