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Journey to Improve Patient Experience

Patient Experience

Executive Leader Support

On behalf of the Executive Team at Adventist Health Ukiah Valley and with great pride and excitement, I support and endorse this application for the C. Duane Dauner Quality Award. Getting to a place of steady and sustained improvement of our patient experience has required clear focus and connecting back to "the why". This journey has helped remind us what is most important for our patients and continually brings us back to our mission. Without the commitment and engagement from our staff and providers we could not have achieved our goal of the seventy-fifth percentile for overall rating of care. An essential component of any improvement strategy is an organized leadership, empowered with the tools needed to promote the change. Our program capitalized on a framework built upon evidence-based strategies. Through extensive efforts with monitoring and real-time feedback we now have high reliable processes. It is our hope and expectation that our patients and community will benefit from our improvements for many years. I am confident with improvements in communication and individualized care, safety and quality will also be positively impacted.

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Executive Summary

Our organization created a strategic plan to improve patient experience. Historically our facility was challenged with improving overall satisfaction rate and remained in the fiftieth percentile ranking in the lowest quartile. The goal of this initiative was to achieve seventy-fifth percentile ranking in overall satisfaction by the end of the calendar year, 2019. With the assistance of evidence based interventions coined as "must haves" we began to see a slow upward trend in our scores. This process required constant attention to hardwire key strategies. Our staff needed to be engaged in the process. To enable this change, leaders engaged frontline staff to be part of the process through selection of the focused measures, consistent monitoring, celebrating and data sharing. The executive team set the priorities to create a focus on unit specific goals supported by visual boards with goals and current progress. Discussion on progress and or barriers were integrated into the staff daily shift huddles. The organization reached the seventy-fifth percentile ranking in the fourth quarter 2018 and has maintained scores in this top quartile since then. Staff engagement in individualized patient care has proven to be the biggest key to a steady increase in patient experience.

Background and relevance of the problem being addressed and effort undertaken.

Patient experience is linked to reimbursement, market share, loyalty, employee satisfaction and turnover. There is a strong relationship between the quality of employee interactions with patients and the overall patient experience or satisfaction scores. Our organization chose to work on how we manage and engage our employee's with evidence based practices as one improvement strategy. We also looked at the specific interactions that influence the patient experience as monitored through the hospital patient's experience, Hospital Consumer Assessment of healthcare Providers and Systems (HCAHPS) survey. The strategies surrounding improving the HCAHPS survey scores included implementing evidence based practices across the organization. When we began our journey our engaged employee rate was running around sixty percent, but more importantly our unengaged score was running near twenty percent. Our employee satisfaction score was a respectable 4.07 grand mean and still had opportunities to improve. Our overall patient satisfaction score was running between fifty and low sixties percentile. Our goal was to achieve the top quartile.

The effort, scope, process, strategies and tactics utilized.
The challenges encountered and how they were addressed.

Multipronged efforts were aimed towards accountability at all levels of leadership. Leaders and managers were taught skills to better address performance issues, unwanted behaviors, and manage difficult conversations. The annual staff satisfaction survey became an active working document with action plans reported to the executive team. To grow engagement, leaders received training to coach and how to grow employees through highly reliable management practices. Interventions targeted identification of engaged or disengaged employees. Leaders received evidence based practices to improve the support and growth of engaged employee. They also identified the disengaged employee with intention to improve performance, improve the code of conduct compliance or encourage departure from the organization. The expectation is that the employee's annual evaluation would accurately

reflect their level of engagement. Strategies included monthly or bi-monthly rounding on all staff. Leaders began systematic, monthly rounding with all staff. Rounds addressed positive experiences, recognition of other staff, whether the staff had the tools to do their job. A conscious effort was made to discuss specific safety or system failure concerns. The intent was to listen and engage the staff. Leaders did this by connecting with something personal with the employee. Leaders gain trust with employee by acknowledging they listened and acted on concerns by circling back with information on the actions taken to resolve safety or system failures. These actions validate staff concerns, demonstrate how important we feel their concerns are. There is so much to gain from these practices. Our leaders learn from frontline caregivers and in return enable the removal of barriers to make it easier to complete jobs and to improve the safety of the organization. Communication with employees targeted key issues that affect overall engagement scores and noted problem resolution.

Instrumental to our success was the development of standardized communication boards in each unit. The communication boards connect with mission and priorities or goals. The boards are a visual reminder that by addressing employee identified barriers we listen and care. The boards also post current focused quality initiatives progress.

All staff were taught basic communication process called AIDET; Acknowledge, Introduce, Duration, Explanation, Thank you. The AIDET model was not new to the organization, having been previous rolled out nearly ten years prior. However it was taught as a new initiative and validation was added to the process. Leaders routinely validated all staff's use and accuracy of AIDET to reinforce the value in improving patient satisfaction. Employees should understand the value or the "why" this is important to achieve consistent results. These strategies were put into action over 2015 and 2016.

The next set of strategies focused on the evidence based practices that would improve our patient experience scores. The practices were coined "must haves" to reinforce the practices as part of the culture and how we treat patients and visitors. These strategies included nurse-patient hourly rounding, bedside shift report, and discharge follow-up phone calls, nurse leader rounding and AIDET validation. Each strategy was rolled out individually on one unit at a time until it was felt that the process was well established prior to the next strategy. Clear expectations of the nurses and deliverable due dates were shared. We began to roll out these strategies in January of 2016 with immediate improvement identified. Without the solid establishment of a new process the upward journey quickly disappeared and resulted in one of the organizations poorest scores throughout the four year period. The organization linked the decline with employee morale, low census and high rate of registry nursing.

Efforts to hardwire the evidence-based processes were put into place with improvement achieved near the end of 2016. Efforts included targeted discussions with staff as a group and individually when "must have" threshold were not being met. Leaders continuously monitored, tracked and reported on hourly rounding performance and nurse leader rounding. The unstable results continued to waver during 2017 demonstrating mixed results. In 2018 a major change occurred. The executive team drove a strong push to create department specific visibility boards. The boards identified the key priority focus and quality targets that were tailored to each unit. More importantly, linking all tactics and practices back to the "why" became the focus. This was found to be paramount to keeping front line staff engaged in the practices.

In 2018 new strategies were developed by the executive team. These strategies acted on the concerns that there were too many priorities and needed to focus on key metrics that aligned with organizational goals. Of those priorities patient experience was at the top. While the "must haves" were still expected, the units chose one or two questions from the HCAHPS survey for their department to work on. These questions must have meaning or purpose for their department. The visibility board was created with help from performance improvement and quality. The ongoing maintenance of the board was the department responsibility. The visibility board focused on the key quality metrics for the organization and tailored to the components of those key metrics that the specific unit was to focus on for improvement. An example of how the metric was tailored was to share the overall patient safety scores for the organization and also include the department rate or date of last event for unit specific hospital acquired infections or patient falls. Daily huddles were moved to be held by the communication board. The quality metrics are reviewed with staff at each huddle, twice daily. The huddles also discuss any barriers or opportunities to improving the rates. This created a clear vision of priority for the staff and engaged them in the process.

Describe the results of the effort.

Truthfully, we created an unstable process until 4th quarter 2018. Our organization demonstrated improvement overall and then would slide back. Visibility boards were revised in the fourth quarter 2018 to link and engage staff in the overall process. The boards focused the attention on communication surrounding the key metrics and made it meaningful to the staff. All leadership were brought in to assist with validation and the completion of the daily leader rounds. This made it clear that we needed engagement from all staff in addition to the clinical areas to improve patient and staff engagement. Associates at all levels were expected to be engaged in improving the overall experience for patient. As we submit this application our patient experience scores have remained at the 75th percentile level on our HCAHPS scores for two quarters (six months). Executive leadership has celebrated success across the organization as an indication of importance and pride. They used pictures of staff and created community posters with those pictures which celebrate the achievement of the top quartile in patient experience. Our staff satisfaction score for overall grand mean improved to 4.83 with 5.0 being the highest score obtainable.

Discuss the significance of the results.
How do the results demonstrate outstanding achievement?

Achieving top quartile patient experience scores reflect that our staff are talking with patients on things that matter like medications, preparations for discharge and identify the patient's preferences during their hospitalization. These practices improve the safety of patient care and help to educate patients on how to care for themselves at home. Our organization moved from bottom to top quartile in national patient experience scores over the course of three years. A marked and accelerated improvement took place fourth quarter 2018. The dramatic increase resulted after redefining department level priorities and making a concerted effort to reconnect staff with purpose and "why". These focused actions resulted in the improvement of the organization overall score by thirty percent. Our staff engagement score began at 4.07 and dropped to 3.83 in 2017. We then achieved one full point rise in staff

engagement to 4.83 by the survey in 2018. This represents a significant improvement that required a multi-prong approach using evidence based tools.

Describe sustainability and scaling of the achievements.

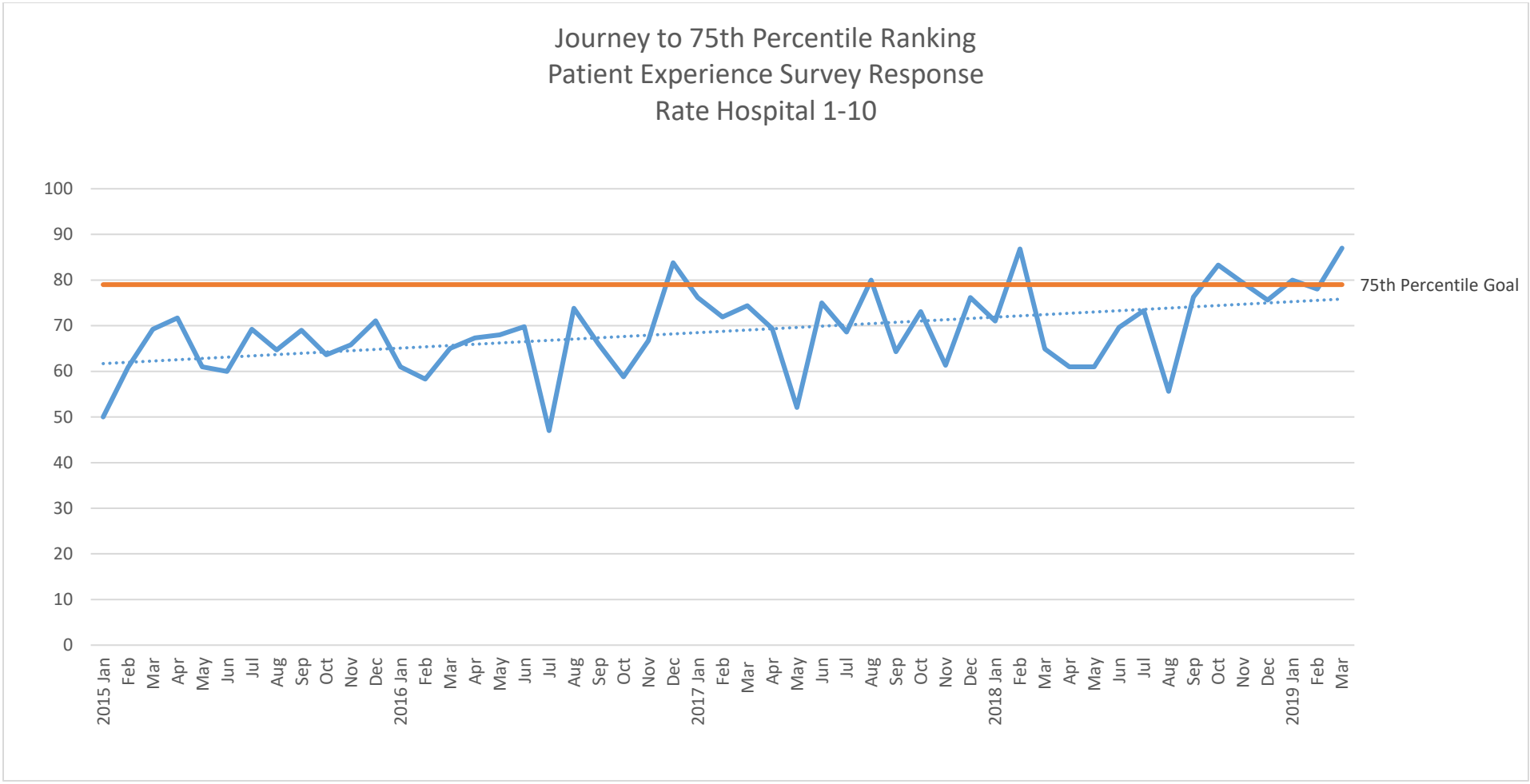
Sustainability requires embedding the tactics into the culture and engagement at all levels. The managers and leaders monitor staff compliance with hourly rounding, discharge calls, bedside report and monthly employee rounding. The executive team monitors for compliance and barriers to achieving monthly targets including the ongoing monthly staff rounding with leaders. The communication boards require a team approach to stay current with data and to ensure the staff huddles continue to address the key metrics daily.

Scaling of events included the slower roll out of each of the "must haves". Each component required staff education, and a period of adoption time before the next component was rolled out. Bedside shift report was rolled out by unit and the process evaluated and reinforced prior to next unit adoption. The discharge phone call process has a software interface with our electronic medical record which identifies the patients to call and tracks call completion.

All of the leaders were taught the basic "must haves". New leadership classes were designed to be certain new leaders received training on the must haves in their onboarding process. The leadership development classes have changed focus to be more of a process improvement training, rather than coaching to improve difficult behavior. As the culture of the organization evolves the practices are expected to become rooted. The mission of our organization supports the love and compassion we are aiming for with all patients and visitors.

Describe key lessons learned.
Advice to colleagues who might try to undertake a similar effort.

Even though we felt our processes were hardwired, they were not. We assume that if monitoring compliance stopped that our processes would begin to fade overtime. Due to this we remain diligent in monitoring "must have" compliance with direct feedback to staff. We continue to engage our employees to help them understand why this is important. What worked best were the visibility boards with front line staff input on the selection of which metrics they would work on to improve overall satisfaction. The second item that worked was our executive team limiting the priorities to work on. These priorities seem to creep up. Even now we have more priorities than we did in 2018 based on events, survey, and system wide improvements programs. What worked was the clear message, through the visibility board, for staff to speak to and work on. Ultimately having front line staff engagement and buy-in is a must. Staff need to hear how personal touches of keeping patients informed, discussing pain and the plan and talking to patients rather than over them makes a difference.


Journey to 75th Percentile Ranking
Patient Experience Survey Response
Rate Hospital 1-10
100
90
80
70
60
50
40
30
20
10
0
75th Percentile Goal
2015 Jan
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Visibility wall

Has quality metrics that are meaningful to this unit. Current Patient experience scores. Daily tracking metrics focus on pain and patient preference. The continuous improvement board staff post opportunities for improvement, the current and ideal state, barriers to reach ideal state and then the next steps and who is accountable for the measures.