PATIENT-CENTERED CARE CASE STUDY
A Picker Institute Series

Bryan Health Educates Patients One Discharge at a Time (Part One)

By **Elaine Zablocki,** *Staff Writer, Picker Institute*

JULY 2015

Organization Profiled

Bryan Medical Center, Lincoln, NE

Darcy Blayney, RN, B.S.N., Process Improvement Specialist, Cardiovascular Services
Dawn Isaacs, RN, M.S.N., Nurse Manager, Surgical/Vascular Unit and Nursing Float Pool
Connie Ganz, RN, Director of Clinical Informatics
Suzan Mulligan, LCSW, Manager of Care Management
Amy K. Schwarz, RN, Clinical Informatics, Patient Education Coordinator
Lisa Vail, RN, D.N.P., NEA-BC, Vice President of Patient Care Services and CNO
Marilyn Viehl, B.S.N., M.H.A., Director of Acute Care Nursing
Jerome Wohleb, Pharm.D., M.B.A., Director of Pharmacy
John T. Woodrich, Chief Operating Officer
Marcy Wyrens, RRT, Director of Clinical Services—Pulmonary Services

picker INSTITUTE

NATIONAL RESEARCH *Corporation*

1245 Q Street • Lincoln, NE 68508
Toll Free (800) 388-4264 • **Fax** (402) 475-9061

For 30 years, Picker Institute has been dedicated to developing and promoting a patient-centered approach to healthcare. For more information about our services, please call toll free at (800) 388-4264.

Organization Profile

Bryan Medical Center, located in Lincoln, NE, is part of Bryan Health, a system of doctors, hospitals, and medical providers. Bryan Health, previously named Bryan LGH Health System, was formed in 1997 through the merger of Bryan Memorial Hospital and Lincoln General Hospital, two hospitals that had been in operation since 1926. It includes:

- Bryan Medical Center, a 672-bed, not-for-profit hospital, with two locations, serving patients from Nebraska and surrounding states.
- Crete Area Medical Center, a critical access hospital about 30 miles outside Lincoln. Its Physician's Clinic is one of the few medical home practices in the state.
- Bryan Physician Network of 23 employed physicians in disciplines such as family medicine, internal medicine, maternal-fetal medicine, neonatology, and psychiatry.
- Bryan Heart, a regional leader in the diagnosis and treatment of heart disease.
- Bryan College of Health Sciences, embedded within Bryan Medical Center, offering undergraduate and graduate education in nursing, nurse anesthesia, biomedical sciences, and healthcare studies.
- Bryan LifePointe, a medically based health, wellness, and fitness center including exercise/health programs, rehabilitation, and spa services.
- Heartland Health Alliance, a regional alliance of 42 community-based rural hospitals.
- The Bryan Foundation, an affiliated foundation charged with securing philanthropic support for Bryan Health.
- Bryan Health Connect, a physician–hospital organization.

Statement of Interest

Hospitals today strive to meet patient needs on many levels. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey documents hospital performance in eight areas of patient-centered care: nurse communication, physician communication, discharge information, pain management, communication about medications, cleanliness, quietness, and responsiveness of hospital staff. The survey also asks how patients rate the hospital overall, and whether they would recommend the hospital to family and friends.

In each of these areas certain hospitals are excellent performers, with consistent high scores on specific HCAHPS measures. Picker Institute case studies explore the ways hospitals achieve these outstanding results, and share examples of best practices.

The Picker Institute has selected Bryan Medical Center as a high performer in delivering patient-centered care based on its exemplary performance in HCAHPS publicly reported data for discharge information among hospitals of its type and size.

Discharge Information

During this hospital stay...

- Did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- Did you get information in writing about symptoms or health problems to look out for after you left the hospital?

A Coordinated, Team Approach

Seven years ago, Bryan Medical Center reinvigorated its focus on improving patient care. "Some of our departments had excellent patient satisfaction scores at that time, but some did not," said Marilyn Viehl, B.S.N., M.H.A., Director of Acute Care Nursing.

Bryan thus embarked upon a journey to excellence. "We wanted to go from being a good hospital to a great hospital," recalled John T. Woodrich, COO.

At face value, "discharge information" may seem to be a relatively simple measure. But it is more than simply printing out educational materials and putting them in a patient's hands. Helping patients adjust to a major change in their life situation, within a short time, is complicated. The discharge information process is an exquisitely timed ballet, a process that includes the admission nurse, bedside nurses, the care management team, the discharge nurse, physicians, pharmacists, and perhaps a dietitian or an advanced practice clinician with expertise in respiratory therapy, diabetes, or physical rehabilitation. All of these educators need to assess patients' ability to learn, their family support system, and their environment after leaving the hospital. All of them need to be aware of other members of the team, so everyone's time is used effectively and each teaching session builds upon previous sessions. That's what it takes for patients to leave the hospital saying, "Yes, I do know what I need to do next."

Bryan Medical Center has put considerable effort into improving discharge planning. This is exemplified in its high scores on the HCAHPS discharge information composite, and its decrease in readmission rates. However, its commitment is displayed just as much in the fact that every Bryan staff member who discusses this subject has a list of additional improvements they would like to see instituted as soon as possible.

In Part One of this case study, we will look at the role of bedside nurses, patient education materials, and specialized admission/discharge nurses. In Part Two, we will discuss care management and special efforts to reduce readmissions.

Core Values with Punch

A year ago, Bryan went through a process to redefine its core values, so that internal behavior and actions reflected a well-established vision, mission, and external brand. Previously the organization had more than 50 "standards and beliefs," but there were so many that few people could remember them, and they didn't reflect the community's view of Bryan.

Senior leaders pulled together a group of frontline staff and said, "These wordy value statements aren't so helpful. We need

something that's clear and easy to remember. We need something that reflects who we are and what the community expects. Could you create core value statements with some punch?"

The group worked for 10 weeks to develop the following value statements:

- One team, one purpose
- Spread a smile, go the extra mile
- Live it, own it
- Care like crazy
- Motivate, appreciate
- Know the way, show the way
- Enjoy the journey

"They are just spot on," reflected Woodrich. "When the group brought its work to our senior management team, we said, 'Wow, they nailed it.'"

The values were introduced to the entire organization, first to the leadership team (150 people), and then to supervisors and coordinators (another 150), and finally in a series of about 30 open-forum meetings to cover all shifts and all employees.

What did Bryan do to achieve exceptional patient survey scores? "We worked to create a clear expectation within the organization that patient experience is a top priority. We worked across every discipline to break down those silos and build a consistent team," said Lisa Vail, RN, D.N.P., NEA-BC, Vice President of Patient Care Services and CNO. "One of our new core values is 'One Team, One Purpose.' What that means is, we are all part of one team and our purpose is to provide exceptional patient care to every patient we serve. Therefore, we have to figure out ways to work together."

"One of our new core values is 'One Team, One Purpose.' What that means is, we are all part of one team and our purpose is to provide exceptional patient care to every patient we serve. Therefore, we have to figure out ways to work together."

—Lisa Vail, RN, D.N.P., NEA-BC, Vice President of Patient Care Services & CNO

Education Starts at Admission

These days most hospital patients have a short length of stay. At Bryan, the average is a little more than three days. That means generally there isn't enough time to learn in full about a chronic condition, or about a major disease that has just been diagnosed. "This means patient education often focuses only on the most essential points they will need to care for themselves safely when they leave the hospital," said Connie Ganz, RN, Director of Clinical Informatics. "We often make pre-discharge arrangements for our patients to receive more extensive education and follow up to manage complex diseases from several Bryan programs such as the Diabetes Center or cardiac rehab."

During the admissions process nurses have a full range of tasks to accomplish, including vital signs and physical assessment. They introduce the patient to the in-room educational television service, which includes programs for heart conditions, mental health, stress management, and other important topics. Everyone gets to watch an admission safety video, which has information about hand hygiene, staff and patient education, patient rounding, and patient rights and responsibilities. The 144 video topics include diabetes, asthma, pain management, life after ostomy, living with kidney failure, taking control of chemotherapy, traumatic brain injury, joint replacement, and many more.

Every patient admitted receives the *Patient Guide to Care*, a booklet with basic information about hospital services. It includes brief descriptions of medical specialties, the hours various services are open, and all the details patients need when they're in a strange place. It also has a section about the discharge instructions patients will receive before they leave the hospital, and the importance of seeing their doctor soon after leaving. The booklet introduces the patient to safety rounds, saying:

"You can expect your nurse or a staff member to check on you every hour from 6 a.m. to 10 p.m. and every two hours from 10 p.m. to 6 a.m.

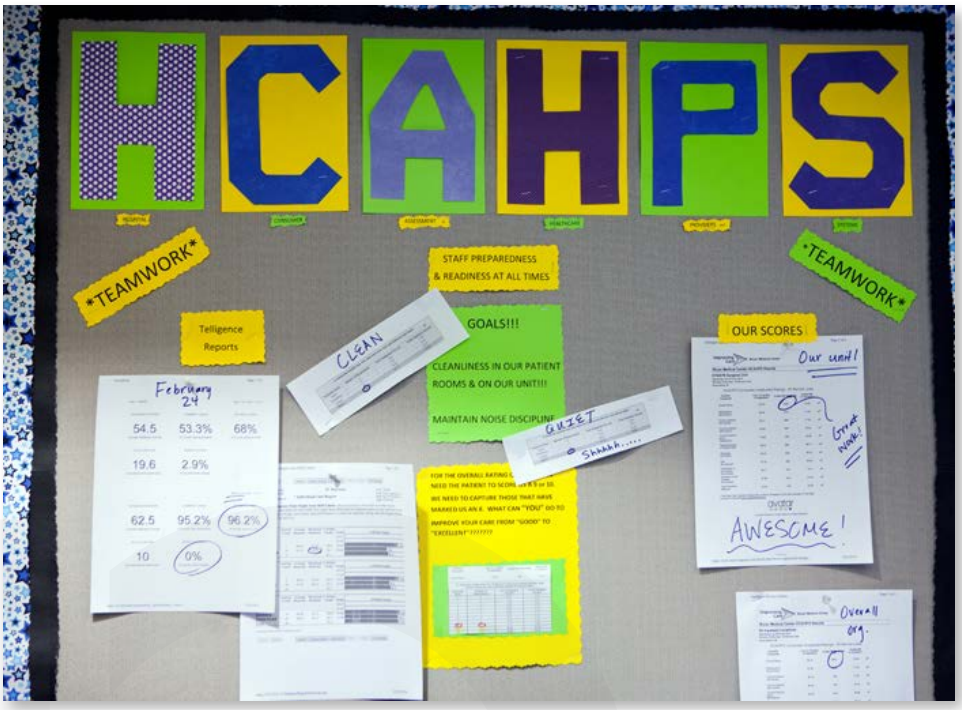
The meaning of Ps & Qs:
Pain: We will address your comfort and pain.
Position: We will help you move and change position.
Personal Needs: We will assist you to the bathroom.
Possessions: Is what you need within reach?
Questions: Ask your nurse if you have questions or concerns.

The nurse manager or their representative will visit you every day to make certain your concerns are attended to and questions are answered."

Specifically encouraging patients to ask questions throughout their stay is one of the ways Bryan ensures that they leave the hospital feeling that they know what to do if symptoms or health problems develop after they leave.

Patients with chronic illness or major life-changing events receive a notebook about their condition, designed with extra flaps and pockets so that every piece of paper they receive during their stay goes into the notebook. In fact, patients with preplanned admissions (such as total hip replacement patients) receive a notebook during their pre-surgery classes and take it with them to the hospital.

Bryan has developed many of its own notebooks containing patient education. It made a conscious decision not to use commercially available materials, because it wanted to include Bryan-specific information, including names and phone numbers. "One reason patients and families feel that they've received high-quality discharge instructions is because education has been going on from the very beginning," said Amy K. Schwarz, RN, Patient Education Coordinator.



Bedside Nurses: The Principal Educators

Since Bryan has specialized nursing units, the nurses tend to have expertise in particular topics. "As soon as the patient lands in bed, the nurses are immediately teaching and explaining, since they've taken care of hundreds of similar patients," said Dawn Isaacs, RN, M.S.N., Nurse Manager, Surgical/Vascular Unit and Nursing Float Pool. "After surgery, patients may be a bit woozy, but typically by the next day we can start educating them."

The family is an essential part of the educational process. "We encourage colon patients to get out of bed on the same day as their surgery," Isaacs said. "At the same time, we explain to the family why it's so important to get patients up right away, so they don't develop blood clots." This inpatient education moves naturally into discussions about discharge. "Similarly, we don't want the patient to just sit at home; it's important to encourage them to move around," Isaacs added.

Every patient is different. Experienced bedside nurses assess each patient's readiness to learn. "We typically say, 'Here's some information I'd like to visit with you about,'" Schwarz said. "We ask whether this is a good time. Do they want their spouse to be here for the teaching session? Do they need their hearing aid or glasses? Are they in pain?"

Quite a few patients need translation services. Bryan uses MARTTI (My Accessible Real Time Trusted Interpreter), a system that accesses medically trained interpreters through a video screen computer service. A provider simply dials into the system and requests an interpreter, who relays information while the patient watches the screen.

"We are just so happy with this service," said Viehl. "It is like Skype. We set up the equipment at bedside, request a translator, and in a minute they get someone who can speak with the patient. This has hugely improved our patient education and discharge planning." During the first half of 2013, Bryan used the MARTTI system for languages that included Albanian, American Sign Language, Arabic, Bosnian, Burmese, Chaldean, Farsi, French, Karen, Kirundi, Kurdish, Laotian, Russian, Spanish, Swahili, Ukrainian, and Vietnamese.

Throughout each hospitalization, the care management team works to identify and document patient needs and make arrangements so needs are met after the patient leaves the hospital. "Assessment and connection starts at the time the patient is admitted," said Suzan Mulligan, LCSW, Manager of Care Management. "It has to be that way. Generally you don't have a whole lot of time with patients and their families, so you have to make the best possible use of the available time."

> "One reason patients and families feel that they've received high-quality discharge instructions is because education has been going on from the very beginning."
>
> *—Amy K. Schwarz, RN, Patient Education Coordinator*

Bryan Invests in Customized Educational Materials

Schwarz has been the patient education coordinator at Bryan Medical Center for the past 10 years. She is responsible for creating and updating all the educational materials patients receive in the hospital, and the discharge instructions given when they leave.

Bryan uses an electronic medical record from Siemens. It is integrated with patient educational materials called Care Notes,

which can be customized. Over time, Schwarz has developed 700 different customized Care Notes covering most clinical situations, often based on specific requests from physicians and clinical nurse specialists. When a new situation develops, staff nurses and nurse managers alert her to changing needs.

"One reason for customization is that when my experts review the standard care notes, they tell me they are too broad, too generic, and do not meet the patient's needs," Schwarz said. "In addition, we often find that when we give patients a generic handout, and their physicians give them different instructions, they call us back and ask, 'Which one am I supposed to do?'"

She is available to develop new or updated materials whenever nurses request them. "They see the physicians every day. When we need a new handout, or we need to revise the current handout, they let me know. Since it is all electronic, I can make the changes in minutes," she said. The system is set up so the electronic medical record can print a paper copy for the patient, and also enter the document into the chart so there is a permanent record.

As much as possible, materials are written so that anyone with a sixth- to eighth-grade education can read them. "You have to watch out for medical jargon," said Schwarz. "For example, the physician writes, 'Ambulate QID,' and our materials translate that as 'walk four times a day.'"

Developing customized materials takes a significant amount of time. "The reason this works smoothly for us is that we can develop information and upload it into a system that makes it available across the entire organization," Ganz said. "In addition to Bryan Medical Center, materials are available throughout our Bryan Physician Network."

In the past, Bryan maintained files of nicely printed educational materials. Under the old system, it was difficult to update materials, or to keep track of the stacks of booklets tucked away in various offices. Now, most educational materials are maintained in an electronic database, updated as circumstances change, and printed on demand by the clinician.

This has generated a considerable cost savings. Previously, the system earmarked $65,000 a year for paper-based patient educational materials. Now, it budgets only $4,000 a year for specialized information that cannot be produced electronically.

Every patient room has a full-sized computer mounted on the wall. When a nurse walks in and swipes her name badge, she can access clinical documentation, medication administration records, and older charts while she's in the room. Another advantage of the new system is that nursing diagnoses and documentation link directly to specific patient education. "When you have a heart failure patient, for example, you automatically bring up a list of topics to teach on; it makes the teaching process much more systematic," said Viehl.

Another advantage of the new system is that patient education orders are part of the electronic medical record, listed right next to an order to start an IV or dispense medication. Nurses and all the other disciplines (occupational, physical, and speech therapy; dietitian, cardiac rehab, and respiratory therapy) are familiar with the same education process and use the same template for documentation.

For each education session, the practitioner documents topics covered, teaching methods used, and teaching challenges such as emotional barriers, cognitive or physical limitations, and other communication issues. Chart notes include whether the patient has previous knowledge, is able to understand key points, or needs additional review. Since everyone is using the same electronic medical record, everyone can see what has been done and what still needs to be done.

"The advantage of this documentation system is that education is integrated," Ganz said. "Nurses and other professionals get electronic reminders about needed education within the clinical information system they use for all aspects of the care they provide throughout the day. Rather than being treated as a separate task, patient education is integrated into their daily work flow."

Schwarz also prepares materials for specialized subjects. "We are fortunate to have someone with a true passion for patient education," said Ganz. "Amy will respond to a phone call, help you find what you need, and get it for you immediately." For example, floor nurses may have difficulty finding a topic in a foreign language, since they don't do it often. They may run into problems coping with an unusual query that just isn't in the system. Schwarz will go to the unit, show them how to find the material, and print it out. "That level of excellence is something we would like to see modeled throughout the organization," Ganz said.

"Nurses and other professionals get electronic reminders about needed education within the clinical information system they use for all aspects of the care they provide throughout the day. Rather than being treated as a separate task, patient education is integrated into their daily work flow."

—Connie Ganz, RN, Director of Clinical Informatics

Cross-Trained Nurses Facilitate Patient Flow

Efforts to measure and monitor patient satisfaction have clearly prompted healthcare organizations to improve patient care. However, many healthcare leaders have noted that as you improve, each next step is a bit more difficult. "One of the biggest challenges in HCAHPS questionnaires is moving responses from 'usually' to 'always,'" said Vail.

Yet Bryan's responses on both discharge-related questions are nearly 100 percent "always." "That's because we have created a standard and very disciplined process for providing those written discharge instructions and having essential conversations at the time of discharge," Vail said.

One of the key steps Bryan took to support timely, effective discharges was creating a new position called admission/discharge/transfer (ADT) nurse. These nurses focus on onboarding patients into the organization; they collect the admission history and start the initial orders for medications and workup. They're also responsible for many discharges. While their typical shift focuses on either admissions or discharges, the nurses are cross-trained to do admissions, discharges, and transfers.

"When we created this position five years ago, we wanted the flexibility to send staff members to units that were receiving patients, to reduce the burden on nurses who are already caring for patients," said Viehl. "The admission nurse gets the patient transferred onto the unit, starts admission assessments, sends down to pharmacy for meds, and generally gets that patient into the system. This is a tremendous benefit to the floors, since they don't have to break stride every time a new patient comes onto the unit."

Two years later, Bryan realized that discharge processes were not functioning smoothly. There were significant delays in freeing up patient beds, even when discharge orders had been written and patients were eager to leave. Bryan did a LEAN analysis and discovered one of the biggest issues in the discharge process was the gap from the time a physician wrote orders and left the patient's room, to the time the unit secretary processed those orders. "There's usually just one unit clerk for an 18-bed unit," said Isaacs. "To the clerk, current patients are a higher priority than a dismissal, so that dismissal chart gets pushed back and pushed back again."

So admission nurses were cross-trained to handle discharges as well. These nurses go from floor to floor as discharge orders are written, and they systematically check for several essential steps:

- Send the discharge medication list to the pharmacy for review.
- Schedule follow-up appointments on the patient's behalf.
- Was patient education completed?
- Were all vaccinations given?

If something has been missed, the discharge nurse starts that process in motion.

The typical discharge takes about 30 minutes or a bit longer, depending on the complexity of the case. On any given day, Bryan schedules two admission nurses, one on each of its two Lincoln campuses, and two discharge nurses, one on each campus, plus additional staffing on exceptionally busy days. Discharge nurses start at 7:30 a.m. and generally work an eight-hour shift. Admission nurses start about noon, and often work a 12-hour shift. Since they are cross-trained, the admission nurses can fill in on discharges until new admissions start coming in.

This role requires experienced nurses who are self-starters. "The ADT nurses float all over the hospital, so we need to make sure they are self-directed, highly engaged nurses," Isaacs said. "They have to be extremely flexible and extremely knowledgeable."

Every patient receives final discharge instructions based on his or her physician's orders. A number of standardized discharge instructions are built in to the Care Notes system. Each one is divided into sections:

- Appointments
- Activity
- Diet
- Incision care
- When to call your provider

Bryan makes all needed follow-up appointments for its patients, including physician visits and outpatient services such as lab tests. The goal is to schedule appointments within seven to 10 days after discharge. Each patient's printed discharge instructions include name, location, and phone number for all appointments.

Discharge instructions are driven primarily by physician orders regarding activity levels, diet, and other essentials for continuing health. Bryan's standard discharge instructions encourage "teach-back" methods. For example, the "Heart Failure Discharge Review" lists six questions about home-based care for heart failure:

1. What seasoning should you limit with heart failure? And why?
2. Tell me how much fluid you can have in one day.
3. Tell me in your own words how you will weigh yourself each day.
4. Tell me when you would call the doctor about your weight.
5. Tell me two signs to watch for that would indicate that your heart failure is worsening. What would you do?
6. What is the name of the doctor you will see after discharge?

Nurses can use these questions to structure a teach-back educational session. The

Care Note includes a second page, "Home Guidelines for Heart Failure," which summarizes essential information about potential health problems in only 200 words. It's designed so the patient can easily take it home and post it on the refrigerator door.

One reason for focusing on the discharge process is that it's the last "taste" of the hospital before patients leave. "We've talked a lot about patient perceptions of care," said Isaacs. "Everything may go perfectly until the last day. Then, if they have to wait five hours before they can leave, that leaves a bad impression."

An advantage of using specialized nurses for admission/discharge is that they aren't juggling several different patients at once. When a patient needs more time for education or seems especially nervous, the nurse can take extra time, because she doesn't have another patient waiting.

The ADT nurses float. They don't start out with a specific schedule of cases. Every morning, there's a "bed briefing" led by the house supervisor, and attended by all charge nurses. Each unit reviews its current census and expected admissions (from scheduled surgeries) and dismissals for the day. The ADT nurses attend, and plan to go wherever the work is most intense. "No one knows exactly which cases they will handle," Isaacs said. "When they show up, the nurses on the unit appreciate them so much. It's like, 'the cavalry has arrived.'"

Continuing Engagement to Promote Long-Term Improvement

Bryan Health's journey to excellence has included a long relationship with the Studer Group. "What drew us to Studer was its evidenced-based concepts, and its continuing research," said Woodrich. "Every hospital tries to offer excellent patient care. What we got from Studer was additional motivation to hardwire best practice. We learned that it's not enough to teach new methods, you also have to build continuing engagement."

"It meant we were all going to be trained in the same skills, the same cultural values," recalled Viehl. "We all focused on being excellent, and thinking that way generates so much positive energy."

The first Studer initiative implemented at Bryan was AIDET. This means that in every encounter with a patient you:

Acknowledge them
Introduce yourself to them
Talk about the **D**uration of this encounter
Explain what you're going to do, and
Thank them

"AIDET isn't just about introducing yourself, about being polite," said Marcy Wyrens, RRT, Director of Clinical Services. "AIDET is an evidenced-based component to reduce fear and anxiety. Its purpose is to help patients feel comfortable and secure in the care you're giving them."

A Studer coach now visits Bryan every month for two days. When survey data and outcomes are below expected levels, the coach engages with the specific management team member and staff responsible for that area. "You know, it's a bit like trying to lose weight," Woodrich said. "When you have an accountable process with targets and deadlines, when you go every week and weigh in at Weight Watchers or Jenny Craig, you're more likely to commit."

Bryan uses a patient call manager system developed by the Studer Group. After a patient has been discharged, nurses from the unit sit before a dual-screen computer. They pull up the medical record on one screen, and "suggested questions" from the call manager on the other screen. The nurse checks to see how the patient is doing and reviews the plan for care and future medical appointments.

"It is kind of a safety check to make sure everybody got the information they need," said Viehl. Through these calls, hospital nurses have a better sense of the challenges their patients face after discharge, such as lacking a ride to the doctor's office, or needing a ramp in order to get out the front door.

"Our nurses learn a great deal from these calls," Viehl said. "Now, when they walk into a patient room, they have a more vivid sense of potential problems after discharge. It means we can alert care management to search for potential solutions, before the patient goes home.... These calls relate to patient satisfaction, but for us they also are part of our safety strategy. We want to know that after our patients leave us, they are safe at home."

Board Commitment to Quality

The Bryan Health and Bryan Medical Center Board of Trustees' commitment to quality deepened three years ago, after a board retreat with a major focus on quality indicators, reducing harm, and all the quality

measures hospitals submit to CMS. The Medical Center board has a quality/safety committee; there also is a quality oversight committee composed of the entire senior management team. Safety incidents are reported to the board at every meeting, and the board quality committee meets with members of the senior management team to review quality issues every other month.

Recently Bryan put together a graphic chart of all of the CMS measures, which leader is responsible for each cluster of measures, and which director or manager is responsible for specific quality programs. Responsibility is clearly defined, and data flows seamlessly to the board and throughout the organization.

"We want to create a culture of accountability and ownership. We track safety items at all levels, precursor events that cause minor harm, as well as serious events that cause major harm," Woodrich said. "We want to track even minor events, because this helps us gather information to avoid a potential incident in the future."

Many discussions of healthcare quality focus on percentage rates of potential problems. "As an organization, we have decided to focus instead on what we call occurrences," Woodrich said. "As an example, if the infection rate in our hospital is 0.02, then maybe we're in the top 5 percent in the country. But to the individual who got the infection, it was 100 percent. Our board members don't want to see a graph. They want to discuss each occurrence of harm. What changes can we make to ensure that this doesn't happen to another patient? That's what we talk about."

While Bryan chooses certain survey measures to focus on, each nursing unit can also choose a specialized area of focus. "As an organization, we have overarching goals, such as 'would recommend' responses from our patients," Woodrich said. "Then we leave it up to nursing units to select their individual goals, the key component in their areas that they need to work on. At the same time, a senior manager or director reviews their plans to ensure they have selected a meaningful goal, not something that's too easy."

"If the infection rate in our hospital is 0.02, then maybe we're in the top 5 percent in the country. But to the individual who got the infection, it was 100 percent. Our board members don't want to see a graph. They want to discuss each occurrence of harm. What changes can we make to ensure that this doesn't happen to another patient? That's what we talk about."

—John T. Woodrich, COO

Continuing Challenges

Bryan Medical Center has outstanding statistics on "discharge information" going back for at least three years. "When we look at Bryan's scores on the full range of HCAHPS measures, however, some results are not to the level we want for our patients," Woodrich said. "It is all about focus. We've noticed that when we embark on a new initiative, we may slide a bit in other areas. During the two months when we were training people how to use our new electronic medical record, our patient experience results went down noticeably. But when we showed the scores to our staff, people brought them right back up again. The key point is that you really do have to set priorities. Never lose sight of the big picture, but if you try to do too much at once, then you're not going to move anything."

There's a recurrent process here. As an organization focuses on a particular area, it develops new skills and processes. Eventually, that area is no longer a weak point. The organization continues to monitor results in that area, while also focusing on a new, challenging goal.

Why do people and organizations choose to devote so much time and effort toward finding more effective ways to offer patient-centered care? "I have been in healthcare for over 30 years," said Vail. "Our patients come to us when they are vulnerable; the hospital is a frightening place to be. We owe it to them to provide exceptional service, compassionate care, and quality outcomes. For me, as a nurse, it's important for us to offer patient-centered care, and work continuously to improve our care, because it's the right thing to do."

Appendix 1. Bryan Health Core Values

We are proud to work for Bryan Health and enthusiastically support the mission, vision, and beliefs of the organization (integrity, service, excellence, collaboration, and leadership). Our core values create a culture of excellence for every person we serve.

As a Bryan Health team member, I commit to ALWAYS live the following core values:

One team, one purpose
- Work together toward common goals.
- Demonstrate a spirit of helpfulness.

Spread a smile, go the extra mile
- Create a warm, welcoming place.
- Go above and beyond when people least expect it.

Live it, own it
- Own your own actions.
- We all impact our organization's results.

Care like crazy
- We enthusiastically care for our work and the people we serve.
- We have the privilege to help people during their most difficult and joyous times.

Motivate, appreciate
- Encourage others to perform their best.
- Never let great work go unnoticed.

Know the way, show the way
- Everyone is a leader—show what right looks like and lead by example.
- Take the initiative to stay informed.

Enjoy the journey
- Love what you do.
- Leave your footprint—be passionate, make a difference, and take pride in your work.

Appendix 2. Bryan Medical Center Quality Oversight Model