Global Clinical Journal

Connecting and developing our clinician community to better serve people

Mapping the Global Patient Experience

Volume 2, July 2020 - English Edition

United Healthcare® Global

We honor the sacrifice of clinicians around the globe who gave their lives while healing others during the COVID-19 pandemic, including the doctors, nurses and other colleagues from our own UnitedHealth Group family.

May their dedication to their profession and the people they served be an inspiration for us all.

A message from the **Chief Medical Officer**

Things can change rather quickly. We were in the process of reviewing submissions for the second edition of the Global Clinical Journal — Patient-Centered Care and the Patient Experience — when COVID-19 was declared a pandemic. Clinicians around the world, including UnitedHealthcare Global's 37,000 clinicians, braced to combat a disease that threatened health care systems worldwide.

Our foundational evidence-based clinical model, our global clinical team cohesion, and our embodiment of UnitedHealthcare values have come to life during this crisis. Our clinicians are modelling behavior consistent with their oath to protect the people we serve with compassion, integrity, dedicated performance and innovation.

At the time of going to print for this edition, approximately 10.4 million people across the world had been infected with COVID-19, and more than 509,500 people had died as a result of the disease. The fallen include patients and health care professionals. These heroes gave their lives protecting others as they worked hard to leverage their craft and training to stem the tide of the disease.

This issue showcases work related to our foundational clinical model. It showcases the work we do in the normal course of activities that prepares us for crises and challenges ahead. It showcases how we, the clinical team at UnitedHealthcare Global, put the patient at the center of everything we do. While this issue is not directly linked to COVID-19 themes because it was finalized prior to the pandemic, we present the work to celebrate the excellence of our clinicians, and in memory of our fallen clinical colleagues.

Margaret-Mary G. Wilson, M.D., MBA, MRCP, FNMCP
Chief Medical Officer & Senior Vice President
UnitedHealthcare Global

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Mental Health Care in the Amil System: The Challenge of Continuity of Care

Introduction

Depression is one of the most prevalent health conditions in the world, according to 2019 data from the World Health Organization. Data indicates that about 264 million people suffer from depression. Between 2005 and 2015, the number of cases increased by 18%. Bipolar affective disorder also has a high prevalence, affecting about 45 million people all over the globe, while schizophrenia affects around 20 million.[1] Unfortunately, suicide is the second leading cause of death for people aged 15-29. Annually, almost 1.6 million people attempt to take their life; of those, sadly, 800,000 die.

Economic analysis shows that investment in the expansion of access to treatment for people with mental disorders has a return on investment of 4:1 driven by improved health and productivity.[2] Integrating mental health treatment with primary care is a fundamental step in making access to services and integrated care possible which, in turn, provides higher-quality care and decreases cost.[3]

Between 2017 and 2018, we observed a 30% increase in psychiatric admissions for Amil Insurance members with a mental health diagnosis. Readmissions within 30 days occurred in 32% of the cases. Amil outpatient services were overwhelmed with low-complexity cases rendering access to outpatient services difficult for severely ill psychiatry patients.

The creation of Amil's mental health program originated from the desire to assess the clinical quality rendered during inpatient admission, manage lengths of stays more efficiently, avoid unnecessary hospitalizations, prevent avoidable readmissions and facilitate follow-up outpatient care after discharge.

The clinical management teams track patients admitted to the hospital with psychiatric comorbidity and collaborate with local care providers to support timely and appropriate referral and transition to mental health inpatient or outpatient teams. These teams integrate outpatient specialty teams with primary health care, offering coordinated, comprehensive care for severe cases.

This innovative integration between teams improves mental health care quality and lowers overall costs, resulting in a network focused on improving patient experience.

Implementation of the Mental Health Program

Amil's Mental Health Program started in September 2018. Currently, there are 11 mental health referral teams: Seven teams in outpatient units owned by Amil (Amil Espaços Saúde) and four teams in accredited outpatient units in Amil's contracted network. These teams are distributed over the states of São Paulo (4), Rio de Janeiro (2), Paraná (2), Rio Grande do Norte (1), Ceará (1) and Pernambuco (1). Each mental health referral team is comprised of a psychiatrist, psychologist and social services assistant who provide care management in an integrated manner with family doctors, family nurses and nursing technicians. The clinical management team is comprised of psychiatrists and nurses who work in the accredited Amil network psychiatric hospitals and manage 80% of admissions for mental health disorders.

The initial steps of the program consisted of tracking and contacting severely ill patients to begin coordination of clinical management providers with main providers and psychiatric admissions. The intention is to establish a collaborative dialogue to strengthen network care and clinical quality through the discussion of evidence and current approaches in the field of mental health.

The mental health referral teams offer integrated clinical management to support primary care providers and facilitate expanded access and seamless transition to psychiatry services. Patients with mild and moderately severe psychiatric illness remain under the care of the primary care medical team, with support from the mental health referral team. In contrast, patients with severe psychiatric comorbidity or patients in mental health crisis are cared for primarily by the mental health team with individualized assistance, with family members or in group.

Care pathways are individualized and developed in partnership with family members and other members of the care team. Direct engagement with the social assistant and nursing technician is available to the patient. The patient reference sources for the program are the clinical management team, general hospitals, psychiatric hospitals, primary care providers, population health management teams and the employee care program.

The key performance indicators were:

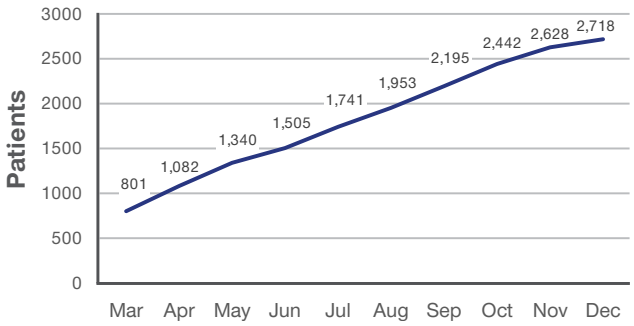
- Number of patients enrolled in mental health referral teams
- Bed days per 1,000
- 30-day readmission rate
- Number of avoided psychiatric urgent admissions to inpatient care

Results

From January to December 2019, more than 2,700 patients were enrolled by the mental health teams of Amil's outpatient units (Figure 1). Approximately 894 cases in crisis were managed avoiding unnecessary emergency room admissions (Figure 6). Around 15,000 patient-provider interactions were observed, including appointments with psychiatrists, psychologists, social assistants and combined appointments with mental health professionals and family doctors and nurses.

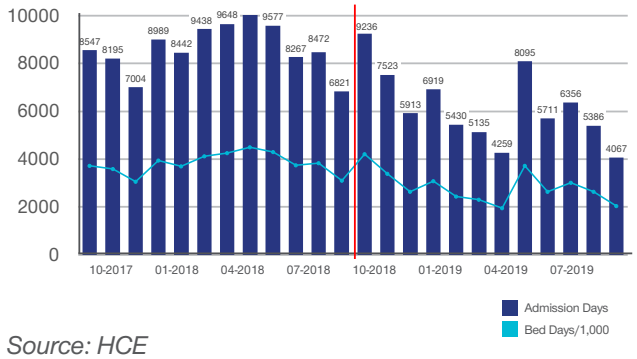
Comparative data analysis shows a reduction in bed days per 1000 (Figure 2) mainly due to the negative trend in length of stay (Figure 3) following implementation of the mental health program. We also saw a reduction in the cost per admission (Figure 4). Comparative analysis of the period between January to November 2018 and the same period in 2019 showed that the 30-day readmission rate in the population with mental health diagnoses decreased by 3 percentage points, representing a 9% reduction. When the same analysis is carried out on the population of enrolled patients in mental health teams, there is a reduction of 12 percentage points, representing a 37.5% decrease in 30-day readmission (Figure 5).

Figure 1. Total number of patients enrolled in mental health teams in 2019.



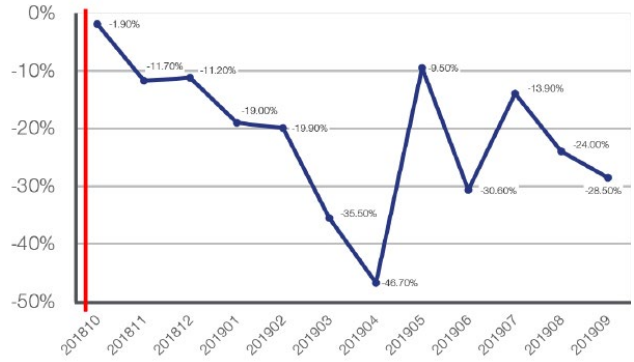
Source: SisWebCad Amil

Figure 2. Admission days / 1,000 active beneficiaries and total volume of admission days. The period before the red line is without clinical management and the period after the red line is with clinical management.



Source: HCE

Figure 3. Length of stay trend since the beginning of clinical management.



Source: HCE

Mental Health Care in the Amil System: The Challenge of Continuity of Care, Continued

Conclusion

Amil's Mental Health Program is an innovative solution with potential for major social impact. It allows for facilitated access and continuous care of patients with psychiatric comorbidity in outpatient clinics and hospital settings. This program facilitates integrated care management, collaborative discussions between care providers, efficient transitional care management and effective follow-up after discharge from hospital. The program also provides crisis management and tailored therapy for all enrolled patients.

Amil's Mental Health Program has enhanced hospital and outpatient network optimization by addressing gaps in continuity of care and transitional care specifically related to mental health care. The mental health reference teams have been especially effective in dealing with mental health crisis cases in the outpatient setting thereby avoiding unnecessary psychiatric admissions.

In the case study, we report on one of the follow-up cases.

This article has been translated from the original submission in Portuguese.

[1]WORLD HEALTH ORGANIZATION. Mental Disorders, 2019. Available at: <https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders>. Access on February 11, 2020.

[2] WORLD HEALTH ORGANIZATION. Mental Health ATLAS 2017, 2018. Available at: < https://apps.who.int/iris/bitstream/handle/10665/272735/9789241514019-eng.pdf?ua=1>. Access on February 11, 2020.

[3]WORLD HEALTH ORGANIZATION AND WORLD ORGANIZATION OF FAMILY DOCTORS (WONCA). Integration of mental health in primary health care: a global perspective. National Coordination for Mental Health. Portugal, 2008.

Authors

Isabela Henriques Ferreira Ramos, M.D., Amil, Brazil
iramos@amil.com.br

Fabiane Minozzo, Psy.D., Amil, Brazil

Samantha Pereira França, M.D., Amil, Brazil

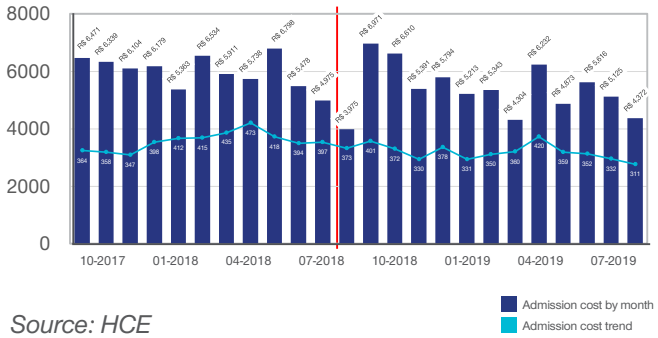
Case Study: "I don't know how to live. I'm thinking about giving up."

MM, a 45-year-old woman had a history of four previous psychiatric admissions, repeated urgent visits to the primary care clinic and non-compliance with her outpatient follow-up and psychiatric medication regimen. MM had fragile family support and exhibited symptoms of self-aggression. She had a history of multiple suicide attempts, one of which resulted in amputation of one of her hands when she tried to throw herself in front of an oncoming train.

The patient was engaged by the Amil Espaço Saúde mental health team in September 2018, following a diagnosis of Borderline Personality Disorder. The team developed a care program that comprised daily follow-up, supervised medication intake under direct observation and clinical consultations, as needed, until stabilization. This approach avoided relapses and established a strong bond with the patient. She exhibited significant improvement and compliance with subsequent outpatient therapy.

She has not been readmitted to the hospital and her visits to the health care center have become much less frequent. MM remains compliant, continues to improve and is now seeking employment.

Figure 4. Admission cost. The period before the red line is without clinical management and the period after the red line is with clinical management.



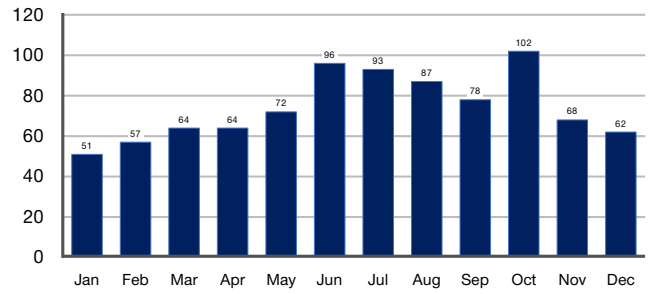
Source: HCE

Figure 5. Psychiatric Readmission Rate in 30 days

	2018 (Jan to Nov)	2019 (Jan to Nov)
% Readmission in 30 days - general population	32%	29%
% Readmission in 30 days - enrolled population	-	20%
Total percentage points reduction - Readmission in 30 days - general population 2018 x enrolled population 2019	12 p.p.	
Total percentage points reduction - Readmission in 30 days - general population by period (2018 and 2019)	3 p.p.	

Source: MicroStrategy

Figure 6. Number of avoided psychiatric urgent admissions – 2019.



Source: HCE

Amil's Mental Health Program is an innovative solution with potential for major social impact. ***It allows for facilitated access and continuous care of patients with psychiatric comorbidity in outpatient clinics and hospital settings.***

Improving Emergency Care Patient Experience through Strategies that Positively Impact Care Timeliness: Clínica del Country, Bogota, Colombia

Introduction

The emergency department (ED) is the main point of entry to hospitals, and thus plays a critical role in shaping the first moments of a patient's experience. The patient's perception of the ED care experience can impact institutional reputation and customer loyalty.

Our hospitals' Net Promoter Score (NPS) revealed that our patient experience did not meet the objectives we had set for our emergency departments. Thus, in order to work on improvement strategies, we identified the root causes for our sub-optimal NPS scores and the major drivers of patient experience. We identified two main drivers: timeliness of care and pain management. This article focuses on our intervention strategy to improve timeliness of emergency care delivery.

Goal

Our goal was to improve the patient experience by reducing the time spent during all phases of emergency care delivery, using the following indicators: turnaround time, number of patients who leave before being seen, complaints and compliments, and patient perception.

We set the following targets:

1. Achieve the *value promise* in wait times for initial medical care after triage in 80% of ED cases (the time it takes for the patient to be seen by a physician and receive treatment following triage). This promise corresponds with 60 minutes for triage level III and 90 minutes for triage level IV and V cases.
2. Achieve a 25% reduction in the rate of patients who leave the emergency room before being seen.
3. Improve patients' perception of the ED.

Methodology

We applied a root cause analysis using graphs of behavioral trend indicators and waiting times at different stages of the care route. Key drivers with the greatest impact were identified. These drivers were prioritized based on magnitude of anticipated impact and effort required to implement a remediation strategy, using Pareto charts and Plan-Do-Check-Act methodology.[1,2]

Summary of Strategies

We developed remediation strategies based on the following domains:

Specialty medical care in the ED: We made changes to the composition of the ED clinical teams by replacing general practitioners with physicians specialized in family medicine, and increasing the number of emergency medicine, general surgery and internal medicine physicians assigned to cover the emergency department.

Assessing the doctors needed per hour and introducing productivity-based payments: We analyzed the average number of patients treated per hour adjusted for the following variables: time of day, average consultation time, physicians' commute time and patient re-evaluation. Based on these figures, we created a shift table with different start and end times for physicians. We also modified physicians' contracts so that they are now entitled to a basic salary, plus a productivity incentive based on their ability to meet an expected target of number of resolved cases and pre-determined quality of care benchmarks.

Providing patients with information on wait times throughout the care process: Our baseline assessment indicated that patients are usually uninformed of their expected wait times in the emergency department prior to being seen by a physician. We remediated this gap by creating an electronic board prominently displayed in the emergency room which allows each patient to view and monitor their expected wait time based on their triage classification.

Optimization of space and reduction in transfer times: A major problem identified in emergency departments with a high influx of patients is the inability of installed capacity to cope with demand. The high occupancy rates in our hospital generated further delays in the ED. We adopted an emergency department patient transfer policy that prioritized bed allocation according to ED volume, facilitated early transfers to surgery and timely transfers of patients within the integrated

UnitedHealthcare Global network of hospitals in Colombia. We also developed and implemented standardized internal patient transfer polices that allowed for a decrease in internal transfer times. These actions decreased our patient transfer time from 20 minutes to seven minutes over a three-month period.

Ongoing remediation – emergency care route: We are currently redesigning the patient journey map to enhance the emergency room patient experience. To date we have worked on increasing the number of triage rooms, completed a shift system for the entire medical care process, optimized procedure and emergency radiology areas to improve transfer, imaging, and image analysis times, and improved communication between specialists.

Results

The changes brought about by the above strategies had a positive impact on the following indicators:

Timeliness of care following triage: The standards for post-triage wait times for initial medical care (service promise: triage III within 60 minutes, and triage IV and V within 90 minutes) based on triage patient classification are being met to this date.

Patients who leave the hospital without being seen: Our baseline analysis indicated that patient desertion of the ED is directly linked to longer waiting times. Prior to June 2019, our patient ED desertion rate was 2.5%. Following the implementation of our strategy, we observed an immediate decrease, achieving levels below the 1.5% proposed target.

Complaints and compliments: Following the implementation of the specialty medicine model in the ED, we witnessed a reduction in patient experience complaints. Complaints about the timeliness of care decreased by 38% between the first and second quarter of 2019. Similarly, patient compliments related to their experience in the ED increased by 142% during the same period.

Patient perception: Our patient satisfaction survey assesses the emergency care cycle through three questions on the timeliness of care. Survey responses revealed a positive trend throughout 2019. The three questions probe the following domains: (1) Satisfaction with information received on delays and wait times in the ER (Figure 4), (2) Satisfaction with wait time to be seen by a physician after triage (Figure 5), (3) Satisfaction with wait time to be called for a follow-up medical checkup (Figure 6).

Net Promoter Score (NPS): This indicator measures patient loyalty based on their willingness to recommend our services. In our hospitals, NPS is the most important indicator for patient experience. As of June 2019, following the implementation of the strategies described above, there has been an increase in our NPS.

Figure 1. Initial care opportunity (patients treated within 60 minutes).

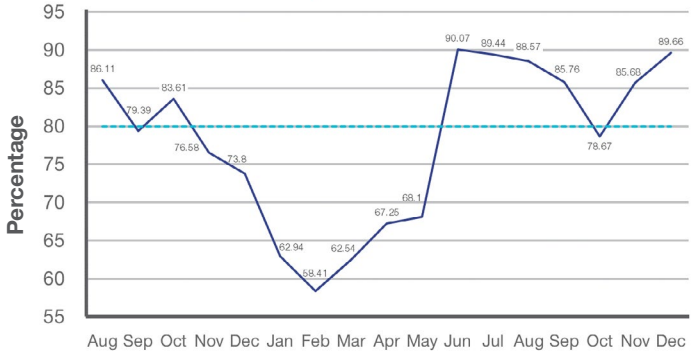
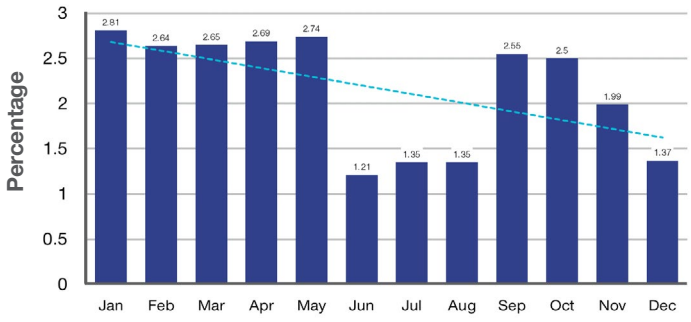


Figure 2. Rate of Patient Desertion from the ED.



Improving Emergency Care Patient Experience through Strategies that Positively Impact Care Timeliness: Clínica del Country, Bogota, Colombia, Continued

Figure 3. Complaints and compliments.

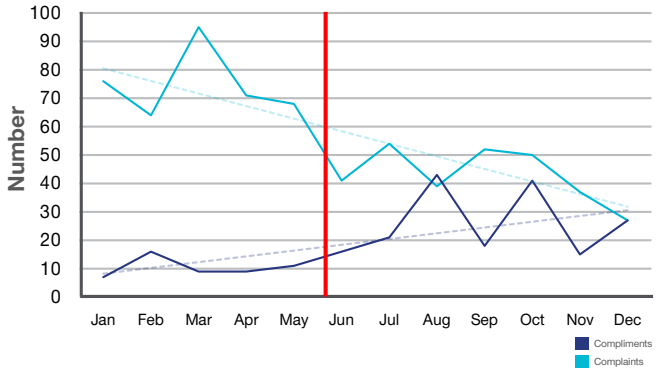


Figure 4. Satisfaction with information received on delays and wait times in the ER.

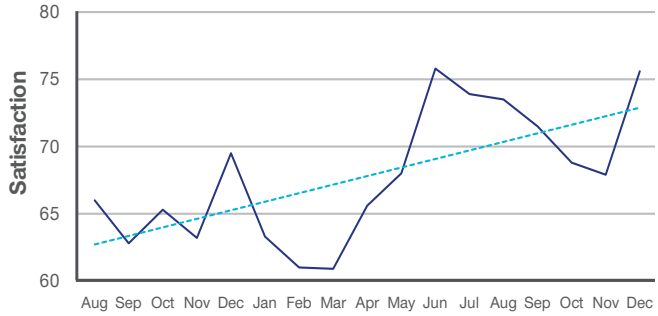


Figure 5. Satisfaction with wait time to be seen by a physician after triage.

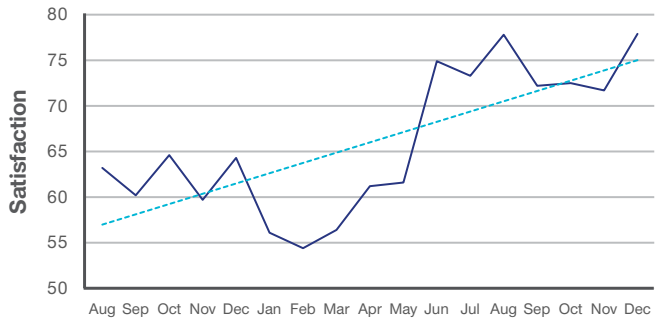


Figure 6. Satisfaction with wait time to be called for a follow-up medical checkup.

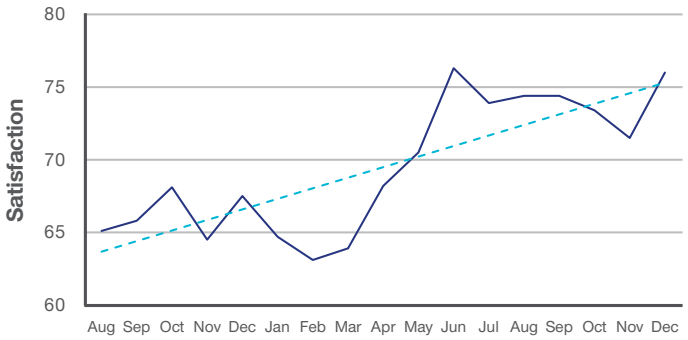


Figure 7. Hospital NPS.

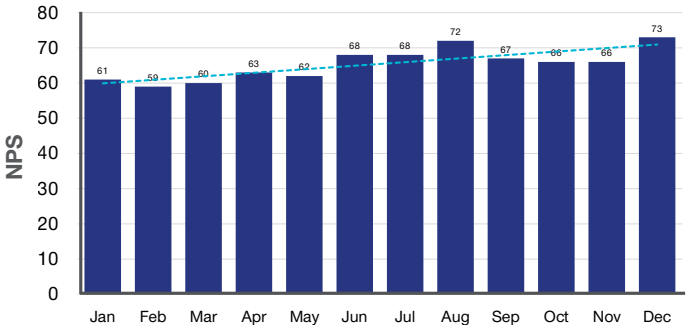
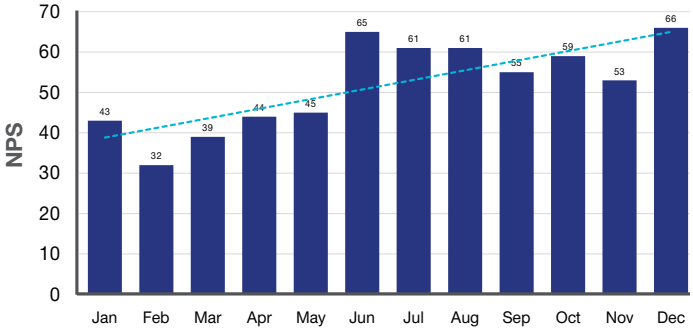


Figure 8. Emergency Department NPS.



Conclusion

At Clínica del Country, we identified the timeliness of care as a major driver of patient dissatisfaction with emergency care. We implemented a remediation strategy that focused on improving timeliness of post-triage medical care, decreasing the patient desertion rate, standardizing transfer processes, increasing ED specialty coverage and the implementation of provider performance-based reimbursement models. These efforts successfully improved patient perception, patient experience and NPS.

[1]Dunford. R., Su, Q., and Tamang, E. (2014) 'The Pareto Principle', The Plymouth Student Scientist, 7(1), p. 140-148.

[2] Peter J. Koiesar (1994) What Deming Told the Japanese in 1950, Quality Management Journal, 2:1, 9-24, DOI: 10.1080/10686967.1994.11918672.

[3]D. F. Hamilton, J. V. Lane, P. Gaston, et al. Assessing treatment outcomes using a single question the Net Promoter Score. Bone Joint J 2014;96-B:622–8.

Authors

Carolina Marquez, M.D., Cliníca del Country, Colombia
carolina_marquez@clinicadelcountry.com

Jorge Ospina, M.D. Cliníca del Country, Colombia

Ana María Quijano, M.D., Cliníca del Country, Colombia

The emergency department (ED) is the main point of entry to hospitals, and thus ***plays a critical role in shaping the first moments of a patient's experience.***

New Patient Experience with Clinical Pathways Based on Evidence-Based Care Guidelines – Clínica Dávila, Santiago, Chile

Introduction

Standardizing clinical practice is fundamental to offering greater value to the patient and improving the quality of service and experience in health care. Clinical pathways based on evidence-based care guidelines accomplish both objectives.[1,2]

Program

The methodology is based on developing an evidence-based clinical pathway with physicians of every specialty using MCG Care Guidelines.[3] The ideal care pathway for each patient is a detailed map of every process of care, including preoperative consultation, admission, intra-hospital care, post-operative care and follow-up care.

The service line clinical team includes the distinctive element of a nurse navigator who fulfills the role of supervising and guiding the patient. Nurse navigators give the patient constant education, answer questions and guide them through administrative and clinical procedures.

Existing clinical staff is trained on the pathway approach by the medical leader and the nurse navigators. Fulfilment of the care pathway is verified through indicators used by the monitoring team, allowing action to be taken for immediate improvement. Since June 2019, 32 pathology care pathways have been developed.

Case Study: "...this is an excellent program and I can't imagine clinical care without it..."

"My experience so far has been very good. I find that this is an excellent program and I can't imagine clinical care without it, as a new patient of a pathology like this cancer, where everything is an alien world with procedures, codes and terms that one does not know, with a long and agonizing treatment that includes bad news, everything seems chaotic. One finds a window through the support of the nurses, creating a link to doctors and helping with solutions to small problems that one encounters throughout."

Ingrid
Service Line Patient with Breast Cancer

Table 1: Number of surveyed patients.

Patients called	297
Patients that answered survey	191 (64%)
Patients with previous experience with Dávila	58 (30%)

Table 2: Net Promoter Score (NPS): Patients with previous experience.

User satisfaction hospitalization — service line experience	74.1%
User satisfaction hospitalization — no service line experience	48.2%
User satisfaction — nurse navigator	87.9%

Table 3: Number of surveyed Service Line doctors.

Surveyed doctors	116
Doctors that answered survey	81 (69.8%)

Table 4: Net Promoter Score (NPS): Service Line doctors.

Medical satisfaction regarding the implementation of Service Line in Clínica Dávila	55.5%

Each patient receives education related to their pathology, allowing them to have the tools to make decisions and act with more certainty. This education also contributes to the health of the patient and their family, improving satisfaction regarding the quality of health care and the patient experience.

A telephone survey was conducted to evaluate the experience of using these pathways in two specialties; neurosurgery and breast cancer surgery.

Results

Out of the total number of patients called, 64% answered the phone survey (191). Only 30% (58) of these patients had previous hospital experience in Clínica Dávila. Of the latter group, the highest Net Promoter Score (NPS) identified was 74%, as compared with an average NPS of 48% prior to these improvements. (Table 2). Physician NPS related to satisfaction with service implementation was 56% (Table 4).

Qualitative analysis of survey results shows that the nurse navigator is a key driver of patient satisfaction (Table 2). Survey respondents indicated the nurse navigator's presence gives patients a sense of security and improves patient perception of quality of care. They also facilitate seamless flow of care and help solve clinical and administrative concerns, which then enable the attending physician to focus on specific requests and demands.

[1]Wolf JS Jr, Hubbard H, Faraday MM, Forrest JB. Clinical practice guidelines to inform evidence-based clinical practice. World J Urol. 2011;29(3):303-309. doi:10.1007/s00345-011-0656-5.

[2]Becker M, Breuing J, Nothacker M, et al. Guideline-based quality indicators-a systematic comparison of German and international clinical practice guidelines [published correction appears in Implement Sci. 2020 May 20;15(1):36]. Implement Sci. 2019;14(1):71. Published 2019 Jul 9. doi:10.1186/s13012-019-0918-y.

[3]Industry-Leading Evidence-Based Care Guidelines. MCG Care Guidelines. https://www.mcg.com/care-guidelines/. Retrieved May 24th, 2020.

Authors

Carolina Asenjo, M.D, Clínica Dávila, Chile
carolina.asenjo@davila.cl

Marcelo Parra, M.D., Clínica Dávila, Chile

Marcela Amar, M.D., Clínica Dávila, Chile

Cherie Gutiérrez, M.D., Clínica Dávila, Chile

Denisse Gómez, RN, Clínica Dávila, Chile

Camila Carrasco, RN, Clínica Dávila, Chile

Carolina Risso, RN, Clínica Dávila, Chile

Figure 1. Most valued aspect of the hospital experience.

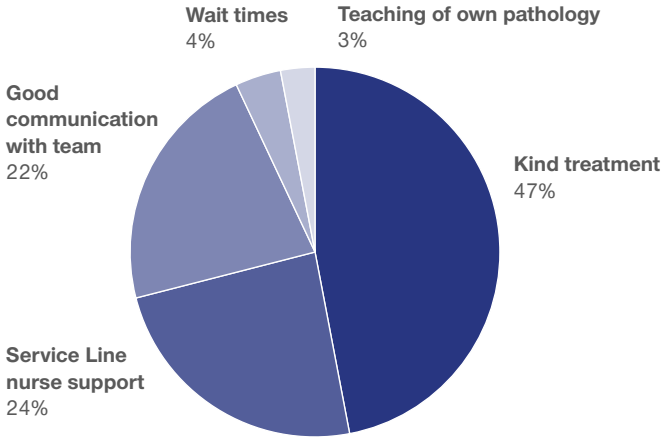
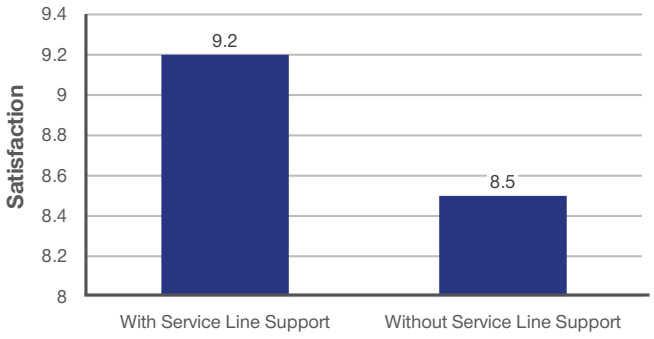


Figure 2. Hospital experience comparison with support from the Service Line clinical team and previous experiences without the Service Line clinical team support.



Implementation of the World Health Organization's *Core Components of Prioritization* to Improve Practices in the Prevention of Central Line-Associated Bloodstream Infections in Americas Serviços Médicos Hospitals, Brazil

Introduction

Central line-associated bloodstream infections (CLABSI) can present a major threat to patient safety. They are associated with higher mortality rates and higher costs, profoundly impacting the patient experience.[1] Data from an International Nosocomial Infection Control Consortium cohort study that included 43 developing countries showed a mortality rate of 17% among patients with CLABSI.[2] In Brazil, a *Brazilian Surveillance and Control of Pathogens of Epidemiological Importance* study found a 40% mortality rate among patients with CLABSI.[3]

In 2016, in an attempt to support countries and health care facilities in developing and strengthening infection prevention and control programs (IPCs) and antimicrobial resistance action plans and practices, the World Health Organization published guidelines on core components of IPCs at the national and acute health care facility level. We aimed to investigate the effect of implementation of the guidelines' core components of prioritization on CLABSI prevention.

The Problem

CLABSI is a preventable health care-associated infection. The strategies used to prevent CLABSI varied widely between hospitals and regions. Ensuring location-specific best practices for health care-associated infection prevention and accounting for changes of culture among health care workers was a challenging mission.

Program Strategy

In the third quarter of 2018, the CLABSI rate within Americas Serviços Médicos was 2%. To reduce this rate, we implemented the World Health Organization's *Core Components of Prioritization* (CCP) as a guide and framework for CLABSI-reduction strategies in Americas Serviços Médicos hospitals.

The World Health Organization's steps to infection prevention control and improvement include:

- Preparing for action
- Baseline assessment
- Developing and executing an action plan
- Assessing impact
- Sustaining the program over the long-term

This framework was applied in 17 hospitals over the course of 16 months (September 2018 to December 2019). Specific CLABSI-reduction strategies implemented were:

1. Technology implementation to support closed systems (wound dressing systems, prefilled flushing syringes).
2. Education for frontline health care workers.
3. Audit, monitoring and feedback: specific audit process bundle related to central line maintenance (catheter in use and necessary, sterile and intact dressing, insertion visualization, inflammatory signs, needleless connector, lines without blood residue).
4. Positive reinforcement and leadership engagement

From September 2018 to April 2019, baseline audits were performed by the hospital infection control teams (ICTs) in conjunction with the corporate infection control team (CICT). Local ICTs were also engaged in follow-up audits and provided systematic feedback over subsequent months. Involvement of local ICTs helped strengthen and reinforce CLABSI-reduction strategies.

Results

Our results showed an overall 40% decrease in CLABSI incidence. In the third quarter of 2019, we reached a CLABSI rate of 1.2%. Audits conducted by the local ICTs showed that this improvement was sustained over the following 12 months. (Figure 1).

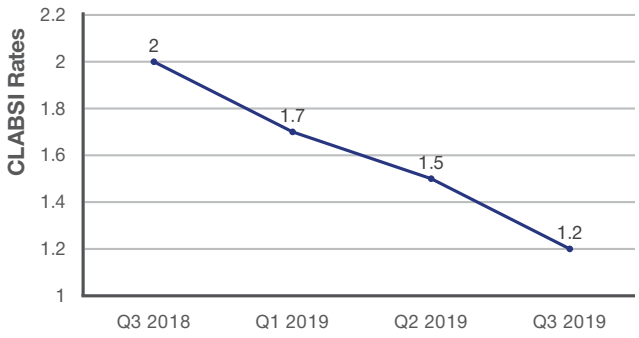
Lessons Learned

A single and static CLABSI prevention strategy cannot be viewed as the sole contributor to reducing infections because the development of a central line associated blood stream infection can usually be attributed to multiple factors. In our experience, implementing a systematic audit process and analyzing continuous feedback drove a significant reduction in our hospital's CLABSI rates. By including frontline health care workers in the audit process, we reinforced a culture change around audits, accountability and feedback that contributed to CLABSI prevention. Finally, the routine dissemination of consolidated process and outcome measures directly influenced and informed quality improvement initiatives.

These strategies improved outcomes and prevented unnecessary treatment, and therefore had a positive impact on the patient experience. According to the Institute for Healthcare Improvement, improving the patient experience requires more than utilizing data strategically because patient experience is often viewed through the eyes of providers rather than patients. Thus, it is important to understand what matters to patients. The infection prevention practices need to ensure greater process safety and positively impact the quality of care and patient experience.

International data reveals that health care-associated infections are the most frequent adverse event in the world. There is also some evidence that illustrates the varied impact of health care-associated infections on the patient's experience and that of their families.[4] One systematic review showed that all forms of health care-associated infections can lead to adverse consequences on patients' social lives and relationships. In these studies, some patients reported expressing guilt, anxiety and fear about possible transmission of health care-associated infections. In many cases, this fear had a significant impact on the patient's daily life, on their relationships with the family and on implications for future work and finances.[5] In addition, it is important to consider that patients do not expect adverse events during hospitalization, but primarily focus on achieving the expected outcome of safely recovering in the hospital.

Figure 1. CLABSI rates in Americas Serviços Médicos hospitals, by quarter.



Conclusion

Implementation of the *World Health Organization's Core Components of Prioritization,* in conjunction with additional strategies driven by local hospital system experience, are effective in improving infection prevention in countries with limited resources. Local hospital engagement and a robust accountability process increase the likelihood of successful CLABSI reduction. Finally, in order to ensure better experiences for our patients — with fewer serious adverse events such as CLABSI and other health care-associated infections — it is recommended to continuously seek to improve care processes in pursuit of the culture of zero damage.

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Authors

Lais Perazo Nunes de Carvalho, M.D.; MBA, Americas Serviços Médicos; lperazo@americasmed.com.br

Daiane Patrícia Cais, MSN, Americas Serviços Médicos

Lígia Maria Abraão, PhD, Americas Serviços Médicos

Sarita Scorzoni Lessa Pires, RN, Americas Serviços Médicos

Fernando Colombari, M.D., Americas Serviços Médicos

Implementation of Ambulatory Infusion Center at Clínica Dávila, Santiago, Chile

Introduction

Clínica Dávila in Santiago, Chile, provides care for many patients with chronic inflammatory diseases (Figure 1). These patients are frequently treated with biological drugs. Since these drugs can have major side effects, patients receiving biological infusion therapy must be monitored closely. Prior to this project, Clínica Dávila admitted patients for biologic infusion therapy and did not have experience with other levels of care to treat these patients.

Many specialties are involved in the treatment of these patients, including, but not limited to: rheumatology, gastroenterology, neurology, immunology and respiratory specialists. With infusions taking up to two days to complete, each treatment meant that patients would spend a great amount of time in the hospital. These inpatient treatments not only affect and interrupt patients' daily lives; they also expose the patient to possible negative consequences of inpatient hospitalization, such as hospital-acquired infections, adverse events, and large expenses. The inconvenience is especially hard for pediatric patients and their families.

To provide our patients with better care and service, we designed a new ambulatory infusion center as an alternative outpatient level of care. We expected a higher level of patient satisfaction and reduced cost of the treatment. Our reporting covers the period from July to December 2019.

Objectives

- Implement a new level of care
- Improve the patient experience
- Modify the current clinical practice of physicians
- Reduce spending on treatments
- Obtain coverage from the insurance system for ambulatory infusion care

The Ambulatory Infusion Center (AIC)

A new area consisting of eight units was designated for the AIC in the outpatient section of the hospital. The area was approved by the Ministry of Health and the following actions were completed:

- Specialty physician teams developed protocols of treatment for each drug.
- A new administrative pathway was designed with a specific admission unit.
- Physicians, nurses and assistants were trained in the protocols of drugs infusion and patient care during the infusion of biological drugs.
- A new agreement was created with the insurance company for the coverage of the treatment in a bundled payment system.
- Patients were informed by their physician that the ambulatory infusion level of care was available to them for infusions of biological drugs.

Relevant Indicators: The new level of care (AIC) was evaluated using several indicators and compared to the previously used level of care (Inpatient) as shown in Figure 2.

Results for Patient Experience: An email survey was conducted of patients treated in the new AIC. Results are shown in Figures 3 and 4.

Results for Physicians' Experience: See Figure 5.

Conclusions

Insurance companies developed a new system for coverage that allowed us to implement a new level of care. This was a key factor allowing us to offer patients this new level of care.

Physicians accepted the new level of care. Their participation in designing clinical protocols helped them understand the benefits for the patients. The main concern of physicians was the safety of patients in this new setting. Their physician NPS for ambulatory infusion was 85.7% and all of them now prefer to treat patients in the ambulatory setting.

We improved efficiency in the inpatient setting and decreased total cost of care because lab and imaging exams were done less frequently when biologic infusion therapy was administered in the ambulatory setting.

Educating patients was easier than expected, with physicians agreeing to promote the new level of treatment. Patients had interviews and phone calls with the nurse center to coordinate the best schedule for each one of them, and later they had the opportunity to ask questions about their own treatments.

Figure 1. Description of patients.

Gender	
Female	28
Male	26

Age	
Range	13-72
Mean	38.6
13-20	3
20-30	12
30-40	17
40-50	12
50-60	5
60-70	4
>70	1

Diagnosis	
Multiple Sclerosis	18
Ankylosing Spondylitis	12
Rheumatoid Arthritis	9
Ulcerative Colitis	5
Chron's Disease	4
Wegener Granulomatosis	3
Lupus	2
Other	2
Total	**54**

Patients have reported 10% higher satisfaction with the ambulatory level of care (NPS 64%) over the previous inpatient care (NPS 54%), as shown in Figure 2. They appreciate the lessened impact on their daily activities compared with inpatient care. They also approved of the nursing care, the ease of admission to this new facility and the decrease in time required in the hospital (a time savings of 84%). The lower cost of the new system is also appreciated by the patients. Particularly for younger chronic patients, ambulatory care was a significant improvement in their management, experience and lives.

Click here for a personal experience of one patient from the new Clínica Dávila AIC.

Authors

Carolina Asenjo, M.D., Clinica Dávila, Colombia
carolina.asenjo@davila.cl

Cherie Gutierrez, M.D., Clínica Dávila, Chile

Max Ventura, M.D., Clínica Dávila, Chile

Natalia Jorquera, RN, Clínica Dávila, Chile

María Eugenia Salazar, RN, Clínica Dávila, Chile

Figure 2. Comparison of Inpatient vs. AIC Results

	Inpatient July-Dec 2018	AIC July-Dec 2018	2019 (16-mo. period)	% change
Hours per event	26.7	4.9		-82%
NPS patient	54%*	64%**		
Number of patients in treatment	17	54		
Number of events	122	121		
Number of events per patient	7.1	2.2		
Lab exams per event	5.4	1.8		-66.6%
Medical fee per event	1.5	1		-33%
Total expenditure per event***	US $2,863	US $1,890		US -$973

**Q1-Q2 2019 **Q3-Q4 2019 ***US $ dollar = 803 CLP 02/13/2020*

Figure 3. Survey results.

Global NPS Q3-Q4 2019	64%
Satisfaction with facility (1-5)	4.3
Satisfaction with nursing (1-5)	4.8
Satisfaction with physician (1-5)	4.7
Based on previous experiences, how do you prefer being treated? (Inpatient/Outpatient)	85.7% preferred outpatient facility (Ambulatory Infusion Center)
28 of the 54 patients responded	51.8% survey response rate

Figure 4. Patient survey results: most-valued attributes.

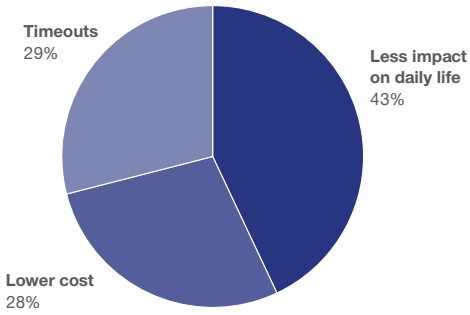

Figure 5. Physician survey results.

NPS Ambulatory Infusion Center	
NPS	85.7%

Physician Preference between Inpatient and Outpatient	
Outpatient (Ambulatory Infusion Center)	100%
Inpatient	0%

UnitedHealth Group Culture in Action: ComPaixão Program – Operationalizing Compassion to Improve the Patient Experience

The Problem: Patients and families often report psychological and spiritual challenges in response to serious illness. These challenges are often overlooked as part of the overall care management plan when patients are admitted to the hospital. The Americas Serviços Médicos clinical team sought to enhance the experience of inpatients and long-stay patients by developing a program that would provide psychological, emotional and spiritual support for patients and families.

The Program: The central concept of the ComPaixão Program — ComPaixão for "compassion" in Portuguese — is to 'listen to our patients, do what matters to them and understand their unique challenges and desires.' This concept is directly linked to our UnitedHealth Group culture value of compassion. Our ComPaixão teams are tasked with practicing active listening, genuinely making our patients feel appreciated and respected and improving their overall experience in hospital. The result is a pleasant, compassionate and empathetic journey through the care delivery system for our patients and their families. This program also seeks to facilitate improved clinical outcomes and increase engagement of our care delivery teams in patient care.

*Every ComPaixão team member **strives to accomplish what matters most to our patients** by doing everything possible to fulfill their wishes.*

Every ComPaixão team member strives to accomplish what matters most to our patients by doing everything possible to fulfill their wishes. In our experience many patients have desires unrelated to their clinical care while in hospital, many of which are relatively easy to fulfill. The ComPaixão program encourages patients to express such desires and works with other stakeholders to respond. Examples of compassionate responses, based on expressed patient desires, include a well-prepared breakfast, a brief stroll under the sun, or even meeting celebrity idols (usually requested by pediatric patients).

Our patients' wishes are fulfilled by the program throughout the year. Semi-annually, we recognize the hospitals that took action in three different categories: (1) Best compassionate response; (2) Best video; and (3) Most compassionate responses. During 2019, the program was responsible for 446 compassionate responses in 21 different Americas Serviços Médicos hospitals. The most recent winners of each award were: (1) Best compassionate response – Hospital Vitória Anália Franco (São Paulo); (2) Best Video – Hospital Samaritano – Higienópolis (São Paulo); and (3) Most compassionate responses – Hospital e Maternidade Madre Theodora (Campinas).

ComPaixão Program Impact:

MC's Story: MC, an 82-year-old woman who lived alone, was hospitalized at Hospital Vitória Anália Franco after a stroke. She was not married and had no children or close relatives. MC had co-existing depression and impaired mobility, rendering her bed-bound; she had voiced a desire to die.

The ComPaixão team had noted in their care of MC that she felt isolated because she had no family. The team arranged for her to be served a special afternoon tea with her favorite snacks and beverages. This was served in an outdoor location on the hospital grounds. MC stated that she appreciated breathing the fresh air for the first time since her illness. MC then invited a physician to join her in singing a duet. Hospital physicians, nurses and other members of the care delivery team stopped to listen and stated that her joy and energy were motivating and inspiring.

Three months after admission, MC had demonstrated significant response to treatment and rehabilitative therapy. She was no longer depressed and was able to stand for the first time after being admitted.

JP's Story: At Hospital Samaritano Higienópolis, JP, an 11-year-old patient, was admitted to the hospital with rhabdomyosarcoma. She informed the ComPaixão team that she had often dreamed of meeting her favorite actress. The team arranged for the child to be taken to the television studio to meet with the actress in person. The actress gave her a tour of the television show's set and spent a considerable amount of time engaging with JP.

JP and her parents were thrilled and very appreciative of the experience. JP's father sent a handwritten message, thanking the team for the experience. The message read: "The team's beautiful work made this treatment easier to bear."

Conclusion: The ComPaixão Program has been well received by patients and providers alike. At Americas Serviços Médicos we are working to scale this program across the care delivery system. We are also exploring the definition of objective measures of success to support quantification of the value created by this program.

Team: Lais Perazo, M.D., MBA, Americas Serviços Mèdicos, lperazo@americasmed.com.br;
Rita Grotto, Americas Serviços Médicos

Patient-Centered, Multidisciplinary Bariatric Unit at Hospital Lusíadas Porto – Five-Year Experience

Introduction: Obesity is a rising global epidemic and is the fastest growing health problem in many developed countries, often leading to significant disability or death.[1,2] Bariatric surgery remains one of the most effective treatments for long-term weight loss and the improvement of associated comorbidities.[3] Additionally, multidisciplinary bariatric units can help create valid, patient-focused clinical pathways for patient evaluation, treatment and long-term follow-up, improving clinical results and patient outcomes.[4]

In 2015, Hospital Lusíadas Porto, part of Lusíadas Saúde in Portugal, implemented a patient-centered multidisciplinary bariatric unit to improve the management of obesity. We share our experience over the past five years in this article.

The Challenge: The challenge was to build a multi-specialty, collaborative and integrated patient-centered model leveraging evidence-based clinical pathways to facilitate comprehensive management of patients with obesity. The defined goals were to improve patient outcomes, achieve higher compliance with pre- and post-operative protocols, decrease length of hospital stay and decrease post-operative morbidity.

We successfully implemented an evidence-based model that aligned with international guidelines and provided a safe environment for the management of both local and international patients. A special focus was dedicated to improving patient experience, ensuring patient empowerment and supporting long-term compliance with follow-up visits.

Standardized processes and procedures were developed to help reduce variation and improve care coordination along care pathways. These processes spanned multiple specialties and all clinical areas, including the outpatient clinics, operating rooms and inpatient units.

The Patient-Centered, Multidisciplinary Bariatric Unit: The bariatric unit at Hospital Lusíadas Porto is multidisciplinary, integrating all specialties relevant to the management of obese patients. These specialties include bariatric surgery, endocrinology, nutrition, psychology, psychiatry, gastroenterology and plastic surgery, among others.

The unit has a patient navigator — a staff member who coordinates patient care and follows patients along every step of the clinical pathway. The navigator has a unique perspective due to their own personal experience of being successfully treated as a bariatric patient at Hospital Lusíadas Porto. As a result, they can relate to the patients' perspectives, easily explain the entire process of care and assist with any questions or concerns.

All patients referred to the unit are initially evaluated by specialists in the core care areas — bariatric surgery, endocrinology, nutrition and psychology. Each patient's clinical pathway is personalized and referrals are made to appropriate specialties as needed.

The average lead time between first consultation, evaluation and approval for treatment by all specialties is 30 days. After a favorable opinion by each of the core specialties, the bariatric surgeon discusses the recommended surgical procedure with the patient, outlining benefits, risks and any other specifics or concerns at this point. After surgery, the patient is required to return for follow-up visits with the multidisciplinary team over a period of at least three years.

Results: Before implementing this unit, bariatric patients were not as likely to receive the benefits of a high-quality, coordinated, multidisciplinary care evaluation. The referral of obese patients to the hospital was low and the experience of these patients was not specifically addressed.

Multidisciplinary teams, standardized procedures and a more humanized level of care brought sustainable, integrated and comorbidity-conscious perspectives. This improved patient compliance with follow-up protocols and translated into improved outcomes. In 2019, we were able to achieve a 97% rate of compliance with pre-operative protocols.

Our care process involves personalized management of each patient's needs and expectations during the entire clinical pathway, from the first outpatient consultation to the long-term follow-up visits. The care process includes a personal escort who guides patients to and from the operating room. Patients reported that this decreased their anxiety and improved patient empowerment. These patient experience improvements are all critical to future compliance and long-term clinical outcomes.

The annual number of bariatric patients surgically treated at Hospital Lusíadas Porto has risen. We now perform more than 100 bariatric procedures per year, with an average of 20% revisional surgery. We were able to decrease our average hospital stay from four days to two days. Our global complication rate is less than 3% and we have no mortality registered to this date. Our volume, safety data and clinical outcomes are in line with the best bariatric centers in the world. The number of new outpatient consultations per year is more than 300, with a rise in patient referrals from abroad.

Lessons Learned: A patient-centered care model attracts new patients due to the favorable patient experience and long-term quality of care. The number of patients treated in our unit has been steadily growing since implementation of our care model in 2015.

An important success factor is appropriate patient selection for bariatric surgery. Patient selection was based on standard evidence-based guidelines (BMI ≥ 40 or BMI ≥ 35 with the presence of at least one obesity-related comorbidity). In our experience, the average pre-operative BMI was 41.1 kgs/m2.

Standardized protocols, personalized patient management, appropriate specialty consultation and evidence-based clinical pathways are critical to optimizing care coordination, reducing surgical lead time and improving clinical outcomes. In our experience, establishing a post-surgery follow-up protocol covering at least three years enhanced patient compliance with outpatient care plans and improved long-term clinical outcomes. Our patient compliance with their follow-up protocol at three years is 80%.

Safe and specialized surgery is critical to success, but so is structuring a collaborative and empowered partnership with our patients, from diagnosis to discharge. This builds understanding, trust and self-esteem. All of these are crucial to the transformation of beliefs and behaviors necessary to sustain long-term favorable outcomes. Multidisciplinary contributions with a coordinated, patient-centered and personalized approach facilitate these achievements.

The Human Touch: Employing one of our former patients as a patient navigator was a critical factor in improving patient-centered management and experience. This patient navigator helps comfort bariatric patients by sharing their first-hand experience and walking with them through all medical and surgical details. This provides a human touch.

Our patients understand they will have the opportunity for a new life after surgery, and they will not have to face the post-operation challenges alone. They know there is always support available from those who successfully lived through the same experience. This network helps patients achieve their goals and have confidence that "We can make it work, together!"

Team: John Rodrigues Preto, MD, Hospital Lusíadas Porto, john.rodrigues.preto@lusiadas.pt;
Filipe Basto, MD, FACP, Hospital Lusíadas Porto

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How to Deliver Bad News in Health Care: Training as a Risk Management Tool

The Problem: Communicating bad news and difficult situations in health care (adverse events, complications, or clinical outcome uncertainty) can be challenging for physicians and health care professionals. Many health care providers do not receive training specifically tailored to the communication of such events. Subsequently, these situations may adversely impact patient care and caregiver wellbeing, as well as increase legal risks. This may have a detrimental impact on care outcomes, organizational reputation and business growth.[1]

The Program: In 2019, Clínica San Felipe, in Lima, Peru, introduced a program to provide health care professionals with effective communication skills and tools necessary to deliver news of difficult events and show participants the impact of these training methodologies on provider behavior and communication. The program comprised 12 sessions (one per month), which sought to teach participants specific communication strategies and tactics to enhance their communication effectiveness. These tactics were implemented in simulated scenarios to help participants practice the correct methods to deliver sensitive or difficult news. Topics covered included: (1) Situations related to patient safety, (2) Review of the most common communication errors and (3) Review of cases that should be reported as adverse events or sentinel events.

Results: Positive results were realized in two areas: First, health care professionals reported increased confidence in communicating unpleasant news; second, following training and implementation of the learned skills in real life settings, physicians and health care professionals saw a decrease in social media and potential legal risk attributed to communication errors. Seventy percent of physicians, after taking the program, felt they had improved their communication skills in delivering bad news in difficult situations. All participants recognized that the tools and tactics they learned helped them confront difficult situations with patients with more confidence and ease.

Several lessons were learned after the first year of this program:

- Physicians should deliver news of difficult events in pairs to benefit from emotional and psychological support of a team member during communication. Having someone else to help walk the patient through the emotional impact of receiving bad news is reassuring to the physician and may lead to a better outcome of the discussion.
- Communication tactics and tools are necessary not only to prevent risk, but also to provide confidence to health care professionals.
- Training in simulated environments can help health care professionals develop high-quality communications skills.

Clínica San Felipe will continue this program in 2020 with 22 sessions. The topics covered will be related to diverse medical specialties. The program will be expanded to other medical establishments including Clínica SANNA El Golf.

Team: Marcela Argumedo Estay, M.D., Clínica San Felipe, Peru, margumedo@clinicasanfelipe.com; Paula Ponce de León Lovatón, M.D., MBA, HCQM, Clínica San Felipe, Peru; Ernesto Aspíllaga Morey, M.D.,MBA, Msc, HCQM, CPE, Clínica San Felipe, Peru

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Clinical Peer Reviews: The Opportunity for Continuous Improvement

The Problem: Clinical peer review provides the opportunity for a provider's peer group to evaluate perceived gaps in clinical management of a case and identify potential opportunities for process or care improvement.[1] Identifying or blaming health care providers can inhibit a macroscopic and systemic view of the problem and related root causes. Therefore, being open to reporting and finding sources of reduced quality – without blame – is necessary to making improvements. Improvement efforts are especially effective if solutions are generated by the personnel involved in the process based on their personal experience and institutional practice.[2]

The Program: In 2019, 10 cases were subjected to clinical peer review by eight doctors. Six cases were medical and four cases were surgical. Review of the cases resulted in 69 proposed improvements, 28 of which have already been implemented and 38 of which are in progress.

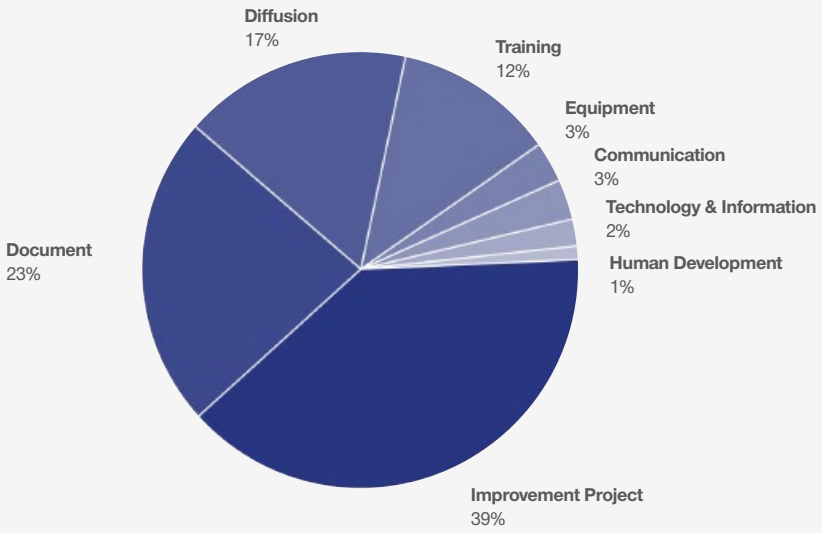
Of the 69 proposed improvements, 26 evolved into full-scale improvement projects because they were more complex and identified improvement opportunities across multiple areas and/or services. Processes targeted for improvement included direct care and administrative processes, both of which have an indirect impact on health care.

Results: The major projects implemented were: The "Bad News" Communication workshop, Chronic Diseases with At-Home Medication, and the "Surgical Passport," which is a route tracker for patients during surgical preparation to be implemented this year.

In conclusion, involving physicians in non-punitive case analysis allows for a highly effective institutional growth experience thereby providing safer, enhanced care for all patients.

Team: Marcela Argumedo Estay, M.D., Clínica San Felipe, Peru, margumedo@clinicasanfelipe.com; Paula Ponce de León Lovatón, M.D., MBA, HCQM, Clínica San Felipe, Peru

Figure 1: Intervention Projects.



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Patient Experience in a New Model of Integrated Care at the Cancer Center – Clínica Dávila, Santiago, Chile

The Program: New evidence-based integrated care models for pediatric and adult cancer patients were implemented in August 2019 in new facilities at Clínica Dávila in Santiago, Chile. An improvement in the patient experience was expected as we moved from being a basic chemotherapy infusion unit to a center for integrated hospital-based and ambulatory care center for oncology patients and their families.

The integrated oncology center is an umbrella facility where all the patient's needs are met, from consultation to chemotherapy. It is staffed by multidisciplinary professionals and a medical team that includes hematologists, oncologists, and bone marrow transplant specialists. This integrated care model of team-based medicine that is centered around patient needs creates a more supportive environment for patients and facilitates personalized care that enhances the patient experience. The care model, built on evidence-based clinical protocols, also supports comprehensive and holistic patient education and counseling.

Challenges Addressed:

- Meet high-quality care standards
- Improve patient experience
- Open new facilities
- Implement an integrated care model to support continuity of care, enhance access and improve outcomes
- Increase capacity to meet the growing patient demand for oncology services

Outcomes: Patient Experience: An email patient survey was conducted between August and December 2019 after implementation of the integrated care model:

- Net Promoter Score (NPS): 94%
- General Satisfaction (1 to 5): 4.8
- 100% of the patients rate the new facility and care model higher than the old model
- Patients volunteered opinions on the best attributes of the experience: warm and humane treatment, empathy, trained staff, environment and new facilities.
- Hear Personal Experience Narrative 1 and 2 and see an overview of the integrated care center.

Lessons Learned: We have learned that our integrated interdisciplinary care model has a positive impact on our NPS and overall patient satisfaction. We have also learned that patients value the opportunity for family members to stay with them during care. Additionally, a comfortable and private environment has a positive impact on patients' moods and experiences.

Team: Carolina Asenjo, M.D., Clínica Dávila, Chile, carolina.asenjo@davila.cl; Pablo Ramírez, M.D., Clínica Dávila; Manuel Yáñez, M.D., Clínica Dávila; José Santander, M.D., Clínica Dávila; Bernardita Alvarado, M.D., Clínica Dávila; Cherie Gutiérrez, M.D., Clínica Dávila; Jacqueline Quezada, RN, Clínica Dávila; Carolina Cabrera, RN, Clínica Dávila; Isabel Fernández, Clínica Dávila

Select Recent Publications

The following articles are recommended for enhancing knowledge related to patient experience and COVID-19.

"Anticoagulation Therapy in Patients with Non-valvular Atrial Fibrillation in a Private Setting in Brazil: A Real-World Study." Silva, P., Sznejder, H., Vasconcellos, R., Charles, G. M., Mendonca-Filho, H., Mardekian, J., Nascimento, R., Dukacz, S., & Fusco, M. D., Arquivos Brasileiros de Cardiologia, 2020 Feb 7.

"Baseline characteristics and risk profiles of participants in the ISCHEMIA randomized clinical trial." Hochman, J. S., Reynolds, H. R., Bangalore, S., O'Brien, S. M., Alexander, K. P., Senior, R., ... & Lopez-Sendon, J., JAMA cardiology, 2019 Feb 27.

"High-performance medicine: the convergence of human and artificial intelligence." Topol, E. J., Nature medicine, 2019 Jan 7.

"At the epicenter of the COVID-19 pandemic and humanitarian crises in Italy: changing perspectives on preparation and mitigation." Nacoti, M., Ciocca, A., Giupponi, A., Brambillasca, P., Lussana, F., Pisano, M., ... & Longhi, L., NEJM Catalyst Innovations in Care Delivery, 2020 March 21.

"COVID-19: protecting health-care workers." Lancet, T., Lancet, 2020 March 19.

"How will country-based mitigation measures influence the course of the COVID-19 epidemic?" Anderson, R. M., Heesterbeek, H., Klinkenberg, D., & Hollingsworth, T. D., The Lancet, 2020 March 9.

"Critical care management of adults with community-acquired severe respiratory viral infection." Arabi, Y. M., Fowler, R., & Hayden, F. G., Intensive care medicine, 2020 Feb 10.

"Coronavirus disease 2019 (COVID-19): protecting hospitals from the invisible." Klompas, M., Annals of Internal Medicine, 2020 May 5.

"Fair allocation of scarce medical resources in the time of COVID-19." Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., ... & Phillips, J. P., NEJM, 2020 March 23.

These publications are listed in the original published language to allow for online search.

Educational Opportunities & Clinician Resources

Ignite Site

Visit **uhc.care/globalCOVID** for important updates, clinical resources and COVID-19 information created specifically for UnitedHealthcare Global clinicians.

Estamos Juntos LinkedIn Group

Estamos Juntos is a simple reminder that although miles, oceans and languages may separate us, we stand together as one team in the fight against COVID-19. Visit **uhc.care/together** to join the Estamos Juntos LinkedIn Group and connect with fellow UnitedHealthcare Global clinicians.

OptumHealth Education

OptumHealth Education (OHE), a UnitedHealth Group company, offers free web-based, accredited medical education. OHE is one of the few jointly accredited organizations in the world, having been simultaneously accredited to provide continuing education activities in the following areas: medical, nursing, pharmacy, psychology and social work.

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