In the fall of 2010, IHI developed a Patient Experience Change Package as part of a collaborative initiative. It reflected the learning from the field at that time, including the results of a July 2010 expert meeting convened at IHI in preparation for the Collaborative.

The Change Package was revised in March 2013 to reflect the learning of teams and faculty from two large Collaboratives, as well as additional interviews, scans of exemplars in patient experience results, and new literature. This revision offers a different organization of the changes, additions from a physician communication pilot, examples from care settings across the continuum, as well as a significant editing of the volume and sequence of changes. We hope it will be of use to further projects in the realm of improving patient experience.

Two patient experience Collaboratives run in partnership with IHI have focused on the following domains of patient experience as reflected in the CAHPS survey: Nurse Communication, Pain Management, Physician Communication, Staff Responsiveness, and Cleanliness with an emphasis on Leadership. The faculty team notes that the experience of participating collaborative teams and exemplars, as well as current literature on organizational culture change, emphasizes foundational work that is cross-cutting through all of the domains that can be addressed, regardless of area of focus (e.g. leadership commitment and behaviors) and other areas of work that cross-cut these particular domains (e.g. engaging patients in their definition of family, definition of pain management, definition of clean room). We look forward to continuously updating the body of knowledge reflected in this document.
Foundational Elements for Improving Patient Experience

**Staff and Physicians**
- Systems designed to support staff and physicians in delivering effective, reliable care in keeping with patients' wishes.

**Leadership**
- Leaders take ownership of defining purpose of work and modeling desired behaviors.

**Engagement**
- Staff, leaders, and physicians engage patients and families so that efforts to improve patient experience reflect actual patient experience.

**Patient and Family**
- System designed to support engagement of patient and family at time of care to create optimal individual patient experience.

**Improvement/Infrastructure**
- Improvement teams are solidly grounded in skills to effect reliable change and gain meaningful understanding of data.

Interchange to support mutual goals of care – calling on staff and physician expertise of health care and patient expertise of self.

**Key areas for improving patient experience**
Patient Experience Change Package: Definition of Levels of Evidence

Developed during the IHI 90-Day R&D Project on Improving the Patient Experience of Inpatient Care · October 30, 2008

Rationale:
Evidence to support the Driver Diagram for improving patient experience is drawn from a variety of sources which provide strong empirical support for the primary and secondary drivers. Due to the range of definitions of what constitutes evidence for healthcare actions, the following are used with this work:

Level 1: Highest level of evidence
- Published literature that provides clear description of actions and results within or across sites
  - Publication in healthcare journals or expert resources, e.g. Picker, Press Ganey, Institute for Family Centered Care, Institute for Healthcare Improvement, Baptist Leadership Institute, etc.
- Experience with application in the field, demonstrated results, studied over time, with sustained results

Level 2: Indications of evidence; less than Level 1
- Experience with application in the field, demonstrated results, sustained over time
- May have shorter period of sustained results than Level 1
- No major publication of this work

Level 3: Emerging ideas worthy of trial by others
- Early adaptors showing positive results
- Links to Level 1 or 2 but shorter trial in the field

Level 4: No evidence
- A potentially good hypothesis worthy of testing; seen as a test of change
### Patient Experience Change Package: Detailed Changes

<table>
<thead>
<tr>
<th>Key Change Idea</th>
<th>Description</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Define and communicate philosophy, intention, and plan for optimal patient experience. Include purpose of work in every leadership meeting, leadership rounding, etc. Include “impact on patients” in discussion of each topic at every meeting.</td>
<td>Level 1</td>
</tr>
<tr>
<td><strong>Label and Link</strong></td>
<td>Establish and clearly articulate link between organizational strategy and tactics to support patient experience. Board members, staff, physicians are able to describe their role in patient experience.</td>
<td>Level 1</td>
</tr>
<tr>
<td><strong>“All In” Behavior</strong></td>
<td>Establish partnerships with patients and families throughout the organization and develop clear expected behaviors for all staff and physicians for collaboration with patients and families (e.g., rounding to listen to patients and families, integrate patient and family needs and safety as primary criteria in decision making). Set these actions as behavioral standards. Develop coaching skills to commend and correct behavioral standards in real-time.</td>
<td></td>
</tr>
<tr>
<td><strong>Storytelling</strong></td>
<td>Use stories to capture patient and family experience and to foster learning and change. Begin every board meeting with a patient story. Develop storytelling skills among leaders.</td>
<td>Level 1</td>
</tr>
<tr>
<td><strong>Leadership Rounding</strong></td>
<td>Conduct regular leadership rounding with patients and families, staff and physicians, and other leaders for the purpose of information gathering (to understand what the daily work is really like), coaching, recognizing, correcting, role-modeling, and providing real-time service recovery when needed.</td>
<td>Level 2</td>
</tr>
</tbody>
</table>
**Leadership Behaviors**

Specify desired behaviors for leadership roles that are consistent with patient experience goals and utilize for evaluation (like demonstration of partnership with patients and families, commitment of time, engaging the hearts and minds of providers). Provide a leadership development process for all leaders in care and support departments to build skills for patient experience.

**Champions**

Engage and develop high-influence physician, board, and staff champions who can carry the patient experience work forward in their spheres of influence.

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### Engagement

<table>
<thead>
<tr>
<th>Key Change Idea</th>
<th>Description</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Develop a clear definition for patient experience in collaboration with staff, providers, patient and family advisors, and board members linked to mission and values.</td>
<td>Level 1</td>
</tr>
<tr>
<td><strong>Advisors and Leaders</strong></td>
<td>Create a process for selecting and orienting Patient and Family Advisors. Work toward developing a Patient and Family Advisory Council. Identify a range of activities to engage Advisors. Provide on-going support to advisors to help create clarity about role and boundaries and to develop storytelling skills.</td>
<td>Level 1</td>
</tr>
<tr>
<td><strong>Improvement Initiatives</strong></td>
<td>Include family members and patients on improvement initiatives and program development projects.</td>
<td>Level 1</td>
</tr>
<tr>
<td><strong>Tools</strong></td>
<td>Involve patients and families in the development and improvement of tools such as patient and family education materials, environmental services checklists for cleanliness, and patient progress notes.</td>
<td>Level 2</td>
</tr>
<tr>
<td><strong>Physical Design</strong></td>
<td>Incorporate the patient perspective and healing in all physical design enhancements. Use evidence-based design for healing and comfort.</td>
<td>Level 1</td>
</tr>
</tbody>
</table>
## Improvement/Infrastructure

<table>
<thead>
<tr>
<th>Key Change Idea</th>
<th>Description</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Improvement</td>
<td>Incorporate improvement methodologies (e.g. the Model for Improvement; Lean) into daily work of care team. Develop a process to obtain improvement ideas. Empower staff to test improvements rapidly and on a small-scale and develop a process for feedback, revision, and eventual spread. Include all staff and providers.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Measurement System</td>
<td>Develop a quantitative and qualitative measurement system to provide timely, pertinent patient experience data for all departments. Aid leaders, staff, and physicians to gain meaningful understanding of data variation to ground decision-making. Avoid data abuse by moving beyond daily evaluation of measures that do not have daily meaning (example: discontinue overly-frequent checking of CAHPS scores with over-reactive responses to normal variation).</td>
<td>Level 1</td>
</tr>
<tr>
<td>Reliability</td>
<td>Use human factors and reliability science to design simple but effective processes that are in use 95% or more of the time. Measure reliability of key processes to guide continued improvement efforts.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Patient Journey</td>
<td>Observe with current and past patients and families their patient experience journey using direct observation and inquiry looking for what is important to them both technically and emotionally.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Key Change Idea</td>
<td>Description</td>
<td>Evidence</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Hire for Values</td>
<td>Recruit leaders, staff, and physicians who demonstrate the values consistent with the patient experience purpose.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Competencies</td>
<td>Develop and sustain required competencies that include compassionate communication, expected team behaviors, appropriate escalation pathways, and teamwork.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Care Team</td>
<td>Identify all employees as caregivers and work to help each to see their role in an excellent patient experience. Consider the care team as multi-disciplinary and create processes to facilitate interaction, communication, and coordination of caregiving.</td>
<td>Level 2</td>
</tr>
<tr>
<td>Orientation</td>
<td>Involve patients and families as part of the orientation process for new employees and providers to reflect patient experience.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Pain Management Expertise</td>
<td>Develop or identify a specialized expert resource to consult with staff and care team regarding difficult pain management issues and train staff on current methods</td>
<td>Level 1</td>
</tr>
<tr>
<td>Pain Management Escalation Pathway</td>
<td>Develop a policy or procedure for staff to follow when a patient has difficult pain management. Develop staff understanding of role of personal bias in addressing challenging pain issues with patients.</td>
<td>Level 3</td>
</tr>
<tr>
<td>Cleanliness Process Standardization</td>
<td>Make the cleaning process reliable and standardized. Consider checklists, posting cleaning schedule, and random audits.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Cleanliness Inspection</td>
<td>Reliably and frequently inspect all patient rooms for cleanliness, clutter, and needed improvements. Use this as an opportunity to talk to patients about their needs and expectations. Eliminate items that are not needed and are not used.</td>
<td>Level 2</td>
</tr>
<tr>
<td>Key Change Idea</td>
<td>Description</td>
<td>Evidence</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Care Rounds</td>
<td>Conduct care rounds every one to two hours to address patient needs relating to toileting, positioning, and pain management. Ensure patient has easy access to call light, water, and other items based on patient needs and desires. (Note: this change idea also appears in the Responsiveness table)</td>
<td>Level 1</td>
</tr>
<tr>
<td>Bedside Connection</td>
<td>Institute system in which key care planning information is brought to patient bedside (unless patient preference is otherwise) for useful interchange about daily care planning and longer-term planning. Example of this connection is bringing nurse to nurse shift-handoff to the bedside with use of that time to update white board and prepare for coming shift.</td>
<td>Level 2</td>
</tr>
<tr>
<td>White Boards</td>
<td>Expand reliable use of white boards as a method of shared communication. Include mutual use and multiple topics related to comfort and communication (e.g., phone numbers, caregivers’ names, questions, notes from family, plan for the day, mutual goals for the day).</td>
<td>Level 2</td>
</tr>
<tr>
<td>Introductions and Understanding Patient Comfort Definitions</td>
<td>During staff introductions, ask how the patient would like to be addressed, who is defined as family, and other interaction preferences such as privacy concerns. Begin process of understanding comfort preferences around issues like light, heat, noise, and patient definition of cleanliness. Create reliable system for these definitions and preferences being shared across shifts and disciplines (e.g. Lauren's List: <a href="http://www.ihi.org/offerings/ihiopenschool/resources/Pages/LaurensListAnInterviewWithSallySampson.aspx">http://www.ihi.org/offerings/ihiopenschool/resources/Pages/LaurensListAnInterviewWithSallySampson.aspx</a>)</td>
<td>Level 2</td>
</tr>
<tr>
<td>Shared Care Plan</td>
<td>Consider the care plan a shared document. Assure opportunities for shared decision making and review the care plan together.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Multi-disciplinary Rounding</td>
<td>Develop a process for patients who need multi-disciplinary rounds. Use a plan of care for rounds and include comfort (specifically, pain and environment). Include patients and families as key interactive members of the team.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Mutually develop comfort goals that include pain management, medications, environment, and activity level for hospital stay and for self-management post-hospitalization.</td>
<td>Level 1</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Narrate Care</td>
<td>Describe to the patient the care being delivered and why this care is recommended rather than assuming the patient knows what and why you are doing the activity (e.g., “Now I am going to wash your back. This will hopefully make you feel better and help the circulation of your skin given your need to be in bed right now.”)</td>
<td>Level 2</td>
</tr>
<tr>
<td>Prepare for Transitions</td>
<td>Involve the patient and family as full partners in completing standardized assessments, planning discharge, and predicting home-going needs. Assist the patient in recording transition issues on the white board or journal. Find out who the learner is in the family (i.e., who needs to be present for planning).</td>
<td>Level 1</td>
</tr>
<tr>
<td>Health Literacy Competency and Reliable Communication</td>
<td>Identify and develop health literacy content expertise. Integrate health literacy into all patient and family interactions. Identify key communication elements to standardize, make reliable, and genuine. Consider scripting, communication prompts, check lists, “Teach Back”, and “Ask Me Three”.</td>
<td>Level 1</td>
</tr>
</tbody>
</table>

**Responsiveness (Under Development)**

<table>
<thead>
<tr>
<th>Key Change Idea</th>
<th>Descriptions</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Rounds</td>
<td>Conduct care rounds every one to two hours to address patient needs relating to toileting, positioning, and pain management. Ensure patient has easy access to call light, water, and other items based on patient needs and desires.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Care Team</td>
<td>Identify all employees as caregivers and work to help each department see their role in an excellent patient experience (e.g. admissions, housekeeping, dietary). Consider the care team as multi-disciplinary and create processes to facilitate interaction, communication, and coordination of caregiving to be immediately responsive to patient needs.</td>
<td>Level 2</td>
</tr>
</tbody>
</table>
### Examples of other change ideas

<table>
<thead>
<tr>
<th>Key Change Idea</th>
<th>Description</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Time</td>
<td>Monitor response time to call lights. Develop a system which facilitates immediate identification of available staff to respond and assigns accountability.</td>
<td></td>
</tr>
<tr>
<td>Service Recovery</td>
<td>Integrate real-time service recovery and/or response to patient complaints as a regular practice for leadership at all levels.</td>
<td></td>
</tr>
</tbody>
</table>

### Patient and Family

<table>
<thead>
<tr>
<th>Key Change Idea</th>
<th>Description</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Presence</td>
<td>Family is defined by the patient (and are not considered visitors) and family presence is directed by patient. Eliminate visiting restrictions, welcome family members to participate in care plan development in acute care and outpatient settings, and customize to patient preference.</td>
<td>Level 1</td>
</tr>
<tr>
<td>Patient Information Access</td>
<td>Consider the patient chart a mutual document and offer opportunities to review chart with the patient and family.</td>
<td>Level 2</td>
</tr>
<tr>
<td>Shared Care Plan</td>
<td>Co-develop a shared care plan with the patient and family members based on patient needs and values. Aid patient in identifying what family members can do to assist in caring for the patient. Identify what skills family members need to aid the patient.</td>
<td>Level 2</td>
</tr>
<tr>
<td>Family Presence at Events and Procedures</td>
<td>Acute care: Develop a process for family to be present per patient preference and have support during rescue events and procedures.</td>
<td>Level 2</td>
</tr>
</tbody>
</table>
Patient Activated Communication
Develop processes for patients and families to be able to directly access assistance when needed (Environmental Services, Nutritional Services, Rapid Response Team etc.) Level 4

Patient Experience Change Package: **Physician Communication (Pilot Work)**

**Overview**

Patients and families benefit from consistent and effective communication by physicians as part of a supportive and integrated care team. Patient evaluation of physicians is a component of CAHPS evaluations and, increasingly, third-party payer agreements.

**What Is the Work?** The materials and methods to improve physician communication are grouped into four chunks. Tackling aspects of all four chunks in parallel will increase the impact of the physician communication work in the short and long term. (See Appendix 1: Physician Communication Driver Diagram)

**The Chunks and Who Has Accountability**

<table>
<thead>
<tr>
<th>Chunks</th>
<th>Who is Accountable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Define and Use Communication Behaviors: the physician with patient and families</td>
<td>Physician Communication Team</td>
</tr>
<tr>
<td>2. Use Fast Feedback Method</td>
<td></td>
</tr>
<tr>
<td>3. Engage Colleagues</td>
<td></td>
</tr>
</tbody>
</table>
Define and Use Behaviors

Focus on physician communication behaviors is not new. While the inclusion of a physician component in the HCAHPS survey has elevated awareness and interest by health system leaders, there is no controversy that effective, compassionate communication between providers and patients should be part of the standard of care. The challenge is not identification of specific behaviors; rather it is to create or enhance methods that support physicians in effective use of the behaviors, with every patient every time. The table below contains a basic set of behaviors. The behaviors are grouped into three segments corresponding to the beginning, middle and end of a patient-physician encounter in the hospital.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Knock, wait for a response</td>
</tr>
<tr>
<td>2.</td>
<td>Warmly greet patient and family; introduce yourself and your role; smile; apologize if patient kept waiting</td>
</tr>
<tr>
<td>3.</td>
<td>Sit, face the patient, make eye contact</td>
</tr>
<tr>
<td>4.</td>
<td>Break the ice, be friendly, make a personal connection</td>
</tr>
<tr>
<td>5.</td>
<td>Listen and don’t interrupt patient</td>
</tr>
<tr>
<td>6.</td>
<td>Restate patient’s history to verify understanding and identify/clarify on top priorities. Ask “what are you most worried about?”</td>
</tr>
<tr>
<td>7.</td>
<td>Display personal manner; be caring about patient, their health and concerns; show kindness</td>
</tr>
<tr>
<td>8.</td>
<td>Give patient information as you go and thoroughly explain what is happening and when things will occur if possible</td>
</tr>
<tr>
<td>9.</td>
<td>Partner with the patient and family in care planning; mutually agree on plan.</td>
</tr>
<tr>
<td>10.</td>
<td>Use Teach Back after each major point, make patient comfortable asking questions, and if there are any barriers or concerns about plan</td>
</tr>
<tr>
<td>11.</td>
<td>Summarize treatment plan using plain language and avoiding medical jargon, agree on next steps</td>
</tr>
<tr>
<td>12.</td>
<td>Communicate confidence in the colleagues and team; be appreciative; close with personal touch</td>
</tr>
</tbody>
</table>

Developed by content and application experts and summarized by Nancy DeZellar Walsh (www.dezellarwalshconsulting.com).
Get Fast Feedback

Monthly or quarterly data on patient experience of physician behaviors are too infrequent to guide effective interventions and improvement. A paper-based form for patients to assess presence or absence of a subset of the physician communication behaviors, and to evaluate their experience during a hospital room encounter has proven to be useful. The feedback form is used to validate the impact of specific behaviors and to gain experience in a local feedback method that can be used to assess physician communication behavior over time. (See Appendix 2: Feedback Form).

Engage Colleagues

Physicians who champion this work – meaning they have been testing the use of the behaviors, learning from the patient feedback, and see the value of this work – are the best people to recruit other physicians. Innovation theory provides a strategy for engaging others. The theory suggests that allowing users to try a change themselves enhances the "stickiness" of the change. Because changing behavior is the goal, it is appropriate to use direct experience to help drive these changes.

In addition, it is helpful to chose colleagues based on predicted receptivity to using specific behaviors. As physician colleagues test the behaviors, they also experience the feedback form. A one-on-one invitation and coaching through PDSA cycles allows the chosen physicians to gain direct experience with the communication behaviors and then to reflect on how and why the behaviors can be used reliably. The recommendation is to test receptivity with one or two PDSA cycles. If the prediction is confirmed, continue testing with the physician. If disconfirmed, move on to another physician.

Formal Leadership: Set Direction, Guide, and Pull

To move from voluntary efforts by interested champions to incorporation of core behaviors and a fast feedback method in daily work, formal physician leadership needs to adopt a set of core communication behaviors as part of expected performance. Formal physician leadership should:

- Include regular reviews of patient experience feedback (both fast and slow);
- Expect continued testing of methods to improve how physicians communicate with patients and families;
- Include questions, observations, and discussion of physician behaviors in leadership rounding;
- Discuss rounding lessons with physicians;
- Provide resources and remove barriers to support deployment of behaviors and the fast feedback system.
Infrastructure Capacities – Not unique to Physician Communications

Three “infrastructure” capacities needed to work successfully and efficiently have emerged:

1. Model for Improvement to test changes and spread experience;
2. Interpretation of slow feedback (e.g. HCAHPS; survey systems like Press-Ganey or Avatar) that uses control charts;
3. Methods to assure and deploy standardized work (including contracting, hiring, assessment, and coaching aligned with defined job skills and work processes).

Lessons and Important Points

1. There are too many behaviors, whether in the list of 12 or the AIDET framework, to tackle at one time and push to reliable practice by a group of physicians in 90 days.
2. Focus on a subset of behaviors is acceptable as a way to build momentum and impact.
3. Consistency of using behaviors is the challenge in communications work.
4. Intention and personal best efforts typically will not yield greater than 95 percent performance.
5. Don’t expect people to change behavior by presenting them with information.
6. 1-1 coaching and testing (through test cycles) gets physicians to use the behaviors on a small scale, quickly.
7. Physicians’ reflections on their behaviors bring behavior to conscious level, amenable to study and revision.
8. Consistent practice with the communication behaviors is needed to create new habits over 90 days.
9. The initial work on a subset of behaviors, the associated feedback method, and engagement with colleagues is a floor not a ceiling.
10. New physician colleagues need to be coached in the behaviors identified by your organization. Given turnover, the work on behaviors has to continue over time.
Key Changes/Actions

1. Identify a basic bundle of communication behaviors to strengthen physician communication while building "behavior improvement capacity."

Proposal [see Appendix 3 – Training Within Industry Job Instruction (TWI JI)]:
- Knock
- Introduce self and acknowledge everyone in room
- Sit and face the patient
- Ask during the encounter, “What are you most worried about (or concerned about)?”

2. Choose a target group of physicians to use the behaviors (e.g., hospitalists; those who seem eager to try new actions). Choice of target group depends on where you have a champion, potential impact on patients, and potential to bridge to other physician groups.

3. Measure performance and impact (see the section on Fast Feedback).

4. Work with colleagues in the collaborative to develop behavior bundles beyond the basic bundle.

This basic bundle does not cover all aspects of effective communication between physician and patient - it is a starting point - a relatively easy way to start to build systems and support for physicians in their work with patients and families. It is not easy to get 95 percent performance using the “all or nothing” bundle counting rule. Think about what it will take to get all physicians – even if you just start with hospitalists in one group – to use all five behaviors in greater than 95 percent of encounters within 90 days!

There is another advantage of common practice in physician behaviors: patients will notice the standardization, which links to an impression of consistency and predictability. The work to standardize is substantive – to achieve reliable performance on a bundle of behaviors requires work that aligns with your hospital’s efforts to improve patient experience (especially safety).

Each organization will undoubtedly identify additional behaviors to deploy as you support and maintain effective communications with your patients and families. Deployment of additional behaviors will demand the same kind of effort needed for the basic bundle, so get started and learn what it takes! The basic bundle can be used for every visit. The formal introduction can be modified if the patient remembers the physician, but recognize that patients may not remember. A reintroduction – at least with a name – helps the patient and family.
Concluding Comments

In his 2008 Perspective article in the New England Journal of Medicine, Dr. Michael Kahn writes that a focus on basic behavior “…provides the necessary – if not always sufficient – foundation for the patient to have a satisfying experience.”¹ As stated in the overview, the challenge is to identify and implement methods to support physicians in the consistent use of effective communication behaviors. Recognizing that rote application of communication behaviors and protocols does not embody effective, compassionate communication, there is value in a narrow focus initially. Physicians can learn to use standard behaviors and there is good evidence that the behaviors enhance the patient experience.

Physician Communication Feedback Form

Rev 12/7/2012

All of your physicians aim to communicate effectively as they care for you. We are testing some changes to reach that aim every time with every person. We ask for your candid feedback to help your physicians. If we get feedback that is less than positive, please explain what we can do to improve, that is really helpful! Thank you—we value your time in completing this form.

1. Did your doctor knock on the door, greet you, introduce him/herself?
   □ NO  ☒ YES

2. Did your doctor sit down?
   □ NO  ☒ YES

3. Did your doctor ask you what your biggest concern was?
   □ NO  ☒ YES

4. Did your Doctor understand concerns you may have about your hospitalization?
   □ N/A - I do not have concerns  □ No  □ Yes  ☒ Very much so

5. Do you understand the plan for your care?
   □ No  □ I am not sure  □ I believe I do  ☒ I am confident that I do

6. Was the time your doctor spent with you enough to address your concerns?
   □ No  □ Could have used more  □ About right  ☒ More than I expected

7. How effective and/or informative was your conversation with your Doctor?
   □ Not effective  □ Neutral  □ Good  ☒ Very effective

Comments:
**Organizing the Knowledge: Know-What, Know-How, Know-Why**

TWI Job Instruction (JI) teachers prepare a “cheat sheet” for the in-person, 1-1 instruction used in the JI method. The sheet summarizes what the teacher knows about the best known way to do a job.

**Job 1: Establish connection with patient**

<table>
<thead>
<tr>
<th>Important Step (“know what”)</th>
<th>Key Points (“know how”)</th>
<th>Reasons (“know why”)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A logical segment of the operation when something happens to advance the work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Knock</td>
<td>1. Make or break the job</td>
<td>1. Give patient control</td>
</tr>
<tr>
<td>2. Introduce self by name</td>
<td>2. Injure the provider</td>
<td></td>
</tr>
<tr>
<td>3. Sit and face the patient</td>
<td>3. Make the work easier to do—“knack”, “trick”, special timing, bit of special information, etc.</td>
<td></td>
</tr>
<tr>
<td>4. Ask “What are you most concerned about/worried about?”</td>
<td>1. The question can come any time before the end of the encounter.</td>
<td>1. Look for appropriate time to give patient an opening.</td>
</tr>
<tr>
<td></td>
<td>2. Don’t interrupt, just listen.</td>
<td>2. Gives patient chance to be heard</td>
</tr>
<tr>
<td></td>
<td>3. Reassure and then ask relevant people to help, e.g. social workers</td>
<td>3. Makes patient feel we care; Strengthens the therapeutic relationship</td>
</tr>
</tbody>
</table>

A copy of the Patient Experience Change Package with a list of resources can be downloaded from IHI.org: (1) Go to [www.ihi.org](http://www.ihi.org). (2) Log in using the email address and password that you used to create your IHI User Profile. (3) Click the “My IHI” at the top of the page. (4) Click “My Enrollments & Certificates” on the left-hand side of the screen. (5) Find the conference name and click on the “Materials/Handouts” link under the conference name.
Patient Experience Change Package: **Resources**

The resources are divided into the following sections:

- **Foundational Resources**
- **IHI Resources**
- **Additional Resources**
  (including Key Organizations)
- **New Resources added in July 2012**

**FOUNDATIONAL RESOURCES**


[https://www.cahps.ahrq.gov/default.asp](https://www.cahps.ahrq.gov/default.asp)


**IHI RESOURCES:**


Conway J. Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future, a Work in Progress. 2006. [http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/Literature/PartneringwithPatientsandFamilies.htm](http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/Literature/PartneringwithPatientsandFamilies.htm)


PFCC Assessment – Improving the Patient Experience of Inpatient Care. [http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/EmergingContent/ImprovingthePatientExperienceofInpatientCare.htm](http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/EmergingContent/ImprovingthePatientExperienceofInpatientCare.htm)


Frampton S., Guastello S. Patient-centered Care: More Than the Sum of its Parts. AJN. September 2010, 110(9); 49–53.


NEW RESOURCES ADDED IN JULY 2012

**Physician Communication**


Nursing Communication


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