1199SEIU/League
LABOR MANAGEMENT
PROJECT

The Labor Management Project's

PATIENT-CENTERED CARE INITIATIVE

Follow-Up Evaluation Report

How Labor and Management Have Successfully Addressed the Patient Experience in Hospitals Throughout New York

September 2014

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Executive Summary

In 2011, the Labor Management Project (LMP) received a Health Workforce Retraining Initiative grant, funded through the New York State Health Care Reform Act (HCRA). The purpose of the LMP's Patient-Centered Care (PCC) program was to improve patient satisfaction at participating hospitals. The intervention included a one-day, eight hour training for 1199SEIU service workers (e.g., housekeeping, transport, dietary, front-line clerical, CNAs, PCAs, PCTs) and non-union supervisory staff. The LMP also provided technical support for a performance improvement (PI) project in selected hospitals.

From April 2012 to December 2013, the LMP trained **3,229** union and non-union staff across **19** hospitals in PCC and assisted in the facilitation of 16 PI projects. PCC training topics included health care reform, patient experience, cultural competence, PI, teamwork and relational coordination,[1] creating a healing environment, and the use of tools such as AIDET.[2] The PI work was intended to increase patient satisfaction through improved staff responsiveness, as measured by HCAHPS[3] and call bells.

To determine the immediate and long-term impact of the PCC training and PI work, the LMP conducted a mixed methods evaluation that included: (1) training evaluations and pre/post quizzes on the day of each training, and (2) surveys, interviews, and focus groups at five hospitals from six months to one year post-training.

Quantitative Findings

The vast majority of PCC trainees reported that the training not only increased their awareness of patient satisfaction, but also provided tools to improve patient satisfaction at their hospitals. The following is the percentage of trainees who gave the training the highest rating upon completion:

I understand better how I can contribute to patient satisfaction 96%

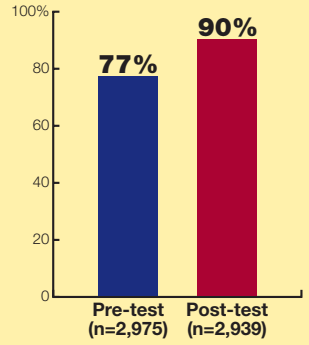
I feel better prepared to provide PCC at my hospital 96%

I will use AIDET with patients at my hospital 98%

I would recommend this training to other workers 97%

The graph to the right shows that average scores for the training knowledge tests increased 13 percentage points—from 77% pre-training to 90% post-training. However, the average score for the knowledge questions on the follow-up survey (representing 270 respondents 6 to 12 months post-training), was only 78%. The fact that the average follow-up survey score was only one point higher than the average pre-training score suggests that knowledge gained in training can be forgotten over time without ongoing reinforcement.

Average Scores for the Pre- and Post-Knowledge Tests Increased Markedly

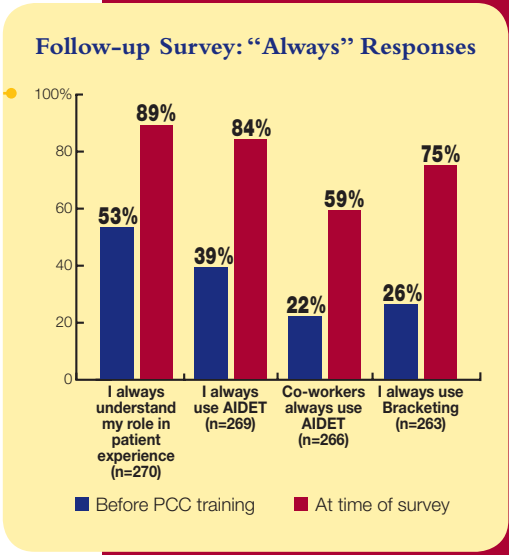


[1] Coordination that occurs through frequent, high quality, and problem-solving communications supported by relationships of shared goals, shared knowledge, and mutual respect.

[2] AIDET is a patient-centered communication technique. (Acknowledge, Introduce, Duration of task, Explain task and what follows, Thank the patient). AIDET is a registered trademark of StuderGroup.

[3] HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national, standardized, publicly reported survey of patients' perspectives of hospital care.

At the follow-up survey, respondents reported increased awareness of the role they play in the patient experience, more frequent use of AIDET and bracketing, and greater practice of AIDET by co-workers.



Qualitative Findings

Analysis of interview, focus group, and open-ended survey questions revealed the following themes.

PCC Training. Across respondent groups, participants expressed appreciation of the PCC training. The training generated a new awareness of the importance of interdisciplinary teamwork and communication in achieving patient satisfaction. AIDET and cultural awareness were elements of the training that participants found particularly useful. Having multidisciplinary training cohorts was also valuable to participants.

Performance Improvement. Participants in the PI work voiced commitment and passion regarding their experience. Important elements of the PI work were the interdisciplinary structure of the team, the teamwork, and the commitment and ownership that team members demonstrated. The fact that all PI team members had equal voice in the process was viewed by many as an important element of the work.

Application. Respondents spoke of applying the knowledge and skills learned during PCC training at their workplaces. The most mentioned practices were AIDET; general PCC skills (including courtesy, cultural awareness, rounding, improved communication, establishing relationships with patients, and putting patients first); and use of skills in the context of the PI initiatives such as "No Pass Zone" and hourly rounding. At the same time, application was inconsistent, with many stating that co-workers, supervisors, and physicians did not always practice PCC.

Success Factors. Respondents spoke of many factors that helped to contribute to successful delivery of PCC. These included commitment, teamwork, and respect. Participants mentioned that their own modeling of PCC practices and modeling by leadership and co-workers served to reinforce PCC as did the use of the same PCC language. Support and stakeholder "buy-in" were also cited as being critical factors for success. Respondents linked job satisfaction with PCC, suggesting that satisfied staff will lead to satisfied patients. Specific practices related to the PI work (hourly rounding, "no pass zone") were cited as important mechanisms for ensuring PCC. Involvement in the PI work provided front-line workers with a voice, empowering them to find solutions to workplace problems.

Barriers. Managers, Physicians, and others who do not model PCC behavior were seen by respondents as undermining efforts to improve PCC at the hospitals. The PCC program was limited in its reach (150 trainees per hospital), thus many were not exposed to the training. Inadequate staffing and difficult or demanding patients and families were also discussed as barriers, as well as system barriers such as technology, supplies, and scheduling. Factors outside the control of the hospitals, such as Hurricane Sandy, and Joint Commission surveys, also impeded continuous PCC practice.

Outcomes. Involvement in the PCC training and PI work led participants to an increased awareness that all staff have a role to play in improving the patient experience. Respondents spoke of improved interdisciplinary teamwork and better relationships and communication. Leadership development was also an important outcome of the PI work.

Sustainability. Participants discussed how best to sustain the PCC and PI work. First, all respondents encouraged the training of all staff within hospitals to create a climate of consistent practice and expectations. Respondents also suggested incorporating PCC into hospital policies and practices, including orientation and in-service training. Sustainability planning was also seen as important—participants cited no clear PCC "owner" upon completion of LMP support.

Labor/Management Relationships. Sponsors in particular spoke of the positive effect that the PCC and PI initiatives had on labor/management relationships. Respondents viewed the planning for and implementation of the PCC training and PI initiatives as a mechanism for reinforcing positive labor/management relationships.

Performance Improvement Results

All PI projects associated with the PCC initiative employed PDSA (Plan, Do, Study, Act) and included data collection to track progress. The PI work led to measurable outcomes such as improved HCAHPS scores and call bell reduction. Out of eight LMP-supported PI projects for which we have data, seven were unit-based and one worked across departments. Four out of eight hospitals measured improvements in HCAHPS scores, with some scores increasing by as much as 40 to 60 percentage points. Three hospitals recorded decreases in the number of call bells; research demonstrates that responsiveness practices associated with these initiatives better enable staff to anticipate patient needs and provide consistent, proactive care. One hospital measured speed of response time, with average response time decreasing by 34% on one unit and 44% on another. Another measured decreases in transport delays and cancellations, as well as decreasing the average length of stay from 7.1 to 5.9 days.

Discussion

The evaluation data corroborate what is known in the literature regarding transfer of training and drivers of excellent patient experience. Factors affecting transfer of training include trainee characteristics (self-efficacy, motivation, perceived utility of training); training design (behavioral modeling, realistic training environment); and work environment (support, opportunity to perform, follow-up). The Institute for Healthcare Improvement (IHI)'s research has identified primary drivers of patient experience: leadership demonstrates that organizational culture is focused on patient-centered care; the hearts and minds of staff and providers are fully engaged; and interactions with patients and families are anchored in respectful partnership. Secondary drivers include: patient-centered care that is publicly verifiable, rewarded, and celebrated, focusing on measurement, learning, and improvement; staff that are available with the tools and skills to deliver care when patients need it; compassionate communication and teamwork as essential competencies; communication that uses words and phrases that the patient understands and that meet emotional needs; and a physical environment that supports care and healing.

The PCC training was extremely well received by participants, many of whom rarely have similar opportunities because of the support/service roles they play in hospitals. The training was able to strongly convey the role all staff can play in ensuring that the patient experience is good during a hospital stay. It also provided approaches and tools that many participants found useful.

The performance improvement work provided the opportunity to put PCC training to use. It brought together staff from different departments and disciplines and built leadership and problem-solving skills. The PI projects showed that with the appropriate resources, support, and teamwork, staff at all levels can join together and improve the patient experience and the associated measures that impact hospital reimbursement. The PCC program also served to bolster labor and management relationships by bringing the parties together to address common goals and create common experiences.

The evaluation also highlights the many challenges faced by healthcare workers and managers in their daily work lives that can negatively affect their ability to provide patient-centered care. These findings underscore the importance of management and union leadership that has a long-term commitment and vision for excellent patient experience, as well as ensuring that systems are in place to support the effective and continuous delivery of PCC and the implementation of performance improvement initiatives that can tackle systemic problems.

Introduction

In 2011, the Labor Management Project (LMP) received a Health Workforce Retraining Initiative grant, funded through the New York State Health Care Reform Act (HCRA). The purpose of the program, entitled "Patient-Centered Care using HCAHPS for Service Workers and Patient Care Technicians—Facility Based," was to improve patient satisfaction at participating hospitals. The intervention included a one-day, eight hour training for 1199SEIU service workers (e.g., housekeeping, transport, dietary, front-line clerical, CNAs, PCAs, PCTs) and non-union supervisory staff. In addition, the LMP provided technical support for a performance improvement (PI) project in selected hospitals. From April 2012 to December 2013, the LMP trained 3,229 union and non-union staff in 19 hospitals in PCC, and assisted in the facilitation of 16 PI projects (see Appendix A).

The one-day training addressed the following topics:

- **Understanding health care reform**
- **Understanding HCAHPS**
- **Understanding patient-centered care**
- **Creating a culture of service excellence, including the use of AIDET**
- **Understanding cultural differences and communicating in culturally appropriate ways**
- **Understanding process improvement**
- **Understanding teamwork and relational coordination**
- **Creating a healing environment**

The performance improvement work generally addressed areas that can be influenced by the engagement of the direct-care workforce, such as responsiveness of staff to patients' needs.

"We want to become a patient-centered heath center. And we want to work better as a team. Everyone is making an effort to make the patient feel more comfortable. The tools were given to us to understand how to make a change"

—FOCUS GROUP DISCUSSION, UNION

For a full understanding of the process and impact of the PCC initiative, the LMP used Kirkpatrick's four levels of training evaluation as a framework. The levels and how they were addressed are described below.

Level 1: Reaction—Measures trainees' immediate reaction to the training. A reaction evaluation explores areas such as satisfaction, value, and intent to use the knowledge and skills imparted. To measure reaction, each PCC training session concluded with participants' written assessment of the training.

Level 2: Learning—Measures the extent to which participants acquired the intended knowledge and skills via the training. LMP Consultants administered a pre/post knowledge quiz to determine if principle concepts had been effectively conveyed.

The results of these assessments of reaction and learning have been reported and shared with participating sites and among LMP stakeholders.

Level 3: Behavior—Examines the extent to which trainees have been able to apply their new knowledge and skills in their work settings.

Level 4: Impact—Documents the results of the training—what changes have taken place because of the training and what are the associated behavior changes?

The follow-up evaluation described herein was intended to measure levels three and four; to achieve that goal, we instituted a mixed methods approach described in this report.

We hypothesized that training alone could have an impact on individual knowledge and behavior. However, the program design included the implementation of PI projects in part because the LMP felt that it would be through a structured, collaborative project involving high-level sponsorship that individual trainees would be able to fully utilize PCC skills and achieve measurable results.

Purpose

The purpose of the trainee follow-up evaluation was to assess the extent to which the participants have been able to put new knowledge and skills to use at the workplace. It also aimed to assess the degree to which new knowledge was retained, factors that enable successful application of knowledge and skills, and barriers to successful implementation.

We know that sustainable change is difficult in complex organizations with a myriad of shifting priorities and external pressures. Thus, the evaluation aimed to investigate those factors that contribute to successful shifts toward patient-centered care as well as those areas and systems requiring additional attention.

Methodology

The LMP Research Team worked with labor and management leadership at several hospitals to survey all PCC-trained staff and to conduct focus group discussions and interviews. We conducted the PCC follow-up survey, nine focus groups, and sixteen interviews at four hospitals—Bronx-Lebanon Hospital, Jamaica Hospital Medical Center, NYU Langone Medical Center, and St. Luke's-Roosevelt Hospital Center. A fifth site, Brooklyn Hospital Center, participated in focus group discussions only.

Patient-Centered Care (PCC) Follow-up Survey

The evaluation team developed a follow-up survey composed of closed- and open-ended questions for self-administration by PCC participants. The survey was comprised of quantitative and qualitative questions; the quantitative questions assessed knowledge retention and the level of PCC practice at the hospitals. The open-ended questions were limited to the following research areas (out of consideration of survey length):

- **Elements of the PCC training that participants felt were particularly valuable**
- **Factors that contribute to successful delivery of patient-centered care at their hospitals**
- **Barriers that make provision of patient-centered care difficult at their hospitals**
- **Questions of how best to sustain the outcomes of the PCC training or PI work**

In partnership with managers and trainers at four participating hospitals, the LMP surveyed 682 PCC trainees, the full complement of trained staff at those sites. To ensure confidentiality, training participants were provided with sealable envelopes to use to return their surveys to the on-site distributors. The LMP also had messengers pick up the packages of returned surveys. Survey participation was voluntary.[4]

Focus Groups and Interviews

The Research Team worked with union and management sponsors at five sites to identify potential interviewees and focus group participants who met the criterion of completing the LMP's day-long PCC training. Additionally, all interviewees and some focus group participants were involved in the LMP-sponsored PI initiative. Thus, findings are based on the perspectives of both PCC trainees and PI participants.

The focus group and interview guides were organized to explore the following research topics:

1) **Elements of the PCC training that participants felt were particularly valuable**
2) **Extent to which participants were able to put their learning into practice at the workplace**
3) **Factors that contribute to successful delivery of patient-centered care at their hospitals**
4) **Barriers that make provision of patient-centered care difficult at their hospitals**
5) **Outcomes of the PCC training and the PI project work**
6) **Questions of how best to sustain the outcomes of the PCC training or PI work**
7) **The effect of the training or PI work on labor/management relationships**
8) **Recommendations for improvements in the PCC training, curriculum, or PI work**

Qualitative Data Collection

Focus Groups (9)
- Frontline (union) Staff (5)
- Managerial & Professional Staff (4)

Interviews (16)
- 3 PI Project Co-Leads
- 8 PI Project Sponsors
- 5 PI Project Participants

[4] See Appendix B for additional information on protection of human subjects.

Evaluation Findings

Elements of the PCC Training That Participants Felt Were Particularly Valuable

Across the groups, all respondents expressed a general appreciation of the PCC training. Respondents felt that the content of the training was informative and valuable in their daily work. They also praised the structure and delivery of the workshops, indicating that the workshop facilitators were engaging and the participatory exercises (e.g., tennis ball exercise, blue/green exercise on culture diversity, AIDET role plays) were memorable and effective in conveying content.

Communication/Patient Experience. Respondents across the board spoke of a new awareness regarding communication with and overall treatment of patients, as well as the critical importance of the patient experience at the workplace.

> *"Some of the most important things are talk to the patient in a different way and get them involved and it makes them comfortable."*
>
> —FOCUS GROUP DISCUSSION, UNION

> *"[The most important things I learned were…] Reinforcement of the service excellence concept in terms of attitudes, our interaction with the patient, making the patient feel that they are the center of the interaction at that time. A review of AIDET, hardwiring communication so we are saying the same things."*
>
> —PI PARTICIPANT, MANAGEMENT

> *"The training was extremely well received. The information and the tips and tools that [the employees] were trained on were very helpful. The feedback was that the training was extremely well received and provided useful information."*
>
> —MANAGEMENT SPONSOR

AIDET. The PCC training introduced AIDET as a strategy for improving the patient experience and creating a more patient-centered environment (see text box—AIDET). Union and management PCC training participants, survey respondents, and management respondents involved in the PI initiative reported AIDET to be a valuable tool. For some, it reinforced training and practices already in place; for others, AIDET was a new tool.

> *"We want to become a patient-centered heath center. And we want to work better as a team. Everyone is making an effort to make the patient feel more comfortable. The tools were given to us to understand how to make a change. I had no idea what AIDET or bracketing was until I went through the training."*
>
> —FOCUS GROUP DISCUSSION, UNION

> *"The group that was giving the training came up with a very good idea and that was the AIDET, which is something everyone can understand and follow up. It's really not that difficult and something we do anyway on a daily basis, but it helps to remember to do those things. So it kept things in order."*
>
> —FOCUS GROUP DISCUSSION, UNION

AIDET® (Studer Group®)

AIDET is a communication approach that promotes simple but important behaviors that all staff can practice when interacting with patients. AIDET stands for:

A cknowledge: Greet the patient with a warm, receptive attitude.

I ntroduce: Offer your name and role in the patient's care. Communicate your desire to help.

D uration: Explain how long a procedure, process, or activity will take, including how long it will take to reach your destination, if applicable.

E xplanation: Provide detailed information. Answer the patients' and/or family members' questions.

T hank You: Thank the patient for choosing the hospital and for trusting you to provide services.

Cultural Awareness. The cultural awareness component of the training was also reported by most categories of respondents to be a memorable activity with valuable information imparted. For some, this new awareness has changed the way they interact with patients.

> *"Sometimes you don't understand what the person is going through because of their culture and language. If you don't understand you might get the wrong impression of the person. We have to understand that we all have different cultures and ways of doing things."*
>
> —FOCUS GROUP DISCUSSION, UNION

> *"Not making assumptions when you go into a room. A patient's behavior may not be the same as what you expect, broadening your perceptions based on cultural and religious differences; being more aware of people's communication style."*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

Co-workers. Respondents commented on the importance of applying what they learned in the training not only to patients, but also to co-workers.

> *"In PCC we are talking about respect and not only respect for your patient but also respect for your colleagues and not be judgmental about it."*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

> *"This hospital is very diverse. It was good to better understand that everyone is not like me. I'm outspoken, and can be boisterous at times while other people are extremely quiet. It's important to remind people to be mindful of other peoples' differences."*
>
> —FOCUS GROUP DISCUSSION, UNION

Multidisciplinary Training Cohorts. Sponsors in particular commented on the value of bringing staff from different departments and disciplines together during the PCC training.

> *"For example, in the classes, there was something started, a foundation set where you have all these disciplines sitting around together, which historically doesn't happen. So now you just have people with more opportunity to talk to each other, even if it was just for one day."*
>
> —MANAGEMENT SPONSOR

"We have to understand that we all have different cultures and ways of doing things."

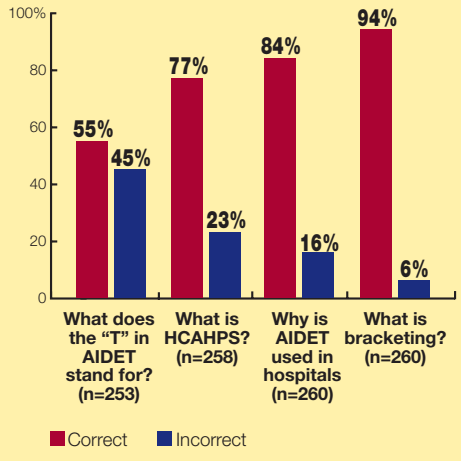
—FOCUS GROUP DISCUSSION, UNION

Extent to Which Participants Were Able to Put Their Learning Into Practice at the Workplace

Quantitative Findings–From Surveys

This research question was addressed via the PCC follow-up survey,[5] the interviews, and focus groups. First, the survey aimed to assess knowledge retention. The chart at right shows that the majority of respondents were able to recall important knowledge elements of the training, with knowledge of bracketing the highest, and with the acronym for AIDET being the lowest. Most respondents were able to respond correctly, however, to the question "Why is AIDET used in hospitals?"

Knowledge Questions



[5] See Appendix C for information on survey response rates and respondents' characteristics.

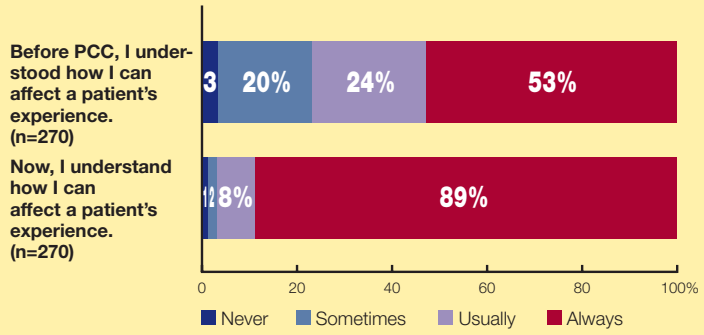
The charts at right represent the responses to questions posed regarding behavior and use of skills—on the part of both PCC participants and their co-workers, before the training and at the time of the survey (6 to 12 months post-training). Asking survey questions retrospectively helps to mitigate "response shift bias." This potential bias can occur in traditional pre/post survey questions about self-reported behavior when respondents are unfamiliar with the concepts being measured pre-intervention, and the respondents' evaluation standard or metric therefore changes following the intervention as awareness shifts.

The first chart shows that the percent of respondents stating they ALWAYS understood how they could affect a patient's experience shifted from 53% before the training to 89% at the time of the survey. As illustrated in the second chart, 39% of respondents reported ALWAYS using AIDET before the training, whereas 84% reported ALWAYS using AIDET at the time of the survey. In the third chart, the percent of respondents reporting co-workers ALWAYS using AIDET was smaller; however, respondents still reported an increase on average—from 22% to 59%. Finally, the last chart shows that 26% of respondents reported ALWAYS using bracketing prior to the training, while 75% reported ALWAYS using it at the time of the survey.

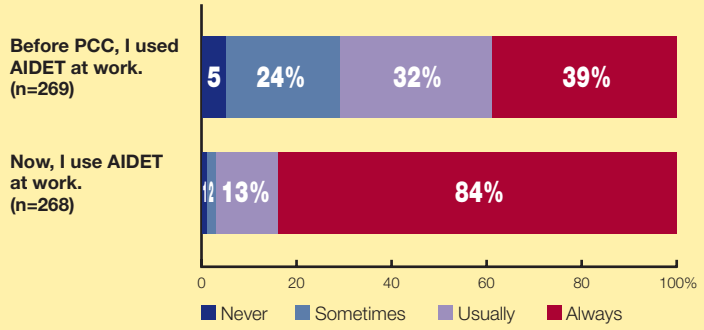
Qualitative Findings—From Focus Groups, Interviews, and the PCC Follow-up Survey

Skills. One purpose of the follow-up evaluation was to examine the extent to which participants were able to use the knowledge and skills imparted during the training in their places of work. Participants reported ability and willingness to use the knowledge and skills learned in the PCC training in their hospitals. The most mentioned practices used in the workplace were AIDET (all PCC trainees and PI participants); general PCC skills, including courtesy, cultural awareness, rounding, improved communication, establishing relationships with patients,

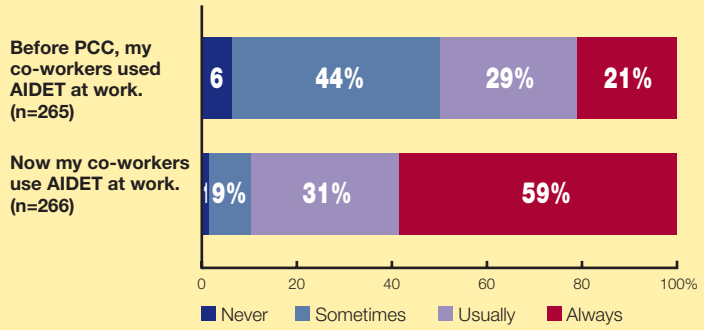
Before and Now, Patient Experience



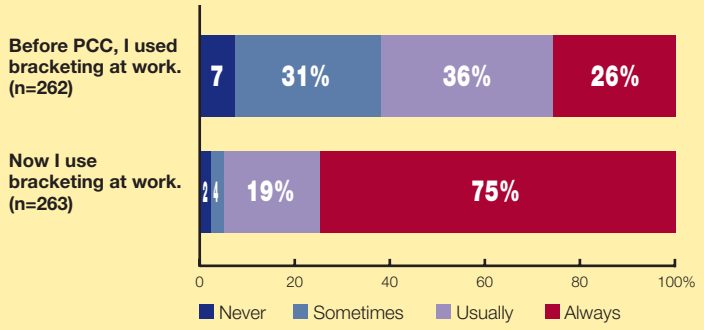
Before and Now, Respondent Uses AIDET



Before and Now, Co-Workers Use AIDET



Before and Now, Respondent Uses Bracketing



and putting patients first (all PCC trainees); and use of skills in the context of the PI initiatives such as No Pass Zone and hourly rounding (all PI participants and sponsors). PCC trainees who were union members also mentioned practicing empathy and compassion, as well as the use of bracketing.

AIDET. All PCC trainees and PI participants—both union and management—reported some level of AIDET use within their hospitals. The reports, however, were inconsistent, with some remembering the AIDET steps well and others only remembering parts of the process. Respondents in some cases reported that AIDET provided them with a tool to reinforce practices already in place. In other cases, respondents stated inconsistent use of AIDET, particularly among co-workers.

> *"We do it in the patient's room. You knock on the door and ask if you can come in and acknowledge yourself and explain what you have to do."*
> —FOCUS GROUP DISCUSSION, UNION

> *"I work in a unit where we did it automatically. It was done automatically, but now we have an acronym for it."*
> —FOCUS GROUP DISCUSSION, UNION

> *"When we go to the patient you have to tell them what you're about to do. Some people go in without saying anything."*
> —FOCUS GROUP DISCUSSION, UNION

PCC Principles. Respondents reported general practice of PCC principles, including being warm and courteous, showing compassion and empathy, and providing information and reassurance to both patients and their families. Frontline workers and managers alike recognized the value of this message. The PCC training both introduced and reinforced the central importance of how staff communicate with patients and address patients' needs.

> *"The way in which we deliver service is most important, and that's what is being surveyed and monitored. Not that the patient came to the hospital and got a room and saw the doctor, but the way we provide the service. We keep the patient informed and part of the team, so the patient feels like "my voice is important."*
> —PI TEAM MEMBER,MANAGEMENT

> *"You transport a person and they'll tell you their problems. Sometimes you don't know what to say. But you have to make them feel like you're listening to them and you care. And by the time you get them where they have to go, you're laughing and joking with them and they feel better."*
> —FOCUS GROUP DISCUSSION, UNION

Factors That Enable Successful Delivery of Patient-Centered Care

Commitment, Teamwork, Respect, and Modeling. The evaluation explored the factors that participants felt were important to the successful delivery of patient-centered care. Respondents reported a wide range of factors. Among these was an overall commitment to making patient satisfaction central, including establishing a relation-

Respondents reported general practice of PCC principles, including being warm and courteous, showing compassion and empathy, and providing information and reassurance to both patients and their families.

ship with patients, making patients comfortable, good communication, attentiveness, respect, and empathy. Respondents also emphasized the importance of teamwork and respect for colleagues. PCC trainees—both union and management—mentioned various instances of modeling PCC behavior, suggesting that having role models who consistently practice PCC can lead to greater uptake in the practices and a shift in organizational culture.

> *"Everyone is speaking the same language. I hear patient satisfaction every day. When I get on the elevator I hear patient satisfaction. The PCC added to that effort that was being done. Everyone from the top of the hospital on down was aware that this is the goal."*
>
> —FOCUS GROUP DISCUSSION, UNION

> *"It's a multidisciplinary approach. Everyone on the health care team is important. From the doctor to the housekeeper. In this PCC training, we acknowledge the importance of the team approach and all of us together are going to acknowledge the patient."*
>
> —FOCUS GROUP DISCUSSION, UNION

> *"It really is a team effort. No one can tell you, "You're just a transporter or you're just dietary." Everyone plays a vital role in what we're trying to accomplish."*
>
> —PI PARTICIPANT, UNION

> *"Over the last couple of months, there have been lots of letters coming in from patients and visitors satisfied with the [security] officers. That's an incentive to the rest of the guys. Officer X, he goes way above and beyond. By him getting all this attention, it's working."*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

PCC Training. Survey respondents reported that the very fact that they received the PCC training and had the opportunity to learn about best practices, such as AIDET and bracketing, helped them to provide better patient-centered care when they returned to work. Survey respondents also mentioned the importance of daily practice.

Those respondents involved in the PI work also felt that the PCC trainings laid a foundation for PI practices, and prepared its participants to engage in that work. For instance, when asked if and how the PCC training prepared one for PI work, a participant stated:

> *"To work as a team. To hear every voice. All of our opinions matter. Everyone in the hospital is an essential part of having the hospital grow."*
>
> —PI PARTICIPANT, UNION

Support and Buy-in. Program participants also reported the kinds of support that helped to create an environment where PCC can be practiced. Support on many levels became particularly important for the PI work. LMP facilitators were reported to have provided professional, motivating, meaningful support to the PI teams. Co-chairs were also said to play a role in facilitation and keeping teams on track. Overall, stakeholder "buy-in" at all levels—from union and hospital leadership to frontline

"All of our opinions matter. Everyone in the hospital is an essential part of having the hospital grow."

—PI PARTICIPANT, UNION

workers and managers—was considered to be an important factor in moving a PCC agenda in general and PI practice in particular. Union and management collaboration was cited as an important element of the PCC work, and at the leadership level this was viewed as important because of the message it conveyed about commitment.

> *"You have to have a manager that buys in because if you don't… you're dead in the water."*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

> *"Our director also went to every floor with a different dietician to see what we can improve."*
>
> —PI PARTICIPANT, UNION

> *"We had a lot of help from the sponsors."*
>
> —PI PARTICIPANT, UNION

> *"But once you get consultants, they have an eye to see things that you haven't noticed because you work here and everything is a part of the culture of the organization. So you've got to work with it. But when a consultant comes in, they have very sharp, keen eyes looking at what the situation and the problem and solution is."*
>
> —PI PARTICIPANT, MANAGEMENT

> *"When the consultants came here, all they did was let us tell them what our problems were. We did the homework after figuring out what all our problems were, and of course they were helping. It was very interactive…not like the Joint Commission or external agencies. You have to do your homework. The team itself went through all that work and all the processes. They were here and said you've identified your problems, so what do you think your solutions are? It's not like they came here imposing. That's the key, it was self-driven."*
>
> —PI PARTICIPANT, MANAGEMENT

Job Satisfaction. Several front-line workers discussed the link between job satisfaction and patient-centered care.

> *"Happy staff make happy patients."*
>
> —FOCUS GROUP DISCUSSION, UNION

> *"They always ask if the patient is okay, but if you don't have a comfortable staff, you won't have comfortable patients."*
>
> —FOCUS GROUP DISCUSSION, UNION

PI Interventions. Specific practices related to the PI work, such as hourly rounding, and "no pass zone" were cited by those involved as being important mechanisms for ensuring patient-centered care. In general, respondents discussed "success" in terms of the PI project work.

> *"To get their support and for them to be loyal to us, hourly rounding is very important for nurses, CNAs, for everyone. If the patient sees that all the time, they will say this is a different hospital. You see the difference. They are tense and all of a sudden they are not tense anymore."*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

"...hourly rounding is very important for nurses, CNAs, for everyone."

—FOCUS GROUP DISCUSSION, MANAGEMENT

"It was very interesting…it reenergized the no pass zone and held all staff accountable. We explained what it was and told them they would be held responsible. So there was no more saying 'it's not my job.' If you see the call bell, you must address it."

—FOCUS GROUP DISCUSSION, UNION

PI Involvement. Other PI participants discussed how their involvement in the PI process enabled them to have a voice in the workplace, empowering them to contribute to solutions for workplace problems.

"I've had a lot of ideas over the years and have never gotten to put my ideas in place. So it [being a co-chair of the PI project] was a chance to give my input into something I know will work."

—PI PARTICIPANT, UNION

Other Factors. Less frequently mentioned factors that participants felt contributed to successful delivery of PCC included: the importance of holding individuals (management and union) accountable for PCC and the patient experience (management PCC trainees, union PI participants); providing reward and recognition (union PI); effective communication (management PI); ownership of the project and unit meetings (union sponsors); and provision of release time and backfill (union sponsors, management sponsors)

"I will say that I think it is important to recognize staff. I think it helps them do a better job."

—PI PARTICIPANT, MANAGEMENT

Barriers to Successful Implementation

Management and Physicians. Given the complex environment in which hospital health care is provided, barriers to the provision of patient-centered care are inevitable and must be examined. When discussing barriers, there were some similarities and differences among the respondent groups. On the side of differences for instance, PCC trainees who were union members cited management as sometimes hindering the provision of PCC. These respondents spoke of a punitive environment, lack of trust, lack of accountability, lack of respect, and inaccessibility of managers. Managers who received the PCC training, in contrast, often cited physicians who do not practice PCC as a barrier to universal adoption of the practices. Physicians are often not hospital employees, are not trained in PCC, and may not be respectful of the important elements of relational coordination and communication.

"But when you do see management, there's another side of the coin. You get negativity. You get more out of someone with kindness than negativity. They need to stop the negativity. There are some that do, but more often than not, it's negative. It's punitive. I'm aware that management is aware of HCAHPS, but listen… support the staff. Because if you do support us, people will do more."

—FOCUS GROUP DISCUSSION, UNION

"The rudeness [of the doctors] is unbelievable. That's another thing. The perception to the patient and family (with blackberrys and cellphones)… it's just is another wall up to the patient and the family."

—FOCUS GROUP DISCUSSION, MANAGEMENT

"it reenergized the no pass zone and held all staff accountable."

—FOCUS GROUP DISCUSSION, UNION

Inconsistent Practices. Nearly all types of respondents cited that having co-workers who do not consistently practice PCC in the workplace is a barrier to creating an environment where the patient experiences him or herself as central to the care being provided. Managers, union sponsors, and survey respondents cited lack of teamwork as an impediment to PCC. This included a reported reluctance to go outside the confines of one's job description.

> *"There is a culture of 'That's not my job. That's not my patient.' "*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

> *"Sometimes if you're in one classification, you feel like you're doing someone else's work instead of saying that I'm just serving the patient."*
>
> —UNION SPONSOR

Staffing. Managers, union sponsors, and survey respondents all cited inadequate staffing as an impediment to consistently providing PCC.

> *"There is just less and less staff, but they keep on piling and piling responsibilities; so there's that element of it, but people have enormous responsibilities so it is a challenge to be that all around, perky person and thoughtful, meaningful and relevant. That's a reality. It makes it difficult to do all of those things."*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

Difficult Patients and Families. Frontline workers cited difficult or demanding patients and families as barriers to providing PCC. Survey respondents also cited language barriers.

> *"Sometimes when the patient is uncooperative and hostile, I get a poor response…"*
>
> —SURVEY RESPONDENT

> *"Sometimes the people you have to deal with are way too difficult to use what I have learned, but I try anyway."*
>
> —SURVEY RESPONDENT

Systems. Union respondents also cited various systems barriers. These included staff transitions, delays, problems with technology, lack of supplies, and delayed diet orders.

Barriers to PI. Managers involved in the PI work cited a number of additional barriers, including the time commitment required for the PI work, poor communication among staff or from management, and disrespect from management that inhibits the PI work.

Managers involved in the PI projects as well as union and management sponsors spoke of a lack of resources to sustain and spread PCC/PI. Union sponsors spoke of a desire to have LMP consultants involved for a longer time period.

Sustainability. Intervening factors outside of the control of the hospitals affected sustainability. The most extreme example was Hurricane Sandy, which shut down one of the hospitals for months. Management respondents also cited surveys (e.g., Joint Commission) as hampering continuation of the work. Union members that participated in the PI work stated that lack of follow-up and lack of ownership led to an abatement of some of the practices put into place under the PI project.

Outcomes of the PI Project Work and the PCC Training

All sixteen interview participants were involved with the PI work, as either co-leads, participants, or sponsors. Participants and sponsors of the PI work—union and management—spoke passionately about the effectiveness and promise of the approach. Important elements of the PI work were the interdisciplinary structure of the team, the teamwork, and participants' commitment and ownership. The fact that all PI team members had an equal voice in the process was viewed by many as an important element of the work.

> *"Everybody took ownership, the housekeepers, nutrition, respiratory, social worker. It was a team, it was us. The patient belongs to each and every one of us. You have doctors, nurses, PCTs, everybody had an equal voice and everybody's opinion was respected. These people created a bond. It was amazing how you saw the bond grow after a month went by."*
>
> —UNION SPONSOR

Across titles, disciplines, and the union/management spectrum, respondents spoke of various outcomes they saw as being associated with the PCC training, the PI work, or both.

All Play a Role in Patient Experience. One theme that emerged from the discussions and interviews was that involvement in PCC and PI increased participants' awareness that each staff person has a role to play in enhancing the patient experience. In the training, this was presented in the context of "relational coordination," visually representing all the various disciplines that impact upon the care and experience of hospital patients, and the importance of teamwork. This concept was reinforced throughout the training and the PI work; as a result, participants gained a greater appreciation of the role others play.

Teamwork and Relationships. Respondents spoke of improved interdisciplinary teamwork and better relationships, resulting from both the PCC training and the subsequent PI work. Management PCC trainees spoke of friendlier, more attentive staff following the PCC training. PI participants and project sponsors spoke of improved communication among staff and with patients.

> *"Sometimes you are working with people who say it's not my job, not my patient, or not my area. That can get in the way. But I think it's gotten better from the training. I don't hear that anymore."*
>
> —FOCUS GROUP DISCUSSION, UNION

> *"After the groups went through [the training], they were saying hello, how are you, good morning. It seemed like the hospital got a lot friendlier."*
>
> —FOCUS GROUP DISCUSSION, MANAGEMENT

Leadership Development. The PI work gave voice to all disciplines, providing a forum for ideas and exchange. Sponsors and managers and union members of PI teams all spoke of the important outcome of leadership development for co-leads and other team members. When non-traditional leaders were given a chance to contribute and develop, it was seen as beneficial to the overall goals of the PI initiative.

"Everybody took ownership, the housekeepers, nutrition, respiratory, social worker. It was a team, it was us. The patient belongs to each and every one of us. You have doctors, nurses, PCTs, everybody had an equal voice and everybody's opinion was respected."

—UNION SPONSOR

"The [frontline workers] really rose to the occasion; they had great ideas about the project and what they wanted to do. They participated in all the trainings and in-services that we did. They were talking to their co-workers and bringing back information."

—PI PARTICIPANT, MANAGEMENT

"We developed leaders, we were able to develop teamwork. They created new concepts for working not only with the tools of the training but how to translate that to the patients and families."

—UNION SPONSOR

Measurable PI Outcomes. All PI projects associated with the PCC initiative employed PDSA (Plan, Do, Study, Act)—a structured methodology for carrying out performance improvement work. Pre- and post-data collection was embedded into the work of the joint labor/management PI teams. The PI work led to measurable outcomes such as improved HCAHPS scores and call bell reduction. Out of eight LMP-supported PI projects for which we have data, seven were unit-based and one worked across departments. Four out of eight hospitals measured improvements in HCAHPS scores, with some scores increasing by as much as 40 to 60 percentage points. Three hospitals recorded decreases in the number of call bells; research demonstrates that responsiveness practices associated with these initiatives better enable staff to anticipate patient needs and provide consistent, proactive care. One hospital measured speed of response time, with average response time decreasing by 34% on one unit and 44% on another. Another measured decreases in transport delays and cancellations, as well as decreases in the average length of stay from 7.1 to 5.9 days. Focus group and interview participants also pointed to the improvements that the PI teams measured. One union sponsor reported fewer grievances. A summary of the PI results can be found in Appendix D.

Recommendations on How to Sustain the Outcomes of the PCC Training and/or PI Work

It is commonly understood that the provision of training alone is likely insufficient to change behavior and organizational practices. This may be particularly true in complex, hierarchical organizations such as hospitals. Further, the PCC training was provided to a small portion of hospital employees at each hospital, and the PI initiatives were launched in only one or two units per hospital. Thus, the questions of both sustainability and spread of the work were of great interest to both the researchers and to the participants.

Train All Staff. One recommended approach posed by all PCC trainees as well as management sponsors was to train all staff in PCC in order to create a climate of consistent practice and expectations throughout hospitals. It was suggested that the training should include physicians since they greatly influence the patient experience. The importance of training all managers was also emphasized.

Incorporate PCC into Hospital Policies and Practices. Interview and focus group participants had a multitude of recommendations for how to "hardwire" PCC within their organizations. Recommendations included incorporating PCC into new hire

"We developed leaders, we were able to develop teamwork. They created new concepts for working not only with the tools of the training but how to translate that to the patients and families."

—UNION SPONSOR

screening and orientation, training, and hospital policies; adopting and sustaining practices such as huddles and rounding that have shown to be effective at improving the patient experience; reinforcing PCC skills and practices through "boosters," in-services for all staff, emails, and daily or weekly face to face reminders; identifying PCC champions; and ensuring that ongoing meetings address PCC.

Union trainees and sponsors also discussed the importance of integrating PCC with other initiatives at the hospitals, for instance TEAMSTEPPS and other training initiatives.

Accountability. Union trainees and sponsors also discussed the need to hold staff accountable for PCC behavior, including supervisors.

Sustainability Planning. In some hospitals, it was unclear who "owned" the initiative once the LMP completed its support. This confusion led to no one championing the sustainability of the work. Sponsor respondents talked of the need for planning for sustainability prior to program launch, including identifying roles and responsibilities for sustaining and spreading the PCC principles.

Further Support. Sponsors suggested it would be beneficial to have further support from LMP consultants, and to expand and sustain PCC through a train-the-trainer model.[6] Managers suggested providing concrete evidence to senior management about the effectiveness of the approaches, and getting their "buy-in" and support. Sponsors also discussed the importance of providing release time so that staff can attend training. Sponsors discussed continuing the practice of data sharing as one means of maintaining momentum.

The Effect of the Training or PI Work on Labor/Management Relationships

Labor/Management Relationships. Sponsors in particular spoke of the positive effect that the PCC and PI initiatives had on labor/management relationships. Respondents viewed the planning for and implementation of the PCC training and PI initiatives as a mechanism for reinforcing positive labor/management relationships.

> *"The joint collaborative … was always presented to everyone as a labor management project; the union and management working together for the same goal. At the end of the day, we are here for patients."*
>
> —UNION SPONSOR

Training. From the management perspective, the training itself helped to shore up relationships because it was seen as an investment in education not normally offered to frontline staff. At the leadership level, the union and management worked together on program planning and trainee selection—this common goal also reinforced those relationships according to at least one management sponsor.

[6] In response to this need and requests by participating sites, the LMP developed and delivered a PCC Train-the-Trainer curriculum. Twelve hospitals sent union and management representatives to participate in that training, and roll-out was underway at four sites at the time of this writing.

"It was an investment in staff, an education that they don't really get. That itself raised that [labor-management] relationship because they feel valued. We're taking the time to educate."

—MANAGEMENT SPONSOR

"I think there were very good working relationships. We were involved with union in selecting people for training. All of this bridges the gap and makes for a better relationship. I do think this has benefitted. Partnering with 1199 on these kinds of projects moves labor management cooperation in a positive way."

—MANAGEMENT SPONSOR

Performance Improvement. Because the PI work deeply engaged both union members and management staff, sponsors saw these projects as boosting those relationships.

"During the project it was very exciting because the team really worked well with leaders on-site, the workers and the floor, all three shifts really seemed to gel and take on ownership. It was a model."

—UNION SPONSOR

Discussion

Triangulation

The PCC follow-up survey findings reinforce the qualitative findings that the training led to improved knowledge and awareness, and introduced tools that many participants were able to use at work. They also validate the perception on the part of participants that some co-workers are less inclined to practice PCC. Thus, while the training was highly valued by participants, the questions of consistent practice, systems to support PCC, and overall sustainability that were uncovered in the qualitative data are suggested in the survey data as well.

Applying PCC Training at Work

Key Factors for the Transfer of Training (Grossman & Salas)

Trainee Characteristics	Training Design	Work Environment
Cognitive ability	Behavioral modeling	Transfer climate
Self-efficacy	Error management	Support
Motivation	Realistic training environment	Opportunity to perform
Perceived utility of training		Follow-up

The challenge of ensuring "training transfer" abounds in training and organizational development circles. Training transfer refers to the application, generalization and maintenance of trained skills on the job. Transfer of training, or "making training stick," has been an ongoing source of inquiry for practitioners and researchers. Examining the literature, Grossman and Salas (2011)[7] identified factors that have shown "the strongest, most consistent relationship with the transfer of training." These included trainee characteristics, features of the work design, and elements of the work environment (see table above).

[7] Grossman, Rebecca & Eduardo Salas. The transfer of training: what really matters. International Journal of Training and Development. 15:2, 2011, Blackwell Publishing Ltd.

Among the trainee characteristics required for successful application of training at work is "perceived utility of training." Our evaluation, as well as data collected immediately post-training, confirms that PCC trainees viewed the PCC material as highly useful and relevant. Other trainee characteristics include motivation to learn and apply skills, as well as self-efficacy (confidence in one's ability to learn and apply trained competencies). It is conceivable that the interactive nature of the PCC training, including role plays and modeling, helped to facilitate both of these contributing factors. In fact, the training design characteristics that contribute to successful transfer include behavioral modeling and a realistic training environment. The positive reviews of the training and the reported intention to use the skills also suggest motivation and self-efficacy were high.

The qualitative data also are in line with the Work Environment characteristics identified by Grossman and Salas—both what enabled participants to put PCC into practice as well as what hindered them when absent. These characteristics include supervisor and peer support, resources and opportunities to apply new skills, and follow-up with additional learning opportunities to reinforce the learning. This latter factor remains a strong expressed need—to provide ongoing training, boosters, reminders, and other reinforcement to those trained, as well as continuing to offer training to all those staff that have not yet been trained. Introduction of a Train-the-Trainer model for both the PCC curriculum and PI facilitation is the next step taken by the LMP to reinforce and deepen the work at hospitals.

Contributing to Excellent Patient Experience

Evidence on how best to achieve excellent patient experience in hospital settings is emerging. Notably, a team at the Institute for Healthcare Improvement undertook a research and development project that included literature review, key informant interviews, and consultation with patients and family members. They identified primary and secondary drivers that contribute to exceptional inpatient hospital experience. The table below outlines those drivers.

The primary driver of "hearts and minds" speaks to engagement of staff and providers; those involved in PCC and particularly in the PI work reported an elevated level of engagement and commitment. Communication and teamwork are essential elements as well. The primary driver of "respectful partnership" speaks to antici-

Institute for Healthcare Improvement (IHI) Patient and Family Experience Drivers[8]

Primary Drivers	Secondary 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	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
HEARTS AND MINDS	
The hearts and minds of staff and providers are fully engaged	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
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)	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
RELIABLE CARE	
Hospital systems deliver reliable, quality care 24/7	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"
EVIDENCE-BASED CARE	
The care team instills confidence by providing collaborative, evidence-based care	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

[8] Balik B, Conway J, Zipperer L, Watson J. Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

pating and responding to a range of needs that go well beyond clinical care. The PCC work encouraged participants to consider and address patients' emotional and cultural needs, and to contribute to the creation of a healing environment.

Conclusion

This evaluation was conducted to demonstrate the outcomes of the PCC program (April 2012 to December 2013) as well as to identify challenges so that future work may be strengthened. Its use of mixed methods provides "triangulated" evidence of the creation of a strong foundation upon which to build. The PCC training itself was extremely well received by participants, many of whom rarely have similar opportunities because of the support/service roles they play in hospitals. The training was able to strongly convey the role all staff can play in ensuring that the patient experience is good during a hospital stay. It also provided approaches and tools that many participants found useful.

The performance improvement work provided the opportunity to put PCC training to use. It brought together staff from different departments and disciplines and built leadership and problem-solving skills. The PI projects showed that with the appropriate resources, support, and teamwork, staff at all levels can join together and improve the patient experience and the associated measures that impact hospital reimbursement.

The PCC program also served to bolster labor and management relationships by bringing the parties together to share common goals and create common experiences. In the words of participants:

> *"My idea of management changed completely. People have to realize that [this] hospital is a business. My relationship with management has changed. I don't look at them as enemies, we are working together…Now we have to get that across to the entire hospital."*
>
> —INTERVIEWEE, UNION MEMBER

> *"Bringing the whole interdisciplinary team together [helped us see that] we are one. It binded us more. We came to understand that we are all one team. [We began to think], how can we work together for the success of the organization and to meet the patient's needs?"*
>
> —PI TEAM INTERVIEWEE, MANAGER

The evaluation also highlights the many challenges faced by healthcare workers and managers in their daily work lives that can negatively affect their ability to provide patient-centered care. These findings underscore the importance of management and union leadership that has a long-term commitment and vision for excellent patient experience, as well as ensuring that systems are in place to support the effective and continuous delivery of PCC and the implementation of performance improvement initiatives that can tackle systemic problems.

Appendices

Appendix A: PCC Participating Hospitals

1. Bronx-Lebanon Hospital Center
2. Brookdale University Hospital and Medical Center
3. Brooklyn Hospital Center
4. Flushing Hospital Medical Center
5. Forest Hills Hospital—North Shore LIJ Health System
6. Jamaica Hospital Medical Center
7. Kingsbrook Jewish Medical Center
8. Maimonides Medical Center
9. Montefiore Medical Center—Wakefield Campus
10. Mount Sinai Queens
11. New York University Hospital
12. North Shore Long Island Jewish Medical Center
13. Nyack Hospital
14. Richmond University Medical Center
15. St. Barnabas Hospital
16. St. John's Episcopal Hospital
17. St. Luke's Roosevelt Hospital—Mt. Sinai
18. Staten Island University Hospital
19. Wyckoff Heights Medical Center

Appendix B: Human Subject Protections

Survey

Surveys were distributed to all PCC participants at each of the four hospitals participating in the full evaluation. While the distribution envelopes had names to ensure they were only given to staff that participated in the PCC training, no names were recorded on the survey itself. Each survey had an identification number so that the LMP Research team could track responses and enter them into a drawing for a $50 American Express gift card. Two respondents per site were randomly selected for this incentive. Only LMP staff knew which identification number corresponded with which PCC trainee—this information was not shared with hospital staff nor was it consulted during the analysis.

Participants were informed that the survey was confidential and voluntary. The surveys included a description of the purpose and use of the survey data, as well as contact names and telephone numbers if respondents had any questions. Department heads distributed the surveys along with sealable, unidentified envelopes for each survey. Respondents returned completed surveys in sealed envelopes to department heads, who in turn gave the sealed envelopes to a hospital point person. That point person returned the surveys, sealed in a larger envelope, to the LMP Research team via messenger.

Focus Groups

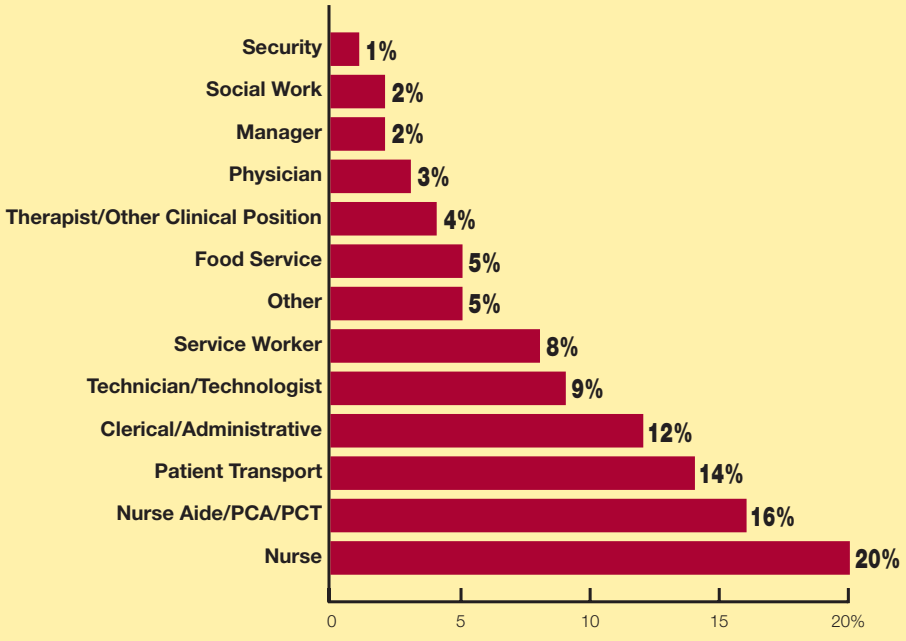
Participation in the focus groups and interviews was voluntary. All individuals were informed of their rights as participants, the purpose of the discussions, and how the data would be used. We requested participants' consent to audio record interviews and focus group discussions; all audio recordings, transcripts, and notes were stored in a protected file to which only members of the LMP Research Team had access. For one focus group session, the LMP Research Team took detailed notes in lieu of audio recording because one participant did not give consent for audio-recording. Interviews were conducted via telephone or in-person.

Focus groups were conducted for labor and management separately to give participants the freedom to share their thoughts in an open and honest manner. Five of the focus groups were comprised of front-line staff and members of 1199SEIU (e.g., housekeeping, dietary, transport, PSA, PCT, CNA, technicians, unit clerks, security); the other four focus groups included managers, RNs, LPNs, and supervisors. Each focus group lasted one hour and was comprised of four to twelve participants.

Appendix C: Survey Response Rates and Respondent Characteristics

Six-hundred and eighty-two (682) PCC trainees received the PCC follow-up survey. The overall response rate was 40%. Response rates for individual hospitals were 67%, 22%, 41%, and 36%. As seen in the chart below, a broad cross-section of the four hospitals' employees returned the surveys. Of the 270 surveys returned, four surveys did not specify a job title.

Survey Respondents' Job Titles or Areas of Work



Appendix D: Performance Improvement Results

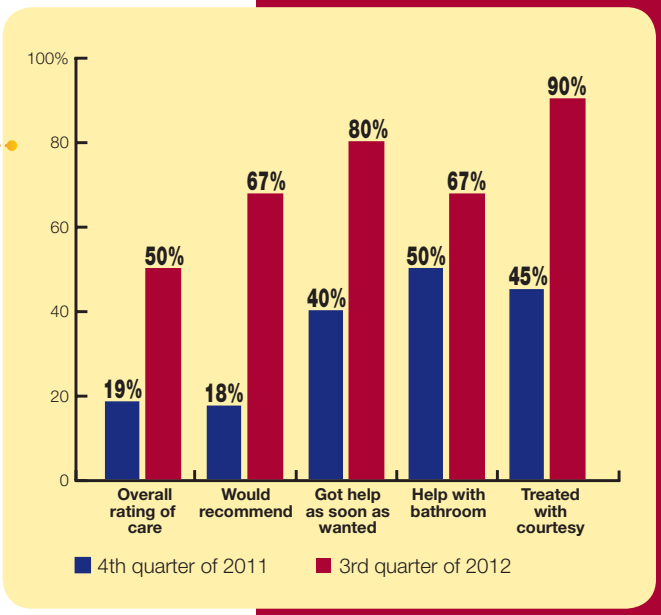
Labor Management Project Performance Improvement Initiatives

HCAHPS

Hospital A: A labor-management team focused on improving responsiveness on one unit. The team developed a curriculum and training program called "HEADS UP," an acronym that provides guidance to all staff to respond to call lights: H = Heads up!; E = Enter the room and introduce yourself if call light is on; A = Attend to the patient; D = Determine what you can or cannot do; S = Safety first!; U = Understand what the patient needs; P = Pass it on if you cannot fill the need yourself.

- **Patients' response on HCAHPS measure regarding always receiving the help they needed as soon as they wanted it increased from 50% to 70%.**

Hospital B: A labor-management team chose to address staff responsiveness to call lights as well as several initiatives shown to be best practices, including a "no pass" policy that trained all staff to respond to call lights. HCAHPS scores increase substantially.

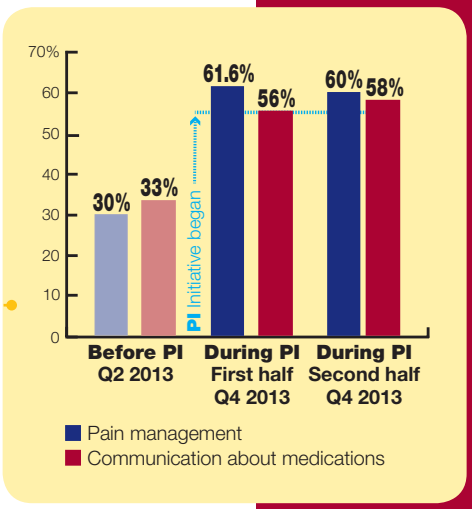


- **The percent of patients reporting they would recommend the hospital increased from 18% to 67%.**
- **The percent who stated they always got help as soon as they wanted it increased from 40% to 80%.**
- **The percent who reported they always were treated with courtesy increased from 45% to 90%.**

Hospital C: A labor-management team conducted a PI initiative on a telemetry unit. Interventions included hourly rounding, using whiteboards and bedside logs, implementing huddles, using "stay in district," which encourages nurses to stay near their room assignments, and implementing a "no pass" policy.

- **Within three months, the team accomplished a 38% decrease in the total number of call bells across all shifts.**
- **The HCHAPS measure of responsiveness increased by 20%; the scores on "hospital rating" and "likeliness to recommend" increased from 8% to 71% and 14% to 71% respectively.**

Hospital D: A labor-management team addressed two elements of responsiveness on a medical-surgical geriatric units: pain management and communication about medications. The team conducted in-service training on the "Patient Education about Medication" protocol and hourly rounding. The team distributed prompts in English, Korean, Mandarin, and Spanish to help patients and their family members communicate with staff about pain and medication.



- **Pain Management HCAHPS score increased from 30% to 61.6% and 60%.**
- **Communication about Medication HCAHPS score increased from 33% to 58%.**

CALL BELLS

Hospital E: A labor-management team in a hospital unit focused on implementing new responsiveness policies; improving interdisciplinary communication about patients' needs within the healthcare team; enhancing communication between the healthcare team and patients from admission to discharge; and addressing barriers to meeting patients' needs quickly.

- **Results from the project showed a 30% decrease in call bells (from 250 to 175) by the midpoint of the intervention, and an overall 55% decrease in call bells (from 250 to 112) by the end of the project.**

Hospital F: A labor-management team selected a reduction in the number of call bells as a key measure for a PI Project on one unit. Interventions included hourly rounding, "stay in district," monthly unit meetings to encourage participation, and a "no pass" policy.

- **Within 3 months, the team accomplished a 24% decrease in the total number of call bells (from 311 to 237) on the unit across all shifts. The evening shift reduced its call bells by 63%. At an estimated 4 minutes per call response, this decrease saved the unit an average of 74 minutes each evening shift—time that could instead be devoted to other patient care needs.**

SPEED OF RESPONSE AND PATIENT SATISFACTION

Hospital G: A labor-management team chose to address staff responsiveness to call lights by implementing "STOP Light"—an initiative that encourages everyone's participation (e.g., nurses, housekeepers, transporters, physicians, and dietitians) in responding quickly to call lights. The interventions were put into place on two units.

- **The first unit decreased its average response time from 4:11 minutes (January to June 2012) to 2:32 minutes (October to December 2012), a 44% improvement.**
- **The second unit reduced their response time from 5:19 minutes to 3:44 minutes, a 34% improvement.**

Hospital H: A labor-management team composed of patient transporters, PCTs, unit clerks, radiology techs, and supervisors from Radiology, Transport, and Nursing worked on reducing transport delays from bed to clinical procedure. The team instituted huddles, scripts for transporters for communicating with patients, and service level agreements that articulated standard flow of patient transport from nursing to radiology.

- **Transport delays decreased from 34.9% to 12.4% over five months.**
- **Transport cancellations decreased from 24.1% to 18.1%.**
- **The percentage of patients who strongly agreed that nurses communicated the procedure to them increased more than fourfold from 15 to 70%, those that strongly agreed that technologists treated them with courtesy and respect increased from 77 to 90%, and the percentage who strongly agreed that they were transported back without delay improved from 38 to 60%.**
- **The length of stay (LOS) for patients decreased from 7.1 to 5.9 days.**

Percentage of Patients Who Strongly Agree Pre- and Post-Implementation Phase (83)