

Commit to Sit: The Patient Experience

By

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Jill M. Zimmerman

Abstract

Two areas of concern were identified in HCAHPS at a Maryland community hospital. One of the areas of concern is that of physician and patient communication. For Fiscal-Year 2017 ending March of 2017, the final percentile ranking for communication with physicians ended with a score of 78.1%, which is a 26th percentile ranking in comparison to like hospitals nationally (NRC, 2017). The purpose of the project was to increase patient satisfaction scores of physician communication that was measured using Press Ganey results. Having the physicians sit at the bedside during patient interactions will increase the overall perception of time spent of the physician at the bedside, the overall compassion of the physician, and the trust of the physician as well. The intervention included an information session for the hospitalist group that included review of HCAHPS data, and a review of literature supporting physicians sitting at the bedside during interactions improve perceptions of physician communication. The hospitalists were then encouraged to sit with their patients as a way to increase overall scores for communication. Following the intervention the Press Ganey scores were obtained and analyzed. Physician communication scores increased following the intervention.

Table of Contents

Title Page	1
DNP Project Team Approval Form	2
Acknowledgements	3
Table of Contents	5
Chapter I: Introduction	
a) Background and Significance	7
b) Problem Statement	8
c) Project Aim	9
d) Clinical Question	10
e) Congruence with Organizational Strategic Plan	11
f) Synthesis of Evidence	12
g) Conceptual or Theoretical Framework	17
Chapter II: Methodology	
a) Needs Assessment	20
b) Project Design	22
c) Setting	23
d) Population	23
e) Tools or Instruments	23
f) Project Plan	24
g) Data Analysis	26
h) Ethical Issues	27

Chapter III: Organizational Assessment and Cost Effectiveness Analysis

- a) Organizational Assessment 28
- b) Cost Factors 30

Chapter IV: Results

- a) Analysis of Implementation Process 32
- b) Analysis of Project Outcome Data 33

Chapter V: Discussion

- a) Findings..... 37
- b) Limitations or Deviations from Project Plan 39
- c) Implications 39

Chapter VI: Conclusion

- a) Value of the Project 45
- b) DNP Essentials 45
- c) Plan for Dissemination 47
- d) Attainment of Personal and Professional Goals 48

References 50**Appendices** 53

Chapter I: Introduction

How important is communication in our daily lives? How important is communication with our patients and families at their most vulnerable times? These are the questions one should think about when providing patient-centered care. Taking the time to sit with the patients and families can change the overall perceptions of the patients' experience; it can also show compassion, build trust, and increase the overall communication with patients and their families, all of which are reflected in patient satisfaction scores.

Background and Significance

Hospital Consumer Assessments of Healthcare Providers and Systems (HCAHPS) was the first national, standardized, publically reported survey of patients' perceptions of hospital care (Studer, Robinson, & Cook, 2010). In December 2005, the Federal Office of Management and Budget approved for this survey to be implemented nationally. According to Centers for Medicare & Medicaid Services (CMS), this survey was designed utilizing three goals: (a) to produce comparable data on patients' perspectives of care in order for consumers to make meaningful comparisons among hospitals, (b) to create incentives for hospitals to improve their quality of care, and (c) to enhance public accountability in healthcare by increasing the transparency of the quality of hospital care (Studer et al., 2010). From this point forward HCAHPS data has transitioned Value Based Purchasing (VBP) from a pay-for-reporting to a pay-for-performance; the amount of reimbursement is directly tied to the survey data obtained. HCAHPS is a natural metrics for determining areas in need of improvement, while also driving quality standards within health care organizations (Studer et al., 2010).

Two areas of concern were identified in HCAHPS at a Maryland community hospital. One of the areas of concern is that of physician and patient communication. Three questions pertain to physician and patient communication; they are: (a) During this hospital stay how often did the doctors listen carefully to you? (b) During this hospital stay, how often did doctors treat you with courtesy and respect? (c) During this hospital stay, how often did doctors explain things in a way you could understand? A review of the literature revealed that when a physician is seated when talking with patients, the patients are more apt to trust the physician (Daniels et al., 2017; Strausser et al., 2005; Lidgett, 2016) and gain a sense of compassion from the physician (Daniels et al., 2017). Patient satisfaction scores and comments provided by the patients are reviewed monthly to evaluate the patients' perceptions of the patient experience as well as any areas that may need improved upon. An overall goal of the hospital is to be ranked as a top decile hospital among other hospitals in Maryland. It is believed that having the physician sit at the bedside can assist with increasing the overall scores of the facility, while also improving the overall communication between physician and patient.

Problem Statement

Physician communication scores have been an area of focus from 2014 to present at the Maryland community hospital. Over the past year (2016-2017), the data that had been obtained implied the physicians needed assistance in gaining the patients' trust, having compassion and understanding, and improving physician communication with patients and families. Patients' perceptions and overall ratings of the inpatient experience have emerged as important indicators of hospital performance. VBP provides financial incentives for hospitals to improve and maintain HCAHPS scores (Elliott et al., 2010). Given patient

satisfaction scores are directly impacted by physician communication scores, the Maryland community hospital received a two million dollar penalty for low patient experience scores. This impact was also received when the facility was penalized an overall total of four million dollars from the Quality Based Reimbursement (QBR). For Fiscal-Year 2017 ending March of 2017, the final percentile ranking for communication with physicians ended with a score of 78.1%, which is a 26th percentile ranking in comparison to like hospitals nationally. The highest rated question from the patients was: During your hospital stay, how often did doctors treat you with courtesy and respect? This question scored 83.9%, which is a 73rd percentile ranking (National Research Corporation, 2017).

Project Aim

What drives patient satisfaction survey scores? A review of literature revealed that patients preferred the physicians to sit at their bedsides versus standing during interactions (Strasser et al., 2005). The aim of the project was to have the hospitalist providers sit at each patient's bedside when having any interactions with patients and families. Having the hospitalist sit during patient interactions will assist with the overall perception of the patients regarding the time spent at the bedside, the overall compassion of the physician, and the trust of the physician as well. Effective communication between patients and caregivers improves the patient experience as well as outcomes (Lidgett, 2016; Studer et al., 2010). Given the Maryland community hospital has a hospitalist service that includes physicians, nurse practitioners, and physicians assistants, they will all be provided education regarding the importance of sitting with patients and families; they will be encouraged to sit with the patients while interacting with patients and families whether the interaction occurs at the bedside or in a conference room. (Since the Maryland community hospital uses a hospitalist

group that includes physicians, nurse practitioners, and physician assistants, the term hospitalist provider will be used in place of physician when referring to this group of healthcare providers.)

The overall objective of the commit to sit initiative was to increase the overall patient satisfaction scores of physician communication by at least 10% from the baseline scores of 26th percentile within 60 days of post education sessions with hospitalist providers. Keeping in mind the initial database for patient experience data was NRC Picker, during the beginning stages of the project the Maryland community hospital changed to Press Ganey as the patient experience vendor and database for information. This database includes a larger number of hospitals, thus causing the end numbers to look differently. The overall increase with Press Ganey should be at least 3% from the start of the project. The last data obtained from the NRC Picker database was June of 2017.

Clinical Question/PICOT

The PICOT question for this project was (P) Will patient satisfaction scores increase? (I) With physicians, nurse practitioners, and physician assistants sitting with each encounter at the bedside. (C) In comparison to the patient satisfaction scores that were obtained without physicians, nurse practitioners and physician assistants sitting during patient interactions. (O) Patients will have the perception of an increase in trust, respect, and courtesy from the physicians, which will cause an increase in the overall communication with physicians' scores in the Press Ganey database. (T) Over the course of three months after the education to the physicians, nurse practitioners, and physician assistants, with the initiation of the commit to sit project.

Congruence with organizational strategic plan

The mission statement of the Maryland community hospital is

To improve the health status of our region by providing comprehensive health services to patients and families. This mission emphasizes three core activities of the Maryland community hospital by providing patient-and family-centered care, improving the health status of our region, and functioning as a regional health system (Meritus Medical Center, 2018).

The vision of the Maryland community hospital is:

To relentlessly pursue excellence in quality, service, and performance. This vision embodies the imperative expressed during stakeholder interviews and planning activities of becoming an organization that continually strives for excellence. In order to achieve this vision, the Malcolm Baldrige Criteria for Performance Excellence was the selected framework utilized for a systematic approach to improvement (Meritus Medical Center, 2018).

The values that are upheld by the Maryland community hospital are:

Our culture is driven by a set of values that focus on the patient and family first: respect, integrity, service, excellence and teamwork. The values express the manner in which all members of the Maryland community hospital will fulfill our mission and achieve our vision (Meritus Medical Center, 2018).

Having the commit to sit initiative is fully aligned with the organization's strategic plan, mission, vision, and values. Sitting with patients shows respect, commitment, and generates a trusting relationship between patients and physicians, nurse practitioners, and physicians assistants.

Literature Review

A literature search of the CINAHL Database system used key words such as physician communication, patient experience, patient satisfaction, physicians sitting, hospital consumer assessment of healthcare providers and systems (HCAHPS), and patient perceptions. The search initially yielded 21,000 articles, dating back to 1939. Limitations to the search were implemented to range from 2011-2017. Studies often focused on specific specialty models, thus information regarding the patient and provider setting were omitted.

Synthesis of Evidence

Two themes from the literature correlated with two areas of concern for the Maryland community hospital regarding patient satisfaction scores. The first area of concern is that of physician and patient communication. When a physician is seated when talking with the patients, the patients are more apt to trust the provider, gain a sense of compassion, and respect (Daniels et al., 2017; Strasser et al., 2005). The second area of concern is that of transition of care and taking the patients and families preferences into consideration with the discharge planning. The following articles address physician communication.

Ten research studies were utilized and evaluated for use in improvement of communication between patients and physicians. The results indicated improved communication when physicians sit during patient interactions. While reviewing this information, it was also noted that overall posture of the care providers during interactions with patients and families set the overall tone for the patient experience.

Al-Amin, Makarem, and Canose (2016) conducted a study utilizing a regression analysis to determine the predictors of poor physician communication. Two sources of information were obtained in relation to patients' ratings of physician communication and the

interactions of the physicians with the patients. Given that physician communication is one of the eight dimensions in the HCAHPS, this aspect was reviewed and evaluated regarding the total impact for patient satisfaction scores. Results include physician communication had a positive association with the overall ratings of the facility as well as the overall patient experience. In the study, an average of 4.65% of patients reported that physicians communicated well “sometimes or never”. In the best performing hospitals, no patients reported that physicians sometimes or never communicated well. The regression analysis indicated the percentage of patients who reported poor physician communication was higher in hospitals with hospitalists providing care. Hospitals where hospitalists did not provide care was the lowest percentage of poor communication of 3.8%, the next lowest level of poor physician communication was with hospitals that employed hospitalists at 4.8%, and the highest level of poor patient communication was from hospitals that contracted independent hospitalists groups at 5.2%. Results of this study suggest hospitals and for-profit organizations should pay close attention to physician communication and provide incentives for improvement in this area, while also paying attention to staffing, the hospitalist model, physician workload, and physician engagement in alignment with organizational goals.

Mazzi et al. (2015) evaluated what patients really appreciated during communication with physicians. Utilizing various videos of medical consultations with patients, participants were asked to watch the videos and evaluate what was important to them and what would have a negative and positive impact on their experience. Participants provided comments and feedback on the physicians and then provided a summary of their interpretation of the overall experience. Upon completion of this study, it was determined that every patient has various expectations as to what good, effective communication may be. One patient may

dislike what a physician may do or say, while the next patient may have a different opinion of the interactions. While the aim of this research study was to develop general communication guidelines for physicians to follow, the expectations of the patients are too different to make the guidelines successful.

Strasser et al. (2005) conducted a study to evaluate the effectiveness and impact of a physician and/or health care provider sitting during conversations with a patient versus standing when communicating with a patient. The study was utilized to determine whether the perception of the patient regarding the physician's compassion and duration of time spent with the patient. This study was completed using a group of patients that had been diagnosed with cancer. The patients were asked to review videotapes of physicians completing consults while standing and while sitting. The patients evaluated the physicians on five different attributes and rated them on a scale of 0-10. The physicians were evaluated on (a) what's best for patient, (b) patient involved in decision making, (c) encouraged patient questions, (d) acknowledged patient's emotions, and (e) caring for the patient. The same script was used for both standing and sitting patient-physician interactions. The results showed that 51% of the patients preferred the physician sitting during interactions instead of standing. The perception of the consultation length of time also increased with the physician sitting. Therefore, the patient satisfaction increases when the physicians are sitting when talking with the patient.

Finkelstein, Carmel, and Bachner (2017) completed a study comparing two different communication styles: task-focused communication and a relationship-building focused communication. Task focused communication refers to the physical examination itself, mainly time spent with the patient, provision and exchange of information, and treatment

recommendations. The relationship building communication refers to the personal manner of the physician towards the patient during a consultation; this includes expressions of positive or negative affect, and closeness or friendliness during the medical encounter. Patients satisfaction with their physicians are commonly and frequently used to evaluate the effectiveness of physician-patient communication. Results included that it is very important for patients to have effective communication with their physicians as it also plays a key role in patient outcomes. The more caring style of communication the physician portrays, the more the patients are satisfied with the overall experiences (Finkelstein et al., 2017).

Marcinowicz, Konstantynowicz, and Godlewski (2010) found that communication skills, in addition to medical knowledge and problem solving abilities, are essential to good practice. Effective communication, which includes verbal and non-verbal communication, is a key factor in patient-centered care. Focusing on communication behavior for both verbal and non-verbal communication can lead to an increase in patient satisfaction. It is highly recommended for providers to obtain training to better understand the effects of their non-verbal behaviors to improve the overall quality of care (Marinowicz et al., 2010).

While reviewing studies that addressed physician-to-patient communication, the evidence became clear that patients prefer physicians to communicate with a compassionate and caring demeanor (Finkelstein et al., 2015; Liget, 2016). The same information holds true for nurses while caring for patients. In a study completed by Yeakel, Maljanian, Bohannon, and Coulombe (2003), nurses were provided educational sessions regarding caring and caring behaviors. The nurses were then asked to implement these caring behaviors when taking care of patients. Results of the study show pre-intervention caring behaviors with a mean of 33.3 and post-intervention mean of 34.3. Patient satisfaction scores mean increased from

pre-intervention of 27.3 to a post-intervention score of 27.7 (Yeakel et al., 2003). These behaviors improved the overall patient satisfaction during their hospital stay.

Lidgett (2016) launched a commit to sit initiative with the nurses in a 19 bed medical surgical unit. One area of focus in the HCAHPS survey is nursing communication. Prior to the commit to sit initiative, the nurse communication overall item score was 69.8%, and during your hospital stay did the nurses listen carefully item score was 71.4%. After implementation of the commit to sit the overall scores of the two items specified had an increase of over 10%, which corresponded to an increase from the 9th percentile to the 43rd percentile. Results of this study demonstrate that sitting while communicating with patients is a simple yet effective way to improve overall patient satisfaction and experiences.

One study was completed by Pattison, Heyman, Barlow, and Barrow (2017) was in regards to nurse leaders and how rounding was completed with patients and families. This study examined whether the nurse leaders' posture (sit versus stand) influenced patients' perceptions of time at the bedside as well as the quality of the interactions. The mean time of the nurse leader standing rounds was 8 minutes and 24 seconds. The perceived average time for the standing group was 12 minutes and 39 seconds. The mean overestimation of time for the standing group was 4 minutes and 15 seconds. The mean time spent in the room for the sitting group was 8 minutes and 36 seconds. The sitting groups perceived average time was 13 minutes and 25 seconds. The mean overestimated time spent with the patient was 4 minutes and 48 seconds. This finding indicates the sitting group was perceived as being in the room for an average of 2.4 seconds longer per each minute over the standing group. Therefore when sitting with patients, the patients perceive the interaction as longer, however there was no significant difference noted from the study results.

In a study completed by Jeffs et al. (2013), insights from patients and families were obtained regarding quality care and opportunities for improvement. Results included that “just doing your job” isn’t enough to provide excellent care. Going above and beyond to show compassion, caring, and timely care is crucial for patients and families. In order to provide “excellent care”, it is important to develop therapeutic relationships with patients and families (Jeffs et al., 2013).

The last research study that was reviewed was completed by Daniels et al. (2017). The goal of this study was to analyze the effects of several variables on overall patient satisfaction. Again the common theme to the study was courtesy of the staff, timeliness, and physician courtesy. The results were obtained from 2,875 patient satisfaction surveys. The strongest variable driving excellent care responses was that of physician courtesy. Positive physician interaction was not only documented as good bedside manner, but also included being polite, respectful, patient, welcoming, and personable. Physicians were described as engaged and attentive when they were not in a rush and did not appear to be overbooked (Daniels et al., 2017).

Conceptual or Theoretical Framework

The theoretical framework utilized within this study is the Theory of Caring created by Jean Watson (Petiprin, 2016). The Theory of Caring addresses the importance of caring, compassion, and trust (Cara, 2003). Watson developed ten carative factors for the basis of the theory. One factor that highlights nursing and communication is the development of a helping-trust relationship, which includes congruence, empathy, and warmth (Petiprin, 2016). The strongest tool a nurse has is his or her mode of communication, which establishes a rapport with the patient, as well as caring by the nurse. Communication includes verbal and

nonverbal communication, as well as listening that connote empathetic understanding (Petiprin, 2016). This framework of caring relates to this project by providing a framework and theory of caring for the healthcare team to utilize; sitting by hospitalist providers reflects a sense of compassion, respect, and caring.

Creating a change in practice within healthcare is often a challenge, and many times it is completed in small steps (Spear, 2004). This evidence-based practice project utilized the Model For Improvement (MFI) (Harris, Roussel, Dearman, & Thomas, 2016) and the Toyota KATA approach (Forss, 2018). MFI identifies three primary questions to guide change. These questions include: (1) What am I trying to accomplish? (2) How will I know a change is an improvement? (3) Which changes can I implement that will result in an improvement? (Harris et al., 2016). The aim of this project is to increase patient satisfaction scores regarding interactions with physicians. Synthesis of the evidence led to the intervention, commit to sit, that is described in Chapter II. And, increases in physician communication in Press Ganey patient satisfaction scores will indicate an improvement in patient satisfaction.

KATA allows for daily evaluations of any of the changes that have been made and implemented by the staff and ancillary departments that are involved in the implementation of the commit to sit. Utilizing the KATA approach assisted in making changes to ensure the patient satisfaction scores were trending in the upward direction. With the Toyota Kata model, changes can be made daily, evaluated daily, or implemented on one day while being evaluated over the course of time. Evaluations of the changes that have been made were being monitored daily through observations and later through evaluation of the Press Ganey Survey data. Toyota Kata is a structured way to create a culture of continuous learning and improvement at all levels of the organization. It is an organization's daily habits or routines

forming its "muscle memory" for continuous learning and improvements (Forss, 2018). With KATA, commit to sit practices will become a standard of work for the hospitalist providers where sitting with patients and families will no longer be viewed as a task, but as a regular action taken when entering patient rooms for interactions.

Chapter II: Methodology

Needs assessment

Prior to implementation of this project, hospitalist providers were encouraged to sit with their patients and families during interactions. Members of the senior leadership team of the organization support sitting with the patients and families. During senior leader rounds, patients were asked whether their hospitalist providers sat with them. The information that was obtained during senior leader rounding was reported to the hospitalist providers during monthly meetings. Through the valuable feedback from the patients, it was noted that sitting at the patient's bedside by the hospitalist provider was not being completed in a consistent or standard manner, which could have been affecting the physician communication scores. The nursing staff also completed purposeful observations of the hospitalist providers on the medical surgical observation unit over a two-week period. It was revealed that some hospitalist providers would sit 80% of the time, while others would continue to stand at the bedside when speaking with patients and families.

Prior to the commit to sit initiative and the change to Press Ganey for survey data for Fiscal-Year 2017 ending March 2017, the final percentile ranking for communication with physicians ended with a score of 78.1%, which is a 26th percentile ranking in comparison to like hospitals nationally. The highest rated question from the patients was: During your hospital stay, how often did doctors treat you with courtesy and respect. This question scored 83.9%, which is a 73rd percentile ranking (National Research Corporation, 2017). During the early stages of planning the project, the Maryland community hospital changed vendors for patient satisfaction to Press Ganey. With the change to Press Ganey, data from the Maryland community hospital became part of a larger data base; the scale for the data of

the percentile ranking being obtained was different, thus all information utilized within this study was strictly Press Ganey for consistency. The pre implementation physician-to-patient communication Press Ganey scores were 44.4% and the Press Ganey pre implementation score for the question “how often did the doctors explain things in a way you could understand?” was 44.1%.

Utilizing the Strengths, Weakness, Opportunities, Threat (SWOT) analysis to evaluate the value of the project, it was noted there are many strengths to implementing the commit to sit initiative. One of the strengths of the project is that of patient satisfaction. Research results support that sitting with patients has assisted in increasing overall patient satisfaction scores for facilities (Ha, Anat, & Longnecker, 2010). It has also been found that physician communication scores are a key driver in the overall score of HCAHPS for facilities (Studer et al., 2010). A physician’s communication and interpersonal skills encompass the ability to gather information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients (Ha et al., 2010).

Another strength found is the consistent group of hospitalist providers that will be present throughout the study. The hospitalist providers are an internally contracted group of that work only within the facility. Having the hospitalist providers within the organization will allow for consistency of healthcare providers throughout the study, while ensuring the education has been provided to all the hospitalist providers.

One of the weaknesses that has been noted is that of the physical layout of the patient rooms. The rooms are very small with many obstacles in the way, such as bedside tables, IV poles, and over-bed tables. There are not many places for the hospitalist providers to sit while

speaking with patients, as there are only two additional chairs in the rooms (which are often occupied by family members), or are located on the opposite side of the room and not easily accessible. Some hospitalist providers do not feel comfortable sitting at the foot of the patient's bed, while other hospitalist providers will sit at the foot of the bed consistently. There are stools provided for in every room however, they are not always readily available for the hospitalist providers to utilize quickly; the stools are stored under the counter in the back corner of the rooms due to lack of space in the rooms. An opportunity for improvement is the availability and accessibility of the stools; working with environmental services to facilitate reorganizing the rooms to make the stools easily accessible may assist in the overall sitting compliance of the hospitalist providers. A threat noted to the commit to sit initiative is that if the stools are easily accessible, the patient's family members or visitors may sit on the stools while visiting with the patients. The stools would not be available for use if the visitors are sitting, as many hospitalist providers would feel rude asking for the stool to sit and speak with the patient. A potential solution for the stools to be used only by hospitalist providers would be to place cleanable signage on top of the stools that states "for use by hospital personnel only". (See Appendix A for SWOT Data.)

Project design

The commit to sit project was a quality improvement project designed to increase the Maryland community hospital's physician communication HCAHPS scores. Utilizing information found in a literature review, education sessions were created and delivered during two lunch and learn sessions for the dayshift (7A-7P) hospitalist team of 18 hospitalists. The six night shift hospitalist providers were not a part of the study. The education sessions were provided via a PowerPoint presentation. The presentation included

the following information: the penalties received by the Maryland hospital related to poor communication scores, information from the literature review that supports previous commit to sit study results, information regarding the past NRC picker data, and where the Maryland community hospital needs to focus to improve the physician communication scores. The education included reasons for improving communication with patients while promoting high quality care. (See Appendix B for Power Point Presentation.)

Setting

The commit to sit initiative was implemented on a 25-bed observation/medical surgical unit at the Maryland community hospital. This hospital is a 247-bed, level-3 trauma center, not for profit facility.

Population/sample

The target population within the commit to sit initiative included patients hospitalized on a 25-bed medical surgical/observation unit. These patients had care provided by the hospitalist providers that work 24 hours a day seven days a week within the Maryland community hospital. The hospitalist group is composed of 24 providers that are contracted to the Maryland community hospital.

Tools and/or instruments

Following discharge, randomly selected patients were provided a Press Ganey patient satisfaction survey via email to complete. In this survey, patients were prompted to evaluate the physician (hospitalist provider) regarding communication for the following questions:

- (a) During your hospital stay, how often did doctors treat you with courtesy and respect?
- (b) During your hospital stay, how often did doctors listen carefully to you? (c) During this

hospital stay, how often did doctors explain things in a way you could understand? The turnaround time for post discharge survey is about 30-60 days post discharge.

Project plan

Interventions and implementation process.

An hour-long education session was held during two of the weekly lunch and learn sessions for the hospitalist group. The education sessions consisted of two parts. Part one included a presentation of the commit to sit project, where information included educational materials regarding sitting at the bedside and the impact that sitting holds. Part two included a presentation of the evidence that supports the commit to sit, which allowed for stakeholder buy in. The education sessions were held during two separate weeks to allow for all of the hospitalist providers working the 7A-7P shift the opportunity to attend. Press Ganey scores related to physician communication and patient comments were reviewed. The implementation schedule for the project was discussed during the educational sessions.

The following standards were created and shared with the hospitalist providers:

(a) During initial interactions with the patients, sitting for a one on one conversation must take place. (b) A hospitalist provider may stand during patient assessments, as this is appropriate posture. (c) During interactions where patients learn of testing results, participate in a question and answers sessions, or are provided instructions, the hospitalist provider should be in a seated position.

During a staff meeting, the nurses, certified nursing assistants, and the secretaries on the observation unit were also provided educational information regarding the commit to sit project prior to implementation of the project. Meeting minutes that described the project were available for review by the staff members that were unable to attend. Providing this

information allowed for the staff to model the sitting behavior for the hospitalist providers. Promoting sitting with all the healthcare staff caring for patients will begin to instill the habit of sitting with the patients during interactions, thus sitting will no longer seem like a task, but a standard act of communication.

Outcomes that will be measured (SMART objectives).

Two objectives of the commit to sit project are as follows:

1. To improve physician-to-patient communication overall Press Ganey scores (which is a total score of all three physician communication scores) by 3% of the pre implementation scores of 44.4% by the end of the three-month trial.
2. To improve “how often did the doctors explain things in a way you could understand” Press Ganey Scores by 3% of the pre implementation score of 41.7% by the end of the three-month trial.

Procedures for data collection.

The Press Ganey survey with HCAHPS data was sent to randomly selected patients for completion directly following discharge from the hospital. The data were collected on the 18th day of every month to allow for an adequate number of patient surveys directly from the Press Ganey Improvement Portal. All identifying patient information was removed prior to reviewing the data.

Evaluation and sustainability plan.

Once the data from the Press Ganey Surveys were collected and reviewed, the results were shared with the hospitalist providers. The Maryland community hospital will continue to encourage the commit to sit during patient interactions. The results will also be shared

with other interdisciplinary departments within the facility to assist with the improvement of the hospital's overall patient experience scores. Having seated interactions with patients will potentially change the atmosphere of the facility to a more caring, patient-centered environment. If the standard is set for all department employees to sit with patients, then commit to sit will be sustained by the facility and become an every patient every time expectation.

Timeline.

This project was completed over the course of six months and evaluated over the time of three months. Meetings with the hospitalist group were held May 15 and 24, 2018. The data collection began on June 1, 2018 and ran through the months of July and August, completing on August 31 2018. Due to the 30 to 60 day delay that may occur with survey completion, data collection went through October to allow for the surveys to be returned and finalized within the Press Ganey database. (See Appendix C.)

Data Analysis

Process to analyze data.

Prior to the implementation of the commit to sit initiative, the Maryland community hospital utilized National Research Corporation (NRC) to obtain and process patient satisfaction data. NRC used a smaller scale database, which led to fluctuations in the percentile rankings of the communication with physicians. Data obtained from patient surveys are now processed via the Press Ganey Improvement database. Patient satisfaction scores regarding physician communication from the Press Ganey database and the questions around physician communication were followed throughout the commit to sit initiative.

Ethical Issues

All surveys were sent to patients via the Press Ganey portal. All patients surveyed implied consent to survey participation by completing and submitting the survey. As an employee of the Maryland hospital, this writer has access to review the survey results. Data was viewed as cohorts; no individual patient names or other identifying data were seen or used in this study.

Chapter III: Organizational assessment & cost effectiveness analysis

Organizational Assessment

Readiness for change.

The Maryland community hospital has embraced change for many years, as health care evolves over time through technology, policies, and various payment options. The Maryland community hospital recognized a need for improvement in physician-patient communication as measured by patient satisfaction surveys. Knowing that 80% of the patient population is treated by the hospitalist group, the hospitalist providers saw need for improvement within their group. Since both the hospital leaders and the hospitalist providers understood the need for improvement with communication with the patients, the project will have strength.

Barriers and facilitators to implementation.

There are several barriers to the implementation process of the commit to sit initiatives. There are different opinions among the hospitalist providers regarding the effects of sitting with patients. Some hospitalist providers understand why sitting with patients is needed; those hospitalist providers sit 90% of the time with patients and families. These hospitalist providers also understand the implications of the 2 million dollar fines the hospital received in the previous year, and could potentially face again in this fiscal year if improvements were not made. Others hospitalist providers do not see the implications to practice and will stand at the patient's bedside with every interaction. Patients that are in isolation rooms have a unique barrier. Many of the hospitalist providers have stated they are not comfortable sitting in an isolation room with patients because the isolation gowns are open in the back. An additional barrier is the delay in obtaining the results from the Press

Ganey surveys; this delay is a barrier because it may not reflect the progress of the efforts put forth by the hospitalist providers with the commit to sit project.

Risks and/or unintended consequences.

There are no risks identified at this time. Even though there are already stools in the rooms, they have been placed out of the families' reach. An unintended consequence would be a patient and/or family member falling over or off one of the stools that were placed in the patients' rooms for the staff to utilize for sitting.

Role of interprofessional collaboration.

Prior to the implementation of the commit to sit project, the various interdisciplinary department members from Nutrition Services, Pastoral Care, Care Management, Social Worker, and Patient Advocacy, did not sit with patients during interactions. Successful implementation of the commit to sit initiative could lead to further implementation across other interdisciplinary departments that are listed above. Understanding the importance of communication is key to the success of this project. The project will begin on one unit, managed, tailored, and then launched on additional units within the Maryland community hospital.

The hospitalist providers will continue to sit with the patients during interactions, while also encouraging their peers to sit. The hospitalist providers will continue to work to improve their overall patient satisfaction scores.

Overall the nurses and certified nursing assistants within the Maryland community hospital can also utilize the commit to sit initiative project. While nurses are obtaining admission information, providing the patients and/or family with educational materials, and providing the patients and/or families with discharge information, sitting should become the

first step prior to discussions within the room. Sitting may provide the patients with the perception that staff are not rushed, and that the patients and families are the center of care.

Cost factors

Budgetary needs.

Budgetary needs for this project include signage that was placed on the stools in each room. The print shop within the Maryland community hospital provided the stickers for each of the stools. The cost per unit was \$3.00 per sheet of stickers. A sheet of thirty stickers was printed for each unit, as there are 25-30 stools on each unit. Each stool will be labeled as “Staff use only”. All educational information was provided to the hospitalist providers via Power Point. The power point was created over the time of two hours at no cost as the creator was the student. However if this Power Point was to be created by a department assistant of the hospitalist group the salary need is \$20.00 per hour for a total cost of \$40.00. The cost of education materials was \$0.10 per sheet printed. Each packet of material contained four sheets of paper with four slides per sheet. The total cost was \$0.40 per handout. Each session, 10 handouts were printed for the hospitalist group. Total cost of handouts per session \$4.00 x2 sessions = \$8.00. (See Appendix D for Budget Table.)

Cost avoidance or savings associated with implementation.

The benefits to the commit to sit initiative could improve overall patient satisfaction scores related to physician communication, thus assisting in improving the overall quality of patient care. With Maryland being a state that reimburses hospitals based on quality standards and metrics, this could assist the facility with obtaining financial growth at the end of each fiscal year. Improving the communication scores will assist in improving the overall patient satisfaction scores for the Maryland community hospital. If the Maryland community

hospital does not improve its scores, it could face a penalty up to four million dollars, with two million dollars being directly related to patient satisfaction score data.

Chapter IV: Results

Analysis of Implementation Process

The project was initially developed while reviewing the National Research Corporation patient satisfaction scores, with the Director of Professional Practice in January, 2017. (The Maryland community hospital later changed to Press Ganey.) While evaluating the scores, it was noted physician communication scores were low throughout the facility. In January, 2018, a meeting was held with the Operations Improvement Team where it was determined after review of literature that sitting with patients helped to increase the physician communication patient satisfaction scores.

The next step of the process was to determine how hospitalist providers were currently interacting with patients. The evaluation included observing if hospitalist providers were sitting, standing, or even leaning against something during the patient encounters. Once multiple observations were completed, it was noted that not every hospitalist provider was sitting at the bedside and there was no standard method to the interactions with the patients.

On May 1, 2018, a survey was sent to the hospitalist providers from the Operations Improvement Team asking about preferences when interacting with patients and identifying obstacles to sitting in the patient rooms. On May 12, 2018, the Operations Improvement Team reviewed the results of this survey. Twenty-four of 30 surveys were returned. Twelve of 24 hospitalist providers preferred to sit in the rooms, however some stated the stools were not always available. It was decided to work with the Environmental Services Team and rearrange the patient rooms so stools would be readily available at all times.

The next step was to provide education to the hospitalist group regarding the importance of sitting with patients and families at the bedside. The education was provided to

the hospitalist group over two lunch and learn sessions, as the hospitalist group rotates teams weekly. The first education session was held on May 15, 2018 and the second session was on May 24, 2018. Once the entire group of hospitalist providers was presented with the education, the hospitalist providers were encouraged to sit with patients and families. The hospitalist providers were very receptive to the information and found the sessions to be very educational regarding patient satisfaction, patient perceptions, and what patient satisfaction scores mean to the organization. On May 29, 2018 a meeting was held with the Environmental Services team to evaluate the progress of the room rearrangements. During June, July, and August 2018, Press Ganey scores pertaining to physician communication were reviewed and shared with the medical services director. (See Appendix C for project timeline.)

Analysis of Project Outcome Data

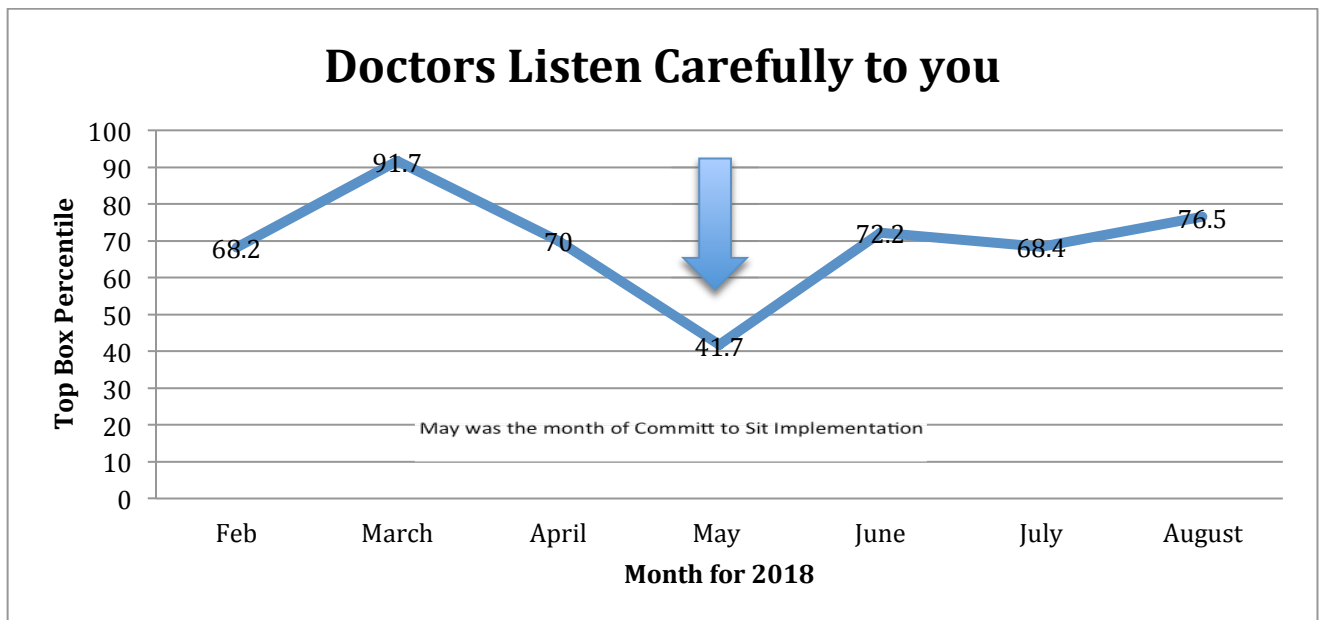
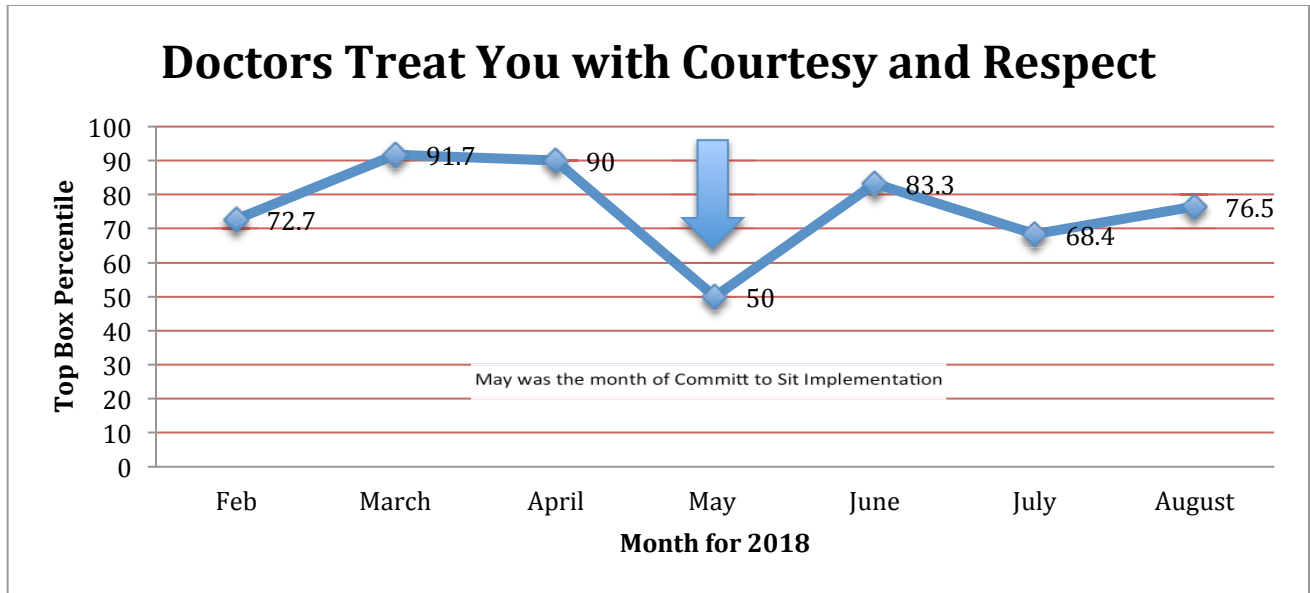
Prior to the start of the commit to sit initiative, the baseline HCAHPS for communication with doctors scores from the Press Ganey Database were: February 2018 (n=22) 68.2%, March 2018 (n=22) 88.9%; April 2018 (n=10) 70%; and May 2018 (n=12) 44.4%. Post implementation of the commit to sit initiative, physicians overall communication scores have continued to increase overall. Post implementation scores are as follows: June 2018 (n=18) 75.9%; July 2018 (n=19) 63.2%; and August 2018 (n=17) 72.5%. (See graphs on next page.) Please note patient satisfaction scores from NRC Picker ended June, 2017 and there was difficulty with mapping the observation unit in the Press Ganey Portal. There was a time lapse of eight months; February, 2018 was the first true obtainment of patient satisfaction scores using Press Ganey. (Refer to Appendix E for Press Ganey Survey.)

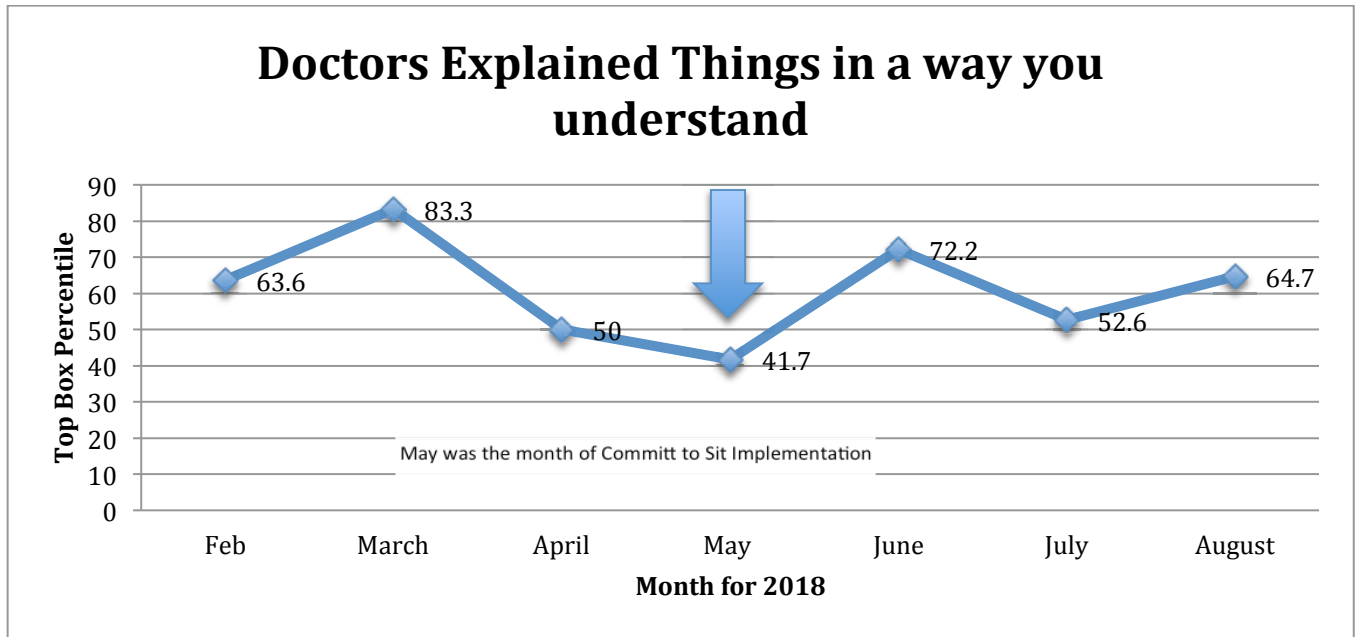
Communication with Doctors Overall Scores		
Pre Implementation		
Month	n=	Top Box Percentile
February	22	68.2%
March	12	88.9%
April	10	70.0%
Comparison Total Overall Average	44	75.7%

Communication with Doctors Overall Scores		
Post Implementation		
Month	n=	Top Box Percentile
May (Implementation of Initiative)	12	44.4%
June	18	75.9%
July	19	63.2%
August	17	72.5%
Comparison Total Overall Average	66	64.0%

The graphs below show information pertaining to the three specific questions related to physician communication. The scores shown below are pre and post implementation.

Note the education sessions for the hospitalist providers were held May, 2018.





Legend

Month of implementation was May. All data on the graphs was obtained from the Press Ganey Database. (See Appendix E for Press Ganey HCAHPS Summary data.)

Chapter V: Discussion

Findings

Outcomes measured against (SMART objectives).

There were two objectives of the commit to sit project that were measured and evaluated following implementation of the project. The first objective was to increase HCAHPS communication with physician Press Ganey scores by 3% of the baseline score of 44.4% by the end of the three-month trial. The second objective was to improve “how often did the doctors explain things in a way you could understand” Press Ganey Scores by 3% of the baseline score of 41.7% by the end of the three-month trial. Please note the baseline scores are the score for the month of May, 2018. When evaluations were completed at the end of each month, the scores increased, and maintained a higher top box percentile ranking than the original baseline score in May, 2018. At the end of the three months, the score for communication with doctors was 72.5%, with an average calculated to 70.53%. At the end of the three months, the score for doctors explain things in a way you understand was 64.7% with a calculated average of 63.1%.

The data reflect changes in care delivery that began to take effect one month after implementation. Many of the hospitalist providers began to sit with patients and utilize the stools at the bedside. Patients and families were using the other chairs in the rooms, leaving the stools to be available for the hospitalist providers when they entered the rooms. Interestingly enough, however, not all of the hospitalist providers sat with the patients. During the implementation of the commit to sit initiative, it was difficult to evaluate the consistency of the hospitalist providers sitting, as many hospitalists preferred to close the

door behind them, which prevented an accurate obtainment of purposeful observations from taking place.

During the month of July 2018, the organization implemented a new electronic health record, which required the hospitalist providers to attend training sessions for the health record. This may have caused a decline in the patient satisfaction scores during that time. (Refer to graphs on pages 35 and 36.) Press Ganey states it is not uncommon to see a decline in patient satisfaction scores six months prior to and six months after an electronic health record goes live (Press Ganey, 2019).

The most important successes of the implementation of the commit to sit was the recognition of the importance of sitting with patients by the hospitalist providers and the senior leadership team, and how it effects the patients' perceptions of communication with the health care team overall. Taking the time to sit with patients provides each patient with the appearance of the hospitalist provider not being rushed; the hospitalist providers were perceived as having a more caring demeanor and showing respect throughout the interactions.

Since the delay of obtaining results from Press Ganey, it was difficult to continue to re-enforce the behavior changes with the hospitalist providers. Without being able to provide the hospital providers immediate information of patient satisfaction scores after the implementation of the commit to sit initiative, it made buy in for sitting with patients a challenge. Throughout the commit to sit initiative, patient satisfaction scores did reflect sitting effectiveness, therefore senior leaders of the Maryland community hospital allowed for the commit to sit initiative to continue to be utilized and disseminated within the remaining areas of the Maryland community hospital.

Limitations or Deviations from Project Plan

The limitations during the course of this project were related to the inability of the nurse leader to directly influence the hospitalist providers. Despite every effort to accommodate the specific request of the hospitalist providers, such as providing stools with signage and having cleaning products for the stools readily available, sitting was not always their mode of positioning when communicating with patients and families. With the results of the data, it appears that unless there is continuous re-enforcement of the behavior, then the behavior of the hospitalists will not change, thus the patient satisfaction results remained stagnant in the latter months.

The project design was good however having more than one month of data would have allowed for a true sense of change. Reinforcement of the information should have been brought to the hospitalist providers more frequently to allow for them to see the implications of sitting with their own patients. It was also unavailable to pull the data for specific hospitalist providers, thus it was difficult to target specific individuals to encourage them to sit with patients at the bedside. With the new Press Ganey portal, hospitalist provider specific data will be available for abstraction and will be utilized for the organization.

Implications

Practice change.

Implications in practice change for healthcare are evident that sitting does provide patients with the perception that hospitalist providers are not rushed and are taking time to explain information during interactions. In the future, this implementation should be sustainable as the physician leadership becomes a stakeholder and includes the commit to sit initiative in hospitalist providers education and practice changes.

Modifications that would improve the future performance would include quarterly updates of the data to the hospitalist group; this would allow for reinforcement of the behavior as well as reward for seeing the improvement of the patient satisfaction scores. Providing patient satisfaction scores to the hospitalist group should be part of the standard work process during monthly team meetings. In addition to regular information sharing, it would be beneficial to have hospitalist specific data to target those hospitalist providers who are not committing to sit, and evaluate the barriers that are keeping them from sitting with their patients. At the time span of the initial commit to sit initiative, specific hospitalist provider information was not available, but this information will be available in the near future for review and evaluation. Their medical director would provide the data obtained via Press Ganey to the hospitalist group, having the expectations that the hospitalist's team would sit at the patient's bedside.

Transferability would be easily completed throughout the organization, with utilization by various committees in the Maryland community hospital. Providing the information to the nursing committees within the Maryland community hospital would allow for nursing to adopt this initiative and utilize it within their own practice routinely while interacting with patients. Nursing staff members have many different tasks they must complete at the bedside and sitting would allow for them to complete these tasks in a more friendly, less rushed appearance.

Future research.

The commit to sit initiative allows for interdisciplinary collaboration, as the simple act of sitting can occur regardless of what role you may hold within the facility. While this project utilized the Operations Improvement Team, Environmental Services Team, and

Corporate Communications Team for label designs, future implementation can include the other entities throughout the organization. For example, staff members from Nutrition Services currently stand in the doorway of the patient rooms to obtain menu choices. With the design layout change of the rooms post implementation, the stools are now readily available upon entering the patients' rooms. This would allow for the Nutrition Services team members to obtain the patient's order while sitting with the patient in a more friendly, less rushed approach.

Dissemination of this project will begin with the nurses of the observation unit. Once the muscle memory of sitting with the patients becomes a standard and the patient satisfaction scores begin to rise, this project can become initiated on the various nursing units within the facility. Nurses have the same questions in the Press Ganey Survey regarding communication as the physicians. This project will also be presented during a Patient Family Advisory Committee meeting to allow for people from the community to provide input on this practice change. Presenting this information to Nutrition Services support staff could result in those staff members sitting with patients while obtaining menu choices. Providing as many staff with the commit to sit information will soon shift the culture of the facility, where members of the healthcare team are to sit with the patients and families, making sitting at the bedside standard practice.

Nursing.

The significance to nursing is the value of sitting with the patients at the bedside. Allowing for time to get to know patients and families is key in developing trusting relationships and positive perceptions. Implementation of the commit to sit initiative with nurses can increase the HCAHPS communication scores of nurses as well. Nurses will be

able to utilize the stools in the rooms to sit with patients while documenting, completing the admission assessment, and completing the discharge. While many patients understand the staff members within facilities are busy, being able to sit with patients for even a few minutes make a difference in the patients' overall experiences.

Recommendations for nursing practice include nurses sitting during patient interactions whenever possible. Opportunities for sitting occur during the admission intake process, while providing patients with educational materials, or when providing discharge information. The nursing environment is often fast paced and the course of the day may change rapidly. Sitting will allow for nurses to sit for a minute, relax, breathe, and change the HCAHPS scores all at the same time.

Advanced practice nurses will play an integral role in the successful implementation of the commit to sit through the development of collegial nurse-physician relationships. Being together and working together as a team to hold one another accountable will be crucial for the success of committing to sit with each patient and family. While many times nurses and physicians do work together for various projects and initiatives, it is interesting to see how difficult it has been for a nurse driven initiative to be committed to and carried through by the physicians in the hospitalist group. Education for nursing continues to advance throughout the changes in times. There are more advanced practice nurses working in tandem with physicians in practice; this culture and shift continues to become prominent in everyday practice. Since patient satisfaction has become the focus as we strive for high quality care, the need for advanced practice nurses to work with physicians in a more team like approach to enhance patient satisfaction score is crucial. As nurse leaders, it will also be important to enhance their own therapeutic relationships with patients and family members in

order to strategically align with the organization's mission and vision of patient centered care.

Health Policy

The enactment of the Deficit Reduction Act of 2005 created an additional incentive for acute care hospitals to participate in HCAHPS. Since July 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) annual payment update provisions ("subsection (d) hospitals") must collect and submit HCAHPS data in order to receive their full IPPS annual payment update. IPPS hospitals that fail to publicly report the required quality measures, which include the HCAHPS survey, may receive an annual payment update that is reduced by 2.0 percentage points. Non-IPPS hospitals, such as Critical Access Hospitals, may voluntarily participate in HCAHPS. The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) includes HCAHPS among the measures to be used to calculate value-based incentive payments in the Hospital Value-Based Purchasing program, beginning with discharges in October 2012 (CMS, 2017).

Given the strict adherence to CMS regulations and the HCAHPS survey results, it will be crucial to implement policy changes at the unit levels within the organization. Current healthcare regulations tie HCAHPS performance to organizational reimbursements. Financial incentives for organizations are implemented to encourage the use of evidence-based strategies to improve HCAHPS performance. Communication with physicians is a component that is used in the calculation of the value-based incentive payments. Each unit in the organization should maintain a commit to sit policy with its staff. Committing to sit with

patients and families during interactions may change the patient satisfactions scores in several areas of the Press Ganey Survey.

Chapter VI: Conclusion

Value of the Project

The value and impact of the commit to sit initiative is financially crucial for many health care organizations; the value includes reimbursements as well as penalties that have been received by health care organizations centered around patient experience data. Knowing that patient experience data correlate with quality data, this metric has been monitored closely by the CMS as well as the Joint Commission. When healthcare members sit with the patients and families during interactions, patients and families begin to feel as though the providers are listening to their concerns, showing them courtesy and respect, and considering their needs in a serious manner. Overall, the commit to sit initiative will have a positive effect while also providing a friendly atmosphere for patients and families.

DNP Essentials

Multiple DNP Essentials were met during the completion of the commit to sit project. Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking was met through the initiation to improve the Press Ganey patient satisfaction scores with the implementation of the commit to sit project. Advanced communication skills were utilized to lead quality improvement.

Essential III: Clinical Scholarship and Analytical Methods for Evidence Based Practice was met. Completing the literature review to support the commit to sit initiative is an example of using analytical methods for evidence based practice. Over the course of time, it was found that completing a quality initiative project was going to be the best practice for achieving the desired outcomes.

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Healthcare was met by utilizing the Press Ganey patient satisfaction collection database. Given the technology available, the Press Ganey database was utilized for completing the results of the patient experience while communicating with the physicians. Getting close to real time feed back from patients has been crucial for the Maryland community hospital to make changes to increase the overall patient experience.

Essential V: Health Care Policy for Advocacy in Healthcare was met. By creating a standard workflow process for the hospitalist providers of the organization to sit with the patients, this DNP essential was met. Understanding CMS regulations regarding the quality of care and healthcare reimbursement to acute care facilities was achieved during the completion of the commit to sit initiative project. Using the research data regarding sitting with patients, assisted the hospitalist providers in understanding the healthcare regulations for health care organizations. Within this standard, the commit to sit project influenced quality of care and health care finance all while improving the overall delivery of care to patients and families.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health outcomes was met. Together nursing, hospitalist, Environmental Services, Operations Improvement, and the Senior Leaders teams were able to effectively communicate, develop, and implement the best practice for communicating with patients and families, breaking down obstacles and barriers to sitting with the patients and families at the bedside. While nurses and hospitalist providers worked together closely to make the commit to sit initiative a success, it was also led with the assistance of the Operations Improvement team and the Patient Experience Committee. With the assistance of the entire interprofessional team, the

communication of the results were shared with the hospitalist providers to ensure the best practice of sitting would continue over the course of the next few months.

Essential VIII: Advanced Nursing practice was met, from the beginning of the project, through the evaluation of the need of the greatest organizations needs regarding HCAHPS, to the design, implementation, and completion of the project. It has been such a wealth of knowledge and information regarding best practice in healthcare, while assisting with providing the hospitalist providers with the information needed to assist in the achievement of increasing the physician communication patient satisfaction scores.

Plan for Dissemination

The information that has been obtained throughout this project will be shared with Nutrition services, Patient Advocacy, and Senior Leadership within the organization. The Patient Experience Committee will be provided the information first, where it will get the process of dissemination throughout the organization. The results will also be shared with the Medical Service Line team; this team is composed of senior leaders, physicians, directors, various unit managers, and community physicians. Sharing this information on this level will assist in the continuation of compliance with the hospitalist providers sitting with patients at the bedside. Other areas of dissemination of this project will occur with nurses of the observation unit. Once the muscle memory of sitting with patients becomes a standard and patient satisfaction scores begin to rise, this project can become implemented on other nursing units within the facility. This project will also be presented during a Patient Family Advisory Council meeting to allow for people from the community and patients to provide input on this practice change. Information about this project will also be presented to the Nursing Leadership Council and the Nursing Research Evidence Based Projects Council.

Presenting this information to Nutrition Services support staff will begin to encourage those staff to sit with patients while obtaining menu choices from the patients. If the information is well received the decision to sit during patient interviews for menu choices will be decided by the Nutrition Services director. By providing as many staff members with the commit to sit information, there may be a culture shift in the facility to always sit with patients and families and become standard practice. Overall this project will be presented at many levels within the organization.

Attainment of Personal and Professional Goals

Personal goals that were met with the completion of this project were that of making a change within an organization. By assisting in such a way, the benefits can be felt throughout the entire organization. This project assisted with the overall patient experience, thus being a nurse leader and influencing patient care from a distance, yet implementing change at the bedside.

Another personal goal that was achieved was the completion of a doctorate degree. When the journey began there was an overwhelming joy of being accepted into a doctorate level program. Now being this close to the end of the program has the greatest feeling of achievement and accomplishment not only for me, but the entire family. The completion of the DNP has been an overall great educational experience that no one will ever take away.

Professional goals are still in continuation. Over the course of time and gaining experience and knowledge, a professional goal is to work in various levels of leadership within acute care organizations to one day reach the end goal of Chief Nursing Officer. This goal will continue to be in the forefront as my professional leadership journey evolves and moves forward.

The final professional goal will be to have a presentation at a national conference. This goal will be reached through working with the organization to make change and present evidence based practice findings to the nurses across the country. Whether it is a poster or a podium presentation, I will move forward to meet this goal.

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Appendix A

SWOT Analysis Chart.

<p style="text-align: center;">Strengths</p> <ol style="list-style-type: none"> 1. Patient satisfaction 2. Consistency of hospital physician 	<p style="text-align: center;">Weakness</p> <ol style="list-style-type: none"> 1. Layout of the patients rooms 2. Rooms are small 3. Stools not readily available to physicians 4. Physicians do not feel comfortable sitting
<p style="text-align: center;">Opportunities</p> <ol style="list-style-type: none"> 1. Availability/accessibility of the stools 2. Arranging of the patient rooms for ease of stool use 	<p style="text-align: center;">Threats</p> <ol style="list-style-type: none"> 1. Patients and families sitting on the stools. 2. Stools being placed in various areas of the room by patients and families 3. Isolation rooms

Appendix B**Hospitalist Group Education Power Point Presentation**

Commit to Sit

Education Sessions

Jill M Zimmerman MSN, RN

Background information

- o Patient Satisfaction scores were evaluated regarding Communication with doctors
- o FY2017 ended in the 26th percentile in comparison to like hospitals
- o The hospital was penalized 4 million dollars for Quality Based Reimbursement
- o 2 Million dollars of the penalty was direct cost related to patient satisfaction scores.

Significance

- o Two areas of focus on Press Ganey Data for patient satisfaction are
 - o Physician and Patient Communication
 - o Did the physician treat you with courtesy and respect
 - o Did the physician explain things in a way that you could understand
 - o Transition of care and taking the patients and families preferences into consideration with discharge planning

So how do we fix it?

- o Commit to Sit
- o Sit with the patients and the families when providing education, test results, or updates on the plan of care.
- o The more we sit with the patients the less rushed we appear

Why sit?

- Studies found physician communication has a positive association with the overall patient experience rating (Al-Amin et al., 2016).
- The more caring style of communication the physician portrays the more the patient is satisfied with their experience (Finkelstein, 2015).

Why Sit?

- Lidgett (2016), launched a commit to sit initiative within a 19 bed medical surgical unit.
 - Nurse communication was scoring 69.8% with listening carefully scoring at 71.4%.
 - Once the implementation of the commit to sit the overall scores had an increase of over 10%.

Why Sit?

- o Results show that 51% of patients preferred the physician sitting (Strasser et al, 2005)
 - o Perception of time increases
 - o Satisfaction scores increase
- o Sitting during patient and family interactions the time spent during the interactions was perceived to be 2.4 seconds longer each minute. (Pattison, Heyman, Barlow, & Barrow, 2017).

Why Sit?

- o Physicians that sat while interacting with patients were described as:
 - o Engaged
 - o Attentive
 - o Not in a rush/did not appear to be overbooked
 - o Compassionate
 - o Respectful
 - o Polite
 - o Welcoming

(Daniels et al, 2017).

Implications for Practice

- Benefit the patient's experience
- Assisting with the organizations overall Press Ganey patient satisfaction scores.
- Will assist the providers in instilling trust into the patients and families and building caring relationships.

Conclusion

- Going above and beyond to show compassion, caring, and timely care is crucial for patients and families.
- In order to provide great care it is important to develop therapeutic relationships with patients and families.

(Jeffer, Beswick, Martin, Campbell, Rose and Ferris, 2013).

Questions & Comments

o Thank you all for your
time and cooperation!

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<file://localhost/Users/jillzimmerman/Documents/Hospitalist Education.pptx>

Appendix C**Project Timeline.**

January 1, 2018: Patient satisfaction data was reviewed with Sarah Harné-Britner

January 10, 2018: Held a meeting with the operations improvement team to review the information found, and determined a project idea.

January 13, 2018: Evaluated the current state of the unit and completed physician evaluations and observations.

March 30, 2018: Ordered Staff use only labels for the stools in the rooms

April 10, 2018: All stools on the 27-bed unit were labeled for staff use

May 1, 2018: Survey was sent out to the physicians regarding their preference on postures when interacting with patients

May 12, 2018: Operations Improvement Team reviewed the survey results

May 15, 2018: The first education session was held with the physician group

May 24, 2018: The second education session was held with the physician group

May 29, 2018: Meeting was held with the environmental service team to evaluate layout of the rooms, and availability of the stools to the staff.

June 2018: Evaluation of the Press Ganey data started

July 2018: Evaluation of the Press Ganey data continued

August 2018: Evaluation of the Press Ganey data and review of the data with Sarah Harné-Britner and the Medical Director.

Appendix D

Budget Table.

Item	Cost	Total Expense		
Stickers	\$3.00 per sheet of 30	\$3.00		
Power Point Creation/Salary	\$20 per hour	\$40.00		
Handout Cost	\$ 0.10 per sheet = \$0.40 per handout 10 handouts per session \$4.00 x2 = \$8.00	\$8.00		

Total Cost: \$51.00

Appendix E

Press Ganey HCAHPS Data FY2018.


infoEDGE

INPATIENT REPORT

CAHPS Summary Information - IT Discharge date: 2/1/18-2/28/18

Global DOMAIN	Question	n	%
COMM W/ DOCTORS	Never		3.0
	Sometimes		18.2
	Usually		10.6
	Always		68.2
	Total	22	
Doctors treat with courtesy/respect	Never	1	4.5
	Sometimes	3	13.6
	Usually	2	9.1
	Always	16	72.7
	Total	22	
Doctors listen carefully to you	Never	0	0
	Sometimes	6	27.3
	Usually	1	4.5
	Always	15	68.2
	Total	22	
Doctors expl in way you understand	Never	1	4.5
	Sometimes	3	13.6
	Usually	4	18.2
	Always	14	63.6
	Total	22	

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INPATIENT REPORT

CAHPS Summary Information - IT Discharge date: 3/1/18-3/31/18

Global DOMAIN	Question	n	%
COMM W/ DOCTORS	Never	0	0
	Sometimes	2.8	2.8
	Usually	8.3	8.3
	Always	88.9	88.9
	Total	12	
Doctors treat with courtesy/respect	Never	0	0
	Sometimes	0	0
	Usually	1	8.3
	Always	11	91.7
	Total	12	
Doctors listen carefully to you	Never	0	0
	Sometimes	1	8.3
	Usually	0	0
	Always	11	91.7
	Total	12	
Doctors expl in way you understand	Never	0	0
	Sometimes	0	0
	Usually	2	16.7
	Always	10	83.3
	Total	12	

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1-800-232-8032

INPATIENT REPORT

CAHPS Summary Information - IT Discharge date: 4/1/18-4/30/18

Global DOMAIN Question	n	%
COMM W/ DOCTORS		
Never	0	0
Sometimes	0	0
Usually	30.0	30.0
Always	70.0	70.0
Total	10	
Doctors treat with courtesy/respect		
Never	0	0
Sometimes	0	0
Usually	1	10.0
Always	9	90.0
Total	10	
Doctors listen carefully to you		
Never	0	0
Sometimes	0	0
Usually	3	30.0
Always	7	70.0
Total	10	
Doctors expl in way you understand		
Never	0	0
Sometimes	0	0
Usually	5	50.0
Always	5	50.0
Total	10	

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For a list of filter and benchmark definitions, click here.



1-800-232-8032

INPATIENT REPORT

CAHPS Summary Information - IT Discharge date: 5/1/18-5/31/18

Global DOMAIN Question	n	%
COMM W/ DOCTORS		
Never		2.8
Sometimes		22.2
Usually		30.6
Always		44.4
Total	12	
Doctors treat with courtesy/respect		
Never	0	0
Sometimes	2	16.7
Usually	4	33.3
Always	6	50.0
Total	12	
Doctors listen carefully to you		
Never	1	8.3
Sometimes	3	25.0
Usually	3	25.0
Always	5	41.7
Total	12	
Doctors expl in way you understand		
Never	0	0
Sometimes	3	25.0
Usually	4	33.3
Always	5	41.7
Total	12	

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1-800-232-8032

INPATIENT REPORT

CAHPS Summary Information - IT Discharge date: 6/1/18-6/30/18

Global DOMAIN Question	n	%
COMM W/ DOCTORS		
Never	7.4	
Sometimes	1.9	
Usually	14.8	
Always	75.9	
Total	18	
Doctors treat with courtesy/respect		
Never	1	5.6
Sometimes	0	0
Usually	2	11.1
Always	15	83.3
Total	18	
Doctors listen carefully to you		
Never	1	5.6
Sometimes	1	5.6
Usually	3	16.7
Always	13	72.2
Total	18	
Doctors expl in way you understand		
Never	2	11.1
Sometimes	0	0
Usually	3	16.7
Always	13	72.2
Total	18	

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[For a list of filter and benchmark definitions, click here.](#)



1-800-232-8032

INPATIENT REPORT

CAHPS Summary Information - IT Discharge date: 7/1/18-7/31/18

Global DOMAIN Question	n	%
COMM W/ DOCTORS		
Never	0	0
Sometimes	3.5	3.5
Usually	33.3	33.3
Always	63.2	63.2
Total	19	
Doctors treat with courtesy/respect		
Never	0	0
Sometimes	0	0
Usually	6	31.6
Always	13	68.4
Total	19	
Doctors listen carefully to you		
Never	0	0
Sometimes	0	0
Usually	6	31.6
Always	13	68.4
Total	19	
Doctors expl in way you understand		
Never	0	0
Sometimes	2	10.5
Usually	7	36.8
Always	10	52.6
Total	19	
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For a list of filter and benchmark definitions, click here.		
PRESS GANEY		
1-800-232-8032		

INPATIENT REPORT

CAHPS Summary Information - IT Discharge date: 8/1/18-8/31/18

Global DOMAIN	Question	n	%
COMM W/ DOCTORS			
	Never	0	
	Sometimes	9.8	
	Usually	17.6	
	Always	72.5	
	Total	17	
Doctors treat with courtesy/respect			
	Never	0	0
	Sometimes	1	5.9
	Usually	3	17.6
	Always	13	76.5
	Total	17	
Doctors listen carefully to you			
	Never	0	0
	Sometimes	1	5.9
	Usually	3	17.6
	Always	13	76.5
	Total	17	
Doctors expl in way you understand			
	Never	0	0
	Sometimes	3	17.6
	Usually	3	17.6
	Always	11	64.7
	Total	17	

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