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Impact of COVID-19 pandemic on Patient Experience in the Asian region

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Introduction

The COVID-19 crisis has caused unprecedented disruption in healthcare around the world. The focus of delivering the safest, highest-quality experience to patients has become the guiding objective during this crisis and therefore will require patient centeredness and clinician engagement to achieve it.

Organisations must understand how well patients' needs are being met as traditional care models are disrupted. They should assess how well they are mitigating patients' fears, minimising communication gaps, and managing process flow from the patient perspective. Collecting and analysing data on how well patients' needs are being met and how clinicians and other personnel are holding up under extraordinary strain is critical for management and for learning.¹

Much recent research has been undertaken into the impact of the pandemic on healthcare organisations, caregivers and patients, Press Ganey has been one of the leading agencies in this research with studies conducted into patient and employee feedback collected during the pandemic and

patient perceptions of the increased use of telemedicine over the past 12 months.^{2,3,4} Unfortunately, most of this research has excluded healthcare delivery in Asian countries.

Therefore, Insync Health, (the regional licensee for Press Ganey in the Asia/Pacific region) decided to undertake a research project into the impact of COVID-19 on patient experience in the Asian region during the first 6 months of 2021. With COVID numbers spiking at all-time highs in many countries the timing has been critical, as hospitals again struggle with the challenges that the pandemic has thrown at them and how they support their vulnerable, and at times, scared patients.

The data collection period was 1st February - 30th June 2021. 18 participating Hospitals from Japan, The Philippines, Malaysia and Vietnam received feedback from 3,267 (COVID admitted 14% and non-COVID 86%) patients. Data was made available in real time, so hospitals were able to address any concerns from patients as they occurred.

Key objectives of the study

- To support organisations to gain a deep understanding of their patients – how their patients perceive their care and services during the COVID-19 crisis and beyond;
- To collate data across the region to gain a regional perspective of patient experiences during the COVID-19 environment;
- To identify insights from the data that will lead to the development of tactics and strategies for improvement;
- To allow participants to respond in real time to issues and concerns raised by their patients;
- To assess specific COVID-19 patient issues in the region for future learning.

Protocol

- Each hospital obtained data (1st February – 30th June 2021) relating to their Hospital's Inpatient outcomes, benchmarked with other study participants;
- The same set of validated questions (Inpatient Experience) was used by all facilities in the study along with two options for qualitative feedback and consent;
- An additional domain of items assessing specific COVID-19 factors was included;
- Surveys were available in multiple languages relevant to each country;
- Feedback was requested electronically via on-line survey links with outcomes automatically uploaded into each hospital's assigned reporting portal;
- Participants were requested to distribute a single information page containing a message from the Hospital CEO, an on-line link and QR code to EVERY discharged patient to take home and complete;
- Both COVID admissions, AND non-COVID admissions were to be surveyed.

Key findings

The healthcare crisis has meant patient expectations have changed and models of care delivery have changed. The study outcomes confirm that patients come to healthcare seeking safe, reliable and compassionate care. The typical drivers of patient experience (communication, engagement and compassion, particularly with nursing care and doctor care) remain strong, however COVID-19 factors add an additional dimension, specifically relating to COVID-19 related safety. The impact of convenience (customer service) has shifted - overshadowed by the need to engender trust.

COVID-19 Impact on Patient Experience

A 5-item domain of COVID-19 specific interactions was included to assess each hospital’s proactiveness in informing and responding to the anxieties and assurances sought by patients/families that they will be safe in the hospital environment. Correlations were moderate to high (0.65 – 0.73) confirming the strong association between the hospitals performance in addressing COVID-19 safety and patients’ perception of their overall experience with the hospital. The hospital performance for these issues indicated a need for significant improvement in addressing the needs of patients. The distribution of responses for two main items (Chart 1), indicate the top box response to information and responsiveness was only 40%:

Chart 1:

Information the staff gave you about things being done to ensure safe care during the COVID-19 (Coronavirus) crisis

Staff’s willingness to answer questions you may have had about COVID-19 (Coronavirus)



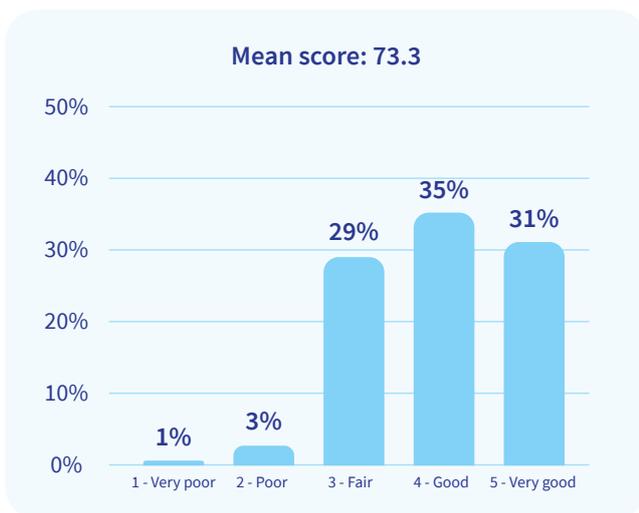
Vaccine Perceptions

A 3-item domain assessed the patient's perception of the efficacy and safety of vaccines made available in each country and the likelihood to be vaccinated. The level of trust in the efficacy and safety of the available vaccines was only 66% positive and intention to be vaccinated 77% positive. There were significant differences by country. Hospitals have limited ability to impact these issues, as the patients' response is more a reflection of several factors that would influence the perception of vaccines, namely:

- The brand and source of vaccines made available to the general public in each country;
- Mainstream media coverage;
- Social media interaction;
- Government messaging; and
- Impact of conspiracy and anti-vaxxer sentiment in each country.

Chart 2:

Your trust in the safety of COVID-19 vaccine



Likelihood that you will choose to be vaccinated against COVID-19



Outcomes by Key Demographic and Background Factors

There was significant variation of perceptions based on key demographic criteria:

COVID vs NON-COVID admitted patients

Patients were asked to indicate whether their admission was due to being diagnosed with COVID-19. 14% of respondents indicated that their admission was because of contracting COVID-19. In relation to the COVID/Vaccine domain there was a statistically significant 4-percentage point difference for most items. (Table 1):

Table 1: Admitted as a COVID-19 patient (Yes/No).

	Information the staff gave you about things being done to ensure safe care during the COVID-19 crisis	Ease of understanding the information the staff gave you about how COVID-19 might affect your care	Extent to which you were given a chance to express your concerns about how COVID-19 could affect your care during your visit	Staff's willingness to answer questions you may have had about COVID-19	How well the staff addressed your concerns for your safety at the facility during the COVID-19 crisis	Your trust in the effectiveness of a COVID-19 vaccine	Your trust in the safety of a COVID-19 vaccine	Likelihood that you will choose to be vaccinated against COVID-19	COVID-19
Overall	79.2	77.1	75.5	77.8	79.2	74.8	73.2	78.9	76.6
Yes	82.5	81.3	78.5	81.2	83.0	75.3	73.9	79.7	79.4
No	78.6	76.3	74.9	77.2	78.6	74.8	73.1	78.8	76.1

Age Group

Table 2: The older the patient, the lower the perception of COVID-19 responsiveness and overall care.

	Information the staff gave you about things being done to ensure safe care during the COVID-19 crisis	Ease of understanding the information the staff gave you about how COVID-19 might affect your care	Extent to which you were given a chance to express your concerns about how COVID-19 could affect your care during your visit	Staff's willingness to answer questions you may have had about COVID-19	How well the staff addressed your concerns for your safety at the facility during the COVID-19 crisis	Your trust in the effectiveness of a COVID-19 vaccine	Your trust in the safety of a COVID-19 vaccine	Likelihood that you will choose to be vaccinated against COVID-19	COVID-19
All responses	79.3	77.2	75.6	77.8	79.3	74.8	73.3	78.9	76.7
0-17	81.3	80.3	79.8	80.5	82.8	80.1	78.4	81.3	80.5
18-34	84.4	83.3	83.2	84.1	84.7	80.4	80.3	83.3	82.8
35-49	80.2	78.3	76.5	79.3	81.3	74.0	72.4	79.5	77.5
50-64	77.6	74.1	72.2	75.3	76.9	72.3	70.6	77.0	74.2
65-79	75.8	72.7	70.7	73.1	73.7	73.8	70.6	78.7	73.2
80+	72.0	70.6	66.6	68.8	73.1	63.1	63.0	71.2	68.1

Legend: # Bottom decile # Bottom quartile # 2nd and 3rd quartiles # Top quartile # Top decile

Gender

Table 3: Female perception was 4 percentage point higher than male perception.

	Information the staff gave you about things being done to ensure safe care during the COVID-19 crisis	Ease of understanding the information the staff gave you about how COVID-19 might affect your care	Extent to which you were given a chance to express your concerns about how COVID-19 could affect your care during your visit	Staff's willingness to answer questions you may have had about COVID-19	How well the staff addressed your concerns for your safety at the facility during the COVID-19 crisis	Your trust in the effectiveness of a COVID-19 vaccine	Your trust in the safety of a COVID-19 vaccine	Likelihood that you will choose to be vaccinated against COVID-19	COVID-19
All responses	79.3	77.2	75.6	77.8	79.3	74.8	73.3	78.9	76.7
Male	76.9	75.3	73.9	75.8	76.9	73.6	72.1	78.3	75.1
Female	81.8	79.4	78.0	80.3	82.1	76.5	74.8	80.2	78.7

Admission Speciality

Table 4: There was significant variation by admitted medical speciality.

	Information the staff gave you about things being done to ensure safe care during the COVID-19 crisis	Ease of understanding the information the staff gave you about how COVID-19 might affect your care	Extent to which you were given a chance to express your concerns about how COVID-19 could affect your care during your visit	Staff's willingness to answer questions you may have had about COVID-19	How well the staff addressed your concerns for your safety at the facility during the COVID-19 crisis	Your trust in the effectiveness of a COVID-19 vaccine	Your trust in the safety of a COVID-19 vaccine	Likelihood that you will choose to be vaccinated against COVID-19	COVID-19
All responses	79.3	77.2	75.6	77.8	79.3	74.8	73.3	78.9	76.7
Cardiac Surgery	71.2	65.4	65.9	70.5	71.2	71.2	63.5	78.8	69.8
Cardiology/Coronary	71.8	68.0	65.6	69.0	75.0	71.8	70.7	75.0	71.4
Gastrointestinal	75.7	73.6	70.8	74.6	76.1	70.0	68.2	77.5	72.2
Gynaecology	84.0	79.0	79.0	79.0	81.0	73.0	73.0	76.0	78.0
Intensive Care Unit	82.7	78.8	79.2	85.4	76.9	82.7	75.0	83.3	80.5
Medical	79.0	77.3	77.0	78.4	78.6	74.6	74.5	78.6	76.8
Medical/Surgical	83.3	81.6	80.8	81.0	83.0	79.9	79.7	82.3	81.4
Neurology	69.7	70.8	69.7	71.1	75.0	64.5	63.2	68.4	69.2
Neurosurgery	76.9	73.1	71.2	76.0	79.0	72.0	68.0	74.0	72.1
Obstetrics	85.2	81.3	82.0	80.5	86.7	75.0	75.8	81.3	81.0
Obstetrics/Gynaecology	85.7	84.7	84.0	84.4	86.9	82.1	80.8	84.8	84.2
Oncology	76.7	78.3	73.3	73.3	73.3	71.7	68.3	71.7	73.3
Orthopaedics	76.4	72.1	72.5	75.4	75.4	73.6	72.2	78.5	74.7
Otolaryngology	85.0	80.0	75.0	80.0	85.0	-	-	-	80.4
Paediatrics	83.8	83.0	81.9	84.4	83.8	83.2	81.9	83.8	83.2
Pulmonary/Respiratory	82.4	80.5	76.9	79.4	83.1	75.4	73.7	80.8	78.5
Renal	78.6	75.0	71.4	78.6	78.6	64.3	64.3	64.3	71.9
Surgical	78.2	77.7	73.4	76.5	77.3	72.2	71.1	76.3	74.4
Urology/Renal	66.4	60.4	59.7	66.2	63.6	65.0	63.6	72.1	64.3
Other Specialty	76.5	74.2	72.2	74.6	75.6	70.6	66.6	76.5	72.9

Outcomes by Standard Inpatient Domains

Table 5: The standard inpatient experience journey was also assessed with outcomes showcased by domain, in descending order.

Survey section	Mean score
Overall assessment	89.0
Nursing care	88.5
Doctor care	88.4
Personal issues	86.6
Room	86.5
Meals	79.4

Outcomes by Inpatient Item - Strengths and Weaknesses

Table 6: Highest performing items related to perceptions of doctor care and nursing care.

Survey section	Mean score
Nurses' attitude towards your requests	90.1
Overall rating of care given at hospital	89.6
Doctors' concern for your questions and worries	89.6
Courtesy of the person who cleaned your room	89.3
How well doctors kept you informed	88.9

Table 7: Lowest performing items related to perceptions of COVID-19 and Vaccines.

Survey section	Mean score
Your trust in the safety of a COVID-19 vaccine	73.3
Your trust in the effectiveness of a COVID-19 vaccine	74.8
Extent to which you were given a chance to express your concerns about how COVID-19 could affect your care during the visit	75.6
Ease of understanding the information the staff gave you about how COVID-19 might affect your care	77.2
Staff's willingness to answer questions you may have had about COVID-19	77.8

Priority Index – Greatest Opportunities for Improvement

The Insync/Press Ganey priority index is a way of combining two very important pieces of information:

1. the actual score achieved on a particular item, and
2. the degree to which that item is associated with overall experience.

Combining these two pieces of information helps a facility to know where efforts should be placed for quality improvement. For example, one item might be very low in score (e.g., quality of food) but not particularly associated with overall experience, in comparative terms. Because it is not highly associated with experience, the facility might choose to place quality improvement resources elsewhere. Conversely, an item might be very highly associated with overall experience (e.g., doctor/physician kept you informed) but not low in score. Attempting to raise the score would probably be difficult and may perhaps be unnecessary if most of your patients are very satisfied already.

A priority index was formulated from the study data to assist and support, not only participating hospitals from the study but all hospitals in the Asian region to prioritise actions for improving patient experience at their own hospital. Below is a listing of the top 10 items recommended for attention in order of priority, including a brief definition to assist interpretation:

	<u>Study Mean Score</u>	<u>Correlation Coefficient</u>
1. Response to concerns/complaints made during your stay	85.3	0.83
The question measures the patient’s perceptions of the appropriateness of actions that resulted when the patient mentioned something that troubled or worried him or her or when the patient expressed dissatisfaction with something that happened (or failed to happen). A complaint occurs because actions don’t meet expectations. A concern may reflect anxiety, fear, and uncertainty, which is independent of expectation. In either case, the patient hopes that the caregivers in the facility will do something to handle the disquiet or dissatisfaction that has been voiced. The patient will rate what is done (and not done) when responding to this question.		
2. How well staff addressed your emotional needs	86.2	0.83
This question measures the patient’s perception of how well the staff in the hospital assessed and responded to the patient’s existing or changing emotional state. For many people, these emotional needs have existential or spiritual overtones, such as, “Will I continue to live?”; “Am I going to be the same person after I am discharged?”; “Why me?”; “What have I done to deserve this?”; or “Why did I survive and not the person who was in the car with me?” Emotional needs universal to all humans includes the spiritual concepts of hope and meaning.		
3. Staff efforts to include you in decisions about your treatment	87.3	0.83
This question focuses on the extent to which the patient feels awareness, understanding, and participation in decisions regarding their care and treatment. It is important to consider that the patient may not need to make the decision to feel like he or she was included in decisions. Because patients lose much of their autonomy upon entering the hospital, an important goal should be to restore as much decision making as is feasible to the patient.		
4. How well staff worked together to care for you	88.9	0.84
This item measures the patient’s perception of teamwork and the coordination of care. From the patient’s perspective, coordination is visible when information and instructions flow smoothly from department to department and internally on the unit itself. When patients are given contradictory information from different parties, or when patients must assume responsibility for informing each health care professional of their entire case and care needs, patients perceive that not much is being done by staff to proactively work together to deliver care. Patients notice breakdowns in systems and processes indicating poor coordination. Extensive waits to get a room, frequent transfers, test and treatment delays, and any unexpected events are all examples of situations when the patient perceives that coordination is lacking.		

Priority Index – Greatest Opportunities for Improvement

	<u>Study Mean Score</u>	<u>Correlation Coefficient</u>
5. How well the nurses kept you informed	87.7	0.80
<p>This question measures how well patients thought they were informed. The patient expects to understand what will happen, when it will happen, why it will happen, who will make it happen, where it will happen, how it will happen, and what the result will be. Numerous studies have shown that the simple act of providing information is strongly, positively associated with patient experience.</p>		
6. Temperature of the food (e.g., cold food cold, hot food hot)	80.3	0.69
<p>This item measures the patient’s perception of whether foods that are supposed to be cold are delivered cold and whether foods that are typically hot are delivered hot.</p>		
7. Staff concern for your privacy	88.0	0.80
<p>This question addresses two topics: physical privacy and confidentiality. Many people perceive that privacy encompasses confidentiality. Therefore, there is little value in distinguishing between these two topics in the wording of the question. Patients will evaluate this question for all parts of their care experience, from admission through post discharge phone calls.</p>		
8. Amount of attention paid to your special or personal needs	87.7	0.79
<p>This question assesses the effort patients believe that hospital staff made to understand and meet their minimum requirements for care. These needs may be unique and highly variable, necessitating an assessment, documentation, and integration into the care plan.</p>		
9. Quality of the food	78.5	0.68
<p>This measure assesses patients’ evaluations of the food served to them while in the hospital. Unlike many aspects of technical quality in health care, patients have experience with food and have few reservations about critically evaluating the quality of food. Attributes of the quality of food include appearance, taste, texture, aroma, presentation, colour, temperature, and selection. Patients will judge these attributes against the standards they have come to expect in everyday life (e.g., at home and in restaurants). Considering the cost of the hospital stay and the importance of food quality to health, patients may hold hospitals to a higher standard than restaurants or home.</p>		
10. Nurses’ attitude toward your requests	89.6	0.83
<p>This question assesses the patient’s perception of the nurses’ attitudes. In other words, how did the nurses project themselves while caring for the patient? Specifically, patients will focus on verbal and nonverbal behaviours, such as body position, tone of voice, hand and arm movement, and facial expressions.</p>		

Survey Psychometrics

The accuracy of a patient experience questionnaire is assessed by measuring its validity and reliability. Validity is the degree to which a questionnaire measures what it was designed to measure. Reliability is the degree to which survey data are consistent and reproducible across respondents or across surveys. The Inpatient instrument utilised for the Asian COVID-19 Study was found to be psychometrically sound based on validity and reliability testing.

Validity Assessment

The *construct validity* of the survey was assessed using factor analysis. A Principal Components Analysis with Promax rotation was undertaken to determine how the items in the survey map together. The analysis undertaken on the 25 items, indicated a 5-factor model was the best fit accounting for 80% of variance in the survey.

Item	Communication and care	COVID	Doctors	Vaccine	Meals
CVD1. Information the staff gave you about things being done to ensure safe care during the COVID-19 (Coronavirus) crisis	0.02	0.94	-0.02	-0.03	-0.03
CVD3. Ease of understanding the information the staff gave you about how COVID-19 (Coronavirus) might affect your care	-0.06	0.98	-0.01	0.00	-0.01
CVD5. Extent to which you were given a chance to express your concerns about how COVID-19 (Coronavirus) could affect your care during your visit	-0.04	0.96	-0.02	0.02	-0.02
CVD7. Staff's willingness to answer questions you may have had about COVID-19 (Coronavirus)	0.05	0.85	-0.02	0.08	-0.01
CVD8. How well the staff addressed your concerns for your safety at the facility during the COVID-19 (Coronavirus) crisis	0.09	0.87	-0.02	-0.02	0.01
VR5. Your trust in the effectiveness of a COVID-19 vaccine	-0.04	0.04	0.02	0.94	0.00
VR6. Your trust in the safety of a COVID-19 vaccine	-0.11	0.08	0.05	0.92	0.04
VR11. Likelihood that you will choose to be vaccinated against COVID-19	0.15	-0.09	-0.06	0.92	-0.03
R3. Courtesy of the person who cleaned your room	0.41	0.03	0.02	0.07	0.30
R4. Room temperature	0.08	0.34	0.15	-0.08	0.31
M2. Temperature of the food (e.g., cold food cold, hot food hot)	0.03	-0.02	-0.03	-0.03	0.95
M3. Quality of the food	-0.05	-0.03	0.00	0.04	0.96
N3. Nurses' attitude toward your requests	0.98	-0.14	-0.04	0.00	0.02
N4. Amount of attention paid to your special or personal needs	0.99	-0.10	-0.08	0.02	-0.01
N5. How well the nurses kept you informed	0.90	0.06	-0.02	-0.03	-0.03
P1. Time doctors spent with you	0.01	-0.01	0.93	-0.02	0.01
P2. Doctors' concern for your questions and worries	0.02	-0.07	0.98	0.01	-0.01
P3. How well doctors kept you informed	0.01	0.02	0.93	0.01	-0.02
I1. Staff concern for your privacy	0.61	0.16	0.16	-0.01	0.01
I4. How well staff addressed your emotional needs	0.84	0.12	-0.02	-0.03	-0.02
I5. Response to concerns/complaints made during your stay	0.81	0.09	0.01	0.00	0.02
I6. Staff effort to include you in decisions about your treatment	0.658				

The first factor suggests a theme around communication and care (primarily nursing care); the second around COVID-19; the third focused on doctor care; the fourth related to the COVID-19 vaccine and the final one, is focused on meals. Both items related to the room, displayed low factor loadings and cross loaded on two factors, suggesting they do not relate strongly to other items and factors in the survey.

Survey Psychometrics

Convergent and Divergent validity

To demonstrate convergent validity, items in the survey should load at least 0.3 onto the corresponding factor. The survey met this criterion, with all items to scale correlations above this. Divergent validity means that items correlate most with their own factor than with other factors. This criterion was met for all items except for the items related to room.

Predictive validity

To determine whether the survey predicts outcomes that are related to being an inpatient, a multiple regression was conducted using propensity to recommend the hospital, as the outcome and the survey items as predictors. The results of the analysis show that the survey explains 64% of variance in patient likelihood to recommend the hospital they visited, adjusted $R^2 = 0.64$, $F(22, 929) = 77.23$, $p < .000$.

A second equation was conducted using the factors as predictors of propensity to recommend instead of the items. The results show that after controlling for the other predictors, a 1 SD increase in the factor Communication and Care will result in a .575 increase in likelihood to recommend. The results also show that after controlling for the other predictors, a 1 SD increase in the factor COVID, will result in a 0.134 increase in likelihood to recommend, while this was a 0.120 increase in likelihood to recommend when looking at the factor related to doctor. This finding suggest that Communication and care are still key to patients recommending the hospital, more so than any other factors.

Reliability Assessment

The reliability of a survey tells us the level of consistency between items on a scale. All scales presented with acceptable levels of reliability based on a Cronbach's alpha minimum of 0.7.

Factor	Alpha	Any improvements if item deleted
Communication and Care (n=2,783)	0.93	0.94 if item R3 removed
COVID-19 (n=1026)	0.95	NA
Doctors (n=2,940)	0.93	None
Vaccine (n=1,054)	0.93	0.94 if item VR11 removed
Meals (n=3,024)	0.89	NA

Recommendations and Best Practices for Patient Experience Improvement During and Post COVID-19

The Asian COVID-19 Patient Experience Study outcomes confirm that patients come to healthcare seeking safe, reliable and compassionate care. The typical drivers of patient experience (communication, engagement and compassion; particularly with nursing care and doctor care) remain strong, however COVID factors add a dimension, specifically relating to additional COVID-19 related safety.

The findings suggest that while communication and care of patients remains the key driver of patient experience, managing COVID-19 remains important and still had a bigger impact than all other factors in the survey in terms of patient experience.

The study has confirmed that patients are suffering, now more than ever. As health care providers the first step to addressing patients' unmet needs is to acknowledge this fact. However, acknowledging that patients are suffering through the pressures of the pandemic is not enough. It is a call to action. 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 ⁵ with a key focus on communicating to patients HOW we are keeping them safe through these times. Key strategies include:

- We should acknowledge that our patients are suffering and show them that we understand;
- Non-verbal communication skills are as important as the words we use;
- Anxiety and uncertainty are negative outcomes that must be addressed;
- We should show patients that their care is safe, coordinated and continuous, and that we are always there for them;
- Real caring goes beyond delivery of medical interventions to the patient.

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 discomfort/pain and ensuring patient safety protocols are followed.

The Strategic Landscape

The Good News

- In 1 to 2 years, the health threat of COVID-19 will likely be much less
- The public appreciates health care now as never before

The Bad News

- Pressures for efficiency will be intense because of government regulation and employer financial struggles
- Patients and caregivers will both be adapting to new care models

Implications

- Understanding what is important to consumers is critical for success
- The focus has shifted from convenience to trust

Recommendations and Best Practices for Patient Experience Improvement During and Post COVID-19

Key Strategies to build Trust in the New Normal of Healthcare Experience

We need to acknowledge that care delivery is not going to “return to normal” but any changes remain grounded in a commitment to safety for patients, families, and caregivers. With all the media focus on health care’s capacity to manage the pandemic, burnt out caregivers and hospital financial losses, organisations will need to reinforce that their values remain the same even if care delivery models may be different. ⁶ The best way to leverage this reinforcement is through a combination of:

- Clear protocols;
- External social media;
- Internal messaging, e.g., signage; and most importantly
- Train our caregivers in how to better engage and communicate with patients.

A critical component of the approach to addressing patient needs during and post COVID-19 is empathy. Empathy in health care is the willingness of providers to acknowledge patients’ fears, but to then operationalise empathy behaviours and actions. Specific pandemic communication and transparency required:

- Address universal concerns that patients have about getting sick from other patients or caregivers;
- Publicly report the sufficiency of PPE;
- Publicly report caregiver transmission rates;
- Limit the use of waiting areas by patients or families;
- Point out the cleanliness of the facility, including video examples of cleaning processes highlighting the environmental services staff who do the work; and
- Showcase disease-specific interviews with physician leaders about the risks and mitigation occurring.

COVID-19 vs non-COVID-19 Patients

As COVID-19 continues to spread, health care organisations must ensure that they can safely provide care to their non-COVID patients while continuing to meet the ever-changing needs of the COVID-positive patient population. The study revealed a significant disparity in patient experience between these two groups of patients. This dual mission demands thoughtful redesign of care delivery models that will pave the way to a successful future in which hospitals can balance the needs of both groups indefinitely.

Looking for risks, a high reliability concept known as preoccupation with failure, needs to permeate every aspect of patient, staff, and community interaction when considering how to care for COVID and non-COVID patients in the same environment. Leaders need to walk through their facilities looking for all possible situations where exposures could occur (e.g., elevators, restrooms, cafeterias, and clinics), and then put plans in place to mitigate those risks.

They can start by asking the following:

- Can the organisation designate elevators and restrooms in ways that will protect vulnerable patients coming in for non-infection-related treatments (e.g., cancer, immunotherapy)?
- Is the cafeteria closed for dining in, or do tables need to be spaced farther apart? Is there a safe way for at-risk patients to get food without encountering potentially contagious patients?
- Are there enough patients for outpatient clinics to be specialised? Is it possible to assign one urgent care clinic for patients with colds, flu, and stomach ailments and another for patients with injuries? If separate clinics are not an option, can the organisation accommodate separate waiting areas, or have patients wait in their cars before appointments?

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Leaders must review each scenario for pros and cons based on their organisation, the resources that are available, and the types of patients being cared for. Flexibility is key. Care delivery plans and processes built to change quickly and efficiently during COVID spikes will make it easier to continue to deliver safe care to all patients.

Once immediate issues such as these are addressed, organisations must begin thinking strategically about how to operate in a manner that not only provides safe, ongoing care for non-COVID patients, but can be adjusted quickly to accommodate changes in COVID-positive patient volume. Following are some examples:

Outpatient Services: Clinic visits and therapies for patients with routine and chronic conditions can be accommodated via telemedicine. For patients who require occasional hands-on care, alternating telemedicine with in-person visits can decrease potential exposure, help patients get accustomed to virtual visits, and assure them they are getting the care they need. Building provider workflows and schedules that allow for both in-person and telemedicine visits not only increases safety, but it also increases flexibility and provides options for seeing patients with transportation, childcare, work, or other scheduling challenges.

Moving forward, this nimbleness also provides opportunities to expand hours, increase revenue by bringing in new patients, recruit to a wider audience of health care professionals, and decrease overhead expenses by rethinking brick-and-mortar needs. Messaging this as “the way we provide care” will help both patients and providers understand that telemedicine is not just used during pandemics but is part of new and improved operations.

Emergency Services: Using telehealth technology to triage and check in patients prior to their arrival at the hospital allows the care team to direct patients to the most appropriate location for care right away, limiting contact between non-infectious and COVID-positive patients. Even the simple act of having potentially infectious patients come into the ED through a separate door or having them wait to be seen in a specially designated area helps decrease possible spread and reassures patients that they can safely seek care.

Additionally, clearly identifying waiting areas and staff designated for non-COVID patients builds community confidence. Finally, even though there is no way to know for sure who is infectious, having clear plans that are easily communicated to patients on how to minimize exposure to COVID is reassuring to both patients and staff. For example, a patient could pull up to their local ED and receive a tablet already joined to a virtual session with a triage nurse. After the triage, depending on the situation, the patient may be taken immediately into the ED, given the option to wait in their vehicle until called, or wait at home until called, or a provider could immediately address their need through a virtual visit. Each option avoids the need to sit in a waiting room with potentially infectious patients.

Surgical Services: Using a combination of technology and home care services to provide follow-up care, deliver therapies, and check in on patients can allow patients to go home sooner after surgeries, or even avoid hospital stays altogether. Elderly and chronically ill patients may be more likely to schedule procedures if they understand they will not need to be cared for in an environment where they could be exposed to COVID-19.

Inpatient Services: Having conversion plans in place when additional beds are needed to care for infectious patients will ensure that safe, effective care is available in a timely manner. To create these plans, organisations can use checklists and other job aides (e.g., shadow diagrams, kamishibai boards, and tip sheets) to ensure that all needed equipment is available and that transitions go smoothly. Knowing how staffing needs will be met ahead of time and orienting caregivers to the new setting will also prevent confusion in real time.

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Prepared leaders will consider every unit and every space, preplanning for how they could be used to care for infectious patients should the need arise. Specifically, when additional space is needed to care for COVID-positive patients, leaders can do the following:

- Move prepacked isolation carts filled with gowns, gloves, masks, disinfectant, signs, and anything else needed for patients who are in isolation due to a communicable disease to the designated area to be placed outside patient rooms;
- Place tip sheets next to computers reminding caregivers of the appropriate way to document COVID status in the EMR;
- Roll out a cart with signs, tablets, and instruction sheets for visitation options;
- Use portable shelving units with bins to hold N95 masks for reuse; and
- Tape checklists on each ventilator unit outlining precautions needed when a patient is intubated.

Patients, both COVID and non-COVID, need to be confident that they can access the care they need. Embracing the high reliability concept of preoccupation with failure, planning for all possible scenarios, employing new and emerging technologies along with innovative workflows, and communicating well and often will help assure patients that they will receive safe and effective care. With thoughtful planning, organisations can position themselves well to meet their patients' needs.

Staying Connected with Patients and Families

The following are three ways that health care organisations can help their clinicians both connect COVID-19 patients with their loved ones and stay connected to their own families during these trying times.

1. Provide tips and talking points to ease patients' suffering.

Many of us do not know the right words to say or, more often, have the gift of time to slow down and practice the small gestures that can make a big difference during moments of crisis. Singing, praying, reading, or simply talking to patients, whether they are responsive or not, can create warmth and a vital human connection. Develop quick tips or simple job aids/talking points to help families find words or ways to demonstrate that they are “present” with their loved ones, and to help clinicians be “in the moment” with families.

2. Leverage existing mobile communications technology.

Many organisations have stockpiles of older-generation tablets, laptops, and smartphones that can be reactivated and repurposed to help families communicate with their loved ones – whether it is through email, FaceTime, Zoom, WhatsApp, Skype, or a phone call. Simple acts of kindness and empathy – a physician holding a phone to a patient's ear so that her son can recite a prayer for her; a team of nurses who gather at the bedside of their dying colleague and take one last photo with him so that his daughter can see her father is not alone in his final moments – can help family members cope with the circumstances of their loss.

3. Create ways for clinicians to connect with their loved ones.

Organisations have installed communications devices at strategic staff locations so that clinicians can quickly connect with their loved ones. Treating COVID-19 patients places clinicians at great risk of contracting the virus themselves, and many are separating themselves from their families to keep them safe. Making it easy for clinicians to stay connected to their loved ones can reduce the emotional toll accompanying such sacrifices.

The COVID-19 coronavirus has presented the health care community with unprecedented challenges. With the simple strategies we outlined here, keeping the lines of communication open – for patients, clinicians, and families – does not have to be one of those challenges.

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Vaccine Hesitancy and Acceptance

Given the critical importance of optimal community engagement in COVID-19 vaccination programs, closing the identified readiness gaps is a public health imperative. Because providers' advice and guidance exert a strong influence on the likelihood that patients will get vaccinated, health care organisations must integrate into their vaccination implementation plans communication strategies at the individual, community, and population levels to increase uptake of the vaccine.

In a recent Press Ganey study ⁷ patients have substantially more trust in the advice and guidance of their health care providers than in information provided by the government. Approximately 69% of respondents expressed a high level of confidence in their provider's advice, compared with only 47% indicating their confidence in advice from the government. Given this, health care providers and organisations should prepare for an increased demand for individual and community guidance and education.

Press Ganey researchers conducted a key driver analysis to identify the relative importance of each of the COVID-19 vaccine questions on the vaccine acceptance outcome. They found that the specific survey questions with the most influence on patients' likelihood to get the vaccine are those indicating that the benefits of vaccination outweigh the risks, trust in the safety of the vaccine, trust in the effectiveness of the vaccine, and confidence in their provider's advice. Targeted outreach should incorporate these messages to build public confidence and break down barriers to vaccine acceptance.

Because health care providers are the most trusted advisors in guiding acceptance of the COVID-19 vaccine, health care organisations can influence vaccine uptake in the communities they serve by taking the following steps:

- Adopt a model of trust that embeds empathy, authenticity, and logic into the culture of the organisation and prioritises trust-building behaviours and skills;
- Take advantage of multiple communication methods to support and scale messaging to patient populations – for example, the automation of vaccine education and outreach via patient portals and social media;
- Collect, analyse, and segment vaccine readiness data to understand and address the unique needs of the segmented populations;
- Develop and deploy communication strategies addressing the specific concerns of patient segments with low confidence in vaccine safety;
- Proactively communicate how, when, and where patients will be able to access the vaccine; be transparent about vaccine availability; and provide guidance about where to get additional information and help;
- Partner with trusted community organisations and networks to ensure respected leaders in communities of marginalised groups are visibly and meaningfully engaged in vaccination planning, education, delivery, and administration.

Conclusion

The Asian COVID-19 Patient Experience Study has shown that we can no longer take for granted that patients trust their hospitals, as in the past.

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The Asian COVID-19 Patient Experience Study has shown that we can no longer take for granted that patients trust their hospitals, as in the past. Patient experience has shifted so we also need to assess how we engender trust by providing evidence that we are providing exceptional care in exceptional circumstances.

An overarching lesson from the study is that, during times of change, organisations should turn to such data with greater frequency, because what was important last month may be overshadowed by other issues today. Insync/Press Ganey also has found that patients' experience with new models of care is variable and differs in important ways from the models they have replaced.

The key to adjusting the approach to the new normal inpatient experience assessment is to incorporate trust elements. Earning and building trust requires more than good intentions. It requires (1) an effective and comprehensive data strategy that (2) produces insights which (3) drives performance.

Health care organisations and their caregivers performed magnificently during the COVID-19 pandemic. Their readiness to put the needs of patients and their communities ahead of their own, their creativity in meeting those needs, the speed with which changes were made, and the hard work and courage they demonstrated will be among the finest memories those who work in health care will have of this period of their careers.

But the work immediately ahead will also have a major and long-lasting impact. The good news is that the same basic approaches that have emerged in recent months are likely to be critical for meeting patient, provider, and organisational needs. To this end, leaders should commit to using a data-driven approach to guide actions, responding to insights derived from feedback from patients and caregivers, and integrating resilience into their organisation's goal of pursuing high reliability. These steps can help build trust and give organisations the social capital they need to master the new consumerism in current and post pandemic times.

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