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

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%

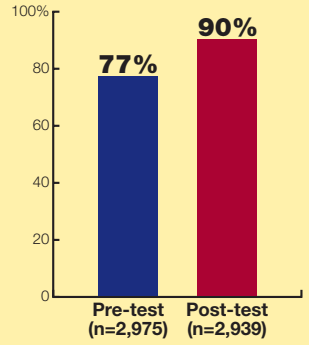
I feel better prepared to provide PCC at my hospital 96%

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

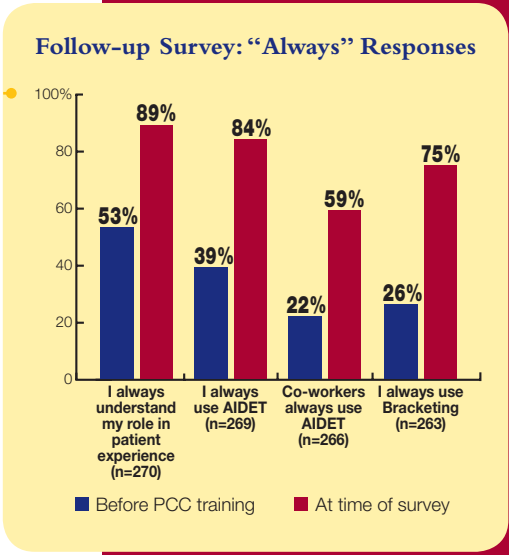


[1] Coordination that occurs through frequent, high quality, and problem-solving communications supported by relationships of shared goals, shared knowledge, and mutual respect.

[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.