Compassionate Connected Care:

A Care Model to Reduce Patient Suffering

The Compassionate Connected Care™ model provides leaders and managers a framework to strategically view data with the goal of reducing suffering by addressing patients' unmet needs.

As the industry evolves toward the ability to define, measure and reduce suffering, we must also prepare staff with a new care model to provide the optimal patient experience through compassionate, connected care.

The Compassionate Connected Care framework (Figure 1) organizes the actions that providers take into four areas: the clinical, operational, behavioral and cultural aspects of patient care. These domains exist across settings, services and caregivers:

- The **Clinical** domain connects clinical excellence with outcomes using clinical data as well as patient-reported outcome measures and nursing-sensitive indicators.
- The **Operational** domain connects operational effectiveness and efficiency with quality using financial data, patient-flow metrics and staffing/scheduling data.
- The **Behavioral** domain connects behaviors with engagement of both providers and nurses through patient experience data.
- The **Cultural** domain connects organizational mission, vision and values with provider engagement using patient, physician, nurse and employee experience data.

Figure 1

Defining Compassionate Connected Care

To define the themes of the Compassionate Connected Care model and translate them into compelling actions for clinicians, more than 100 care providers and patients were asked to provide one-sentence "image statements" that reflected their notions of compassionate and connected care. These one-sentence descriptions were images that might be witnessed in a hospital or medical practice or patient's home. "The clinician sits at eye level and looks me in the eye during the conversation" is an example of an image used in the exercise.

The statements were collected to create an "affinity diagram" that would provide an enduring, clear definition of compassionate, connected care. Affinity diagrams allow a large number of ideas to be sorted into groups in order to review, categorize and analyze them. The diagrams are particularly useful for consensus-building exercises with large groups.

A total of 117 image statements were collected and analyzed to derive the themes of the Compassionate Connected Care framework. Individual image statements were sorted into groups of three or more, after elimination of duplicate or overlapping statements. Statements that conveyed abstract ideas (e.g., "The nurse was kind and empathetic") were discarded. Six themes emerged:

- **Acknowledge Suffering:** We should acknowledge that our patients are suffering and show them that we understand.
- **Body Language Matters:** Non-verbal communication skills are as important as the words we use.
- **Anxiety is Suffering:** Anxiety and uncertainty are negative outcomes that must be addressed.
- **Coordinate Care:** We should show patients that their care is coordinated and continuous, and that "we" are always there for them.
- **Caring Transcends Diagnosis:** Real caring goes beyond delivery of medical interventions to the patient.
- **Autonomy Reduces Suffering:** Autonomy helps preserve dignity for patients.

In addition, specific actions were identified from the statements (Table 1). These actions are tangible and tactical ways in which patient suffering is alleviated in a variety of health care settings.

Table 1

We should acknowledge that our patients are suffering and show them that we understand.	
Actions	**Images**
Bearing witness to their suffering shows patients that we care.	A physician says, "I'm sorry," to a patient who said she didn't sleep well the night before. A doctor who has just told a daughter that her mother is terminally ill sits with her to console her. When care does not go as planned, staff apologize, acknowledge the impact on the patient and engage the patient in exploring options.
Asking the patient what they are worried about allows them to be a person rather than a disease.	The clinician asks what concerns they may address. The clinician asks the patient what they are most concerned about. While caring for a patient, the clinician discovers something personal about the patient that establishes a connection to make a positive, memorable moment for future interactions with the care team. The clinician asks how the patient would prefer to be addressed. The clinician notes a patient's greatest concern on the communication board so all caregivers are aware.
Anticipating and mitigating the patient's discomfort shows concern for their suffering.	The nurse applies EMLA cream to the patient's hand before starting the IV. Staff members update the patient and family of delays at least every 30 minutes. Staff members inform the patient and family of what to expect prior to beginning any procedure or test.
Non-verbal communication skills are as important as the words we use.	
Actions	**Images**
Eye contact matters.	The clinician sits at eye level and looks the patient in the eye during the conversation. The front desk caregiver looks up from the computer to establish eye contact. As the patient begins to say what is really on his mind, the caregiver pushes his/her laptop aside, leans forward and listens attentively. The caregiver explains to a patient that he/she is listening and is fully engaged with the patient while documenting on the computer.
Physically touching the patient closes distance.	The nurse gently holds the patient's shoulder while obtaining blood pressure. The physician sits down and holds the patient's hand while explaining tests and treatments. The clinician takes a seat and holds the patient's hand when the patient starts to cry. The physician makes a point of shaking hands with patients and visitors when introducing himself/herself.
Body position matters.	The physician sits face to face with the patient while talking with him/her. The caregiver sits down at eye level with the patient. The caregiver does not turn his/her back to the patient until the interaction is over and the caregiver leaves the room.

Table 1 Cont.

Anxiety and uncertainty are negative outcomes that must be addressed.	
Actions	**Images**
Reducing uncertainty and anxiety for patients and families acknowledges that they are in a stressful situation.	Caregivers round on patients frequently in a way that is purposeful and meaningful to the patient – inquiring about pain, positioning, toileting and at least one non-disease/treatment-oriented discussion topic. The employee notices a "lost guest" and personally escorts the person to his destination. Staff members describe what will happen next when the patient arrives at the exam room. Clinicians tell patients when they will be in to see them again. Caregivers greet patients warmly (e.g., "We've been expecting you, Mrs. Smith"). Caregivers provide reassuring phrases (e.g., "Mrs. Smith, I am going to be with you every step of the way"; "Mrs. Smith, we are going to take very good care of you"; "Mrs. Smith, we are going to do this together"). Volunteers escort patients and families to their destinations (e.g., surgery area, tests and treatment areas).
Reducing waits shows we understand patients' suffering and respect their time.	There is no lag time in response when a patient presses the call light. Staff members provide an estimate of wait times. Staff members do not pass call lights without inquiring if they can help. Staff members work together to reduce waiting time for bed placement, transfers and testing.
We should show patients that their care is coordinated and continuous, and that we are always there for them.	
Actions	**Images**
Showing patients that the relationship doesn't end when they are not directly in contact deepens the relationship.	The clinician calls the patient for follow-up within 48 hours. Clinicians follow up appropriately when information is received on the discharge phone call. Clinicians show that they are concerned about what will happen when the patient goes home and provide instructions to make them successful in their recovery. Caregivers "manage up" each other, complimenting the caregivers on the care team. The nurse explains who will be taking care of the patient after shift change. The clinician uses good handoff techniques and is accountable for communicating the patient's condition and needs. Caregivers use the teach-back method to ensure patients understand discharge instructions. Patients are provided with written instructions for home care prior to the day of discharge with an opportunity to read and ask questions. Clinicians use data to improve patient care processes.
Real caring goes beyond delivery of medical interventions to the patient.	
Actions	**Images**
Personal touches outside medical care strengthen relationships.	The nursing assistant brings a patient his/her favorite dish from the cafeteria as he/she awakens from surgery. The director of service excellence walks a patient's service dog outside the hospital to give a stressed family member time to grab lunch. The nurse talks with a patient about his/her children. The nurse is simply silent while touching the patient or family during a difficult time.
Caring for the patient means caring for the family.	The nurse gives a warm blanket to a family member who is cold. On a nightly basis, the nurse holds the phone to the ear of a terminally ill patient, so his daughter can say goodnight. Caregivers provide instructions to the family prior to discharge to ensure they are comfortable with caring for the patient at home.

Table 1 Cont.

Autonomy helps preserve dignity for patients.	
Actions	**Images**
The patient is a full participant in guiding his/her care.	The clinician asks patients and family members about their preferences in care issues lying ahead. The clinician asks the patient for his/her preferences on even minor issues, such as the preferred hand for an IV. The clinician provides a full range of care options when discussing diagnosis and treatment plans. Caregivers involve the patient in bedside shift reports.

Application

Each patient group represents different care experiences, so evaluations of care may vary based on the type of care received. The Compassionate Connected Care model provides leaders and managers with a framework to look at data strategically with the goal of reducing suffering and meeting patients' unmet needs. Caregivers can target improvement efforts and resources rather than deploying generic improvement processes that may or may not work for a specific patient population.

As an example of how the Compassionate Connected Care framework might influence care, a clinician going to the bedside of a hospitalized patient would mentally consider the three major actions of nonverbal communication: making eye contact, touching the patient and assuming a body position that encourages communication and preserves the patient's sense of dignity. Using the actions of autonomy, the clinician would provide the patient with options for pain relief and then allow the patient to choose the option that he thinks best meets his pain need at that time. Providing the patient with the ability to make decisions about his care not only preserves his dignity, it also allows him to participate in his care.

Other items from the Actions column in Table 1 are similarly explicit – clinicians of all types can show interest in the impact of illness on patients' families, clarify that there will be continuity between settings and do what they can to preserve patients' sense of autonomy and dignity. These recommendations are not for any one type of clinician; they are intended to characterize the care delivered, and are thus for all clinicians and their supporting personnel.

While it may not be possible to eliminate inherent suffering caused by the very nature of illness and disease, clinical staff should mitigate it when possible by promoting confidence in the care team's clinical skills, effectively managing pain and ensuring patient safety protocols are followed. Health care leaders should remove barriers to optimal care that cause avoidable suffering and limit the response to inherent suffering. This includes creating a culture of teamwork and improved care coordination; interacting respectfully with colleagues, patients and families; and providing a clean, quiet environment conducive to healing and recovery. The provision of optimal care also includes preventing exposure to process deficiencies that create additional patient suffering through unnecessary waits or lack of timely communication.

This approach resonates with providers at the bedside much more than "chasing a score" or reimbursement. It is important for leaders to understand performance scores and how they drive reimbursement, but the focus should be on the patient experience – the score will come as a natural consequence of that focus and will, in turn, drive better financial performance.

Understanding how the organization fares within each domain of the Compassionate Connected Care model allows more targeted improvement efforts. By evaluating patient experience data within the Compassionate Connected Care construct, the organization is better able to determine where resources and effort are best spent to improve. For example, if the clinical scores demonstrate a high level of performance for medical patients but the operational scores suggest opportunity, effort and resources may be targeted specifically for medical patients based on process efficiency and wait times, rather than taking a more generic approach to improvement.

Direct care providers are more likely to adopt evidence-based initiatives if the benefits to patients are communicated as well as the benefits to the caregivers. For instance, the evidence is clear that patients who are involved in decisions about their care tend to have better outcomes. Focusing on the patient and taking actions that involve them in their care are evidence-based initiatives that resonate with caregivers. Improvements in scores may result from those efforts, but they are not the focus of the improvement effort. Helping providers understand that it is all about the patient is critical for engaging physicians, nurses and employees, and provides a much more credible and worthy goal than a score or percentile rank.

Conclusion

Patients suffer. As health care providers, the first step to addressing patients' unmet needs is to acknowledge this fact. However, acknowledging that patients suffer is not enough. It is a call to action. The Compassionate Connected Care framework is a way in which to frame that action. Each of the components of the Compassionate Connected Care model is necessary but not sufficient alone. Addressing patient suffering encompasses action within each domain in order to provide the optimal experience for a patient population that is increasingly informed, and a provider population that is increasingly under stress. By connecting with patients rather than striving for a percentile rank, patient suffering is reduced and providers can get back to why they chose their profession in the first place.

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