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Cover Page Footnote

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An evaluation of the effectiveness of a unique patient experience response program that provided virtual, visual and emotional connectivity to patients and families during the COVID-19 crisis

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Abstract

In April 2020, the New York State Department of Health issued guidelines regarding suspension of hospital visitation due to coronavirus disease 2019 to protect staff and patients and prevent spread of the virus. Recognizing that patients would need extraordinary emotional support as they faced this frightening journey, two hospitals from a health system in the national epicenter provided avenues to bridge gaps in connectedness and communication. Our program provided virtual, visual and emotional connectivity by utilizing repurposed staff to serve as *patient experience ambassadors*. This program reduced the burden on clinical staff while preventing furlough. A descriptive correlational study was conducted that measured satisfaction of the program and connection provided. Subjects recruited for the study included patients and family members who used virtual platforms. Variables were measured using a Likert – type scale ranging from excellent to poor. Relationships between the variables were examined. This study revealed that participants were satisfied that the program improved connectedness; provided an adequate alternative to limited hospital visitation; provided emotional support and peace and closure in end-of-life situations. Respondents were satisfied with the patient experience ambassadors and would recommend the program. The overall rating was “good” (Mean = 3.267 SD 0.1039 Range 3.12 – 3.37) indicating a moderate to high degree of satisfaction. There were statistically significant differences in responses for connectedness, adequate alternative and rating in end-of-life visits versus others. There were no significant differences by hospital. The virtual communication platforms were successful in providing emotional support and bridging the gap in communication between patients and their loved ones.

Keywords

Virtual visits during covid-19, patient experience, patient & family partnership, perceptions, person-centeredness, COVID-19, culture

Introduction

The COVID-19 pandemic and nation-wide modified hospital visitation policy put restrictions on the way patients and families maintain social connection. As a result, both patients and families were looking for avenues to bridge gaps in connectedness and communication. Much of COVID-19 is about symptom control for all patients, supporting families in crises, decision support in the face of uncertainty and providing psychosocial and spiritual support.¹ Due to the surge of COVID-19 cases, optimizing patient-family connection and end-of-life provisions beyond uniform specialist service was necessary.

As the COVID-19 patient population filled hospitals beyond capacity, hospitals nation-wide experienced drastic reorganization, mass furloughs and layoffs. Our *Connect* program evolved out of the necessity to support overwhelmed frontline healthcare clinicians to provide an elevated degree of emotional support, compassion and

connectivity to isolation patients in medical solitary confinement leaving families feeling scared, anxious and helpless. During this time of social distancing and uncertainty, every connected moment between patients and families became crucial to the patient experience.

The virtual visits comprised of social interactions and did not include symptom management and/or clinical conversations. The purpose of this study is to evaluate the effectiveness of the *Connect* program that provided families, caregivers and significant others the opportunity to virtually visit and maintain connection with patients hospitalized during the first wave of the COVID-19 pandemic.

Program Development

The Joint Commission’s change management methodology, Robust Process Improvement (RPI), was used to successfully implement this program.² The steps that are included in RPI are defining the change, assemble

the strategy, assess the culture, engage the right people, solicit support and involvement, make it personal, align operations and infrastructure and monitoring progress.

A strategy was assembled to utilize identified repurposed staff that could serve as patient experience ambassadors preventing furlough and granting continuity of full-time employment status during the pandemic. The Director of Patient Experience engaged key stakeholders to make a plan that was approved by the executive leadership team at both facilities. This solicited support and involvement from the care team who related to the mission of the program: to provide hope, connection and resilience to our patients and the community we serve during a time of social distancing and uncertainty.

A resource analysis was conducted to assess the need at each site. It was determined that iPad equipment with a functioning camera, microphone and video-chat application was necessary. Eight iPads in total were secured for this operation; four were allocated to each site. Once the devices were secured, employees were identified that were willing to be repurposed as *patient experience ambassadors*. A job description was created that outlined mandatory criteria for this position. This included full-time employment status and having clinical and customer service experience. The program targeted the COVID-19 positive and patient under investigation population. Therefore, it was mandatory that the potential candidates be comfortable with isolation precautions, infection control protocols and emotionally challenging situations. These employees needed to be flexible to work various shifts and collaborate with numerous members of the care team. The *patient experience ambassadors* were selected from outpatient and elective care service lines because of their prior experience with infection control policy and standards. Identified staff included dental assistants, medical assistants, licensed practical nurses, physical therapists, physical therapy assistants, practice support associates, an endoscopy representative and echo technologists.

The Director of Patient Experience oversaw day-to-day operations of the program in collaboration with the patient advocates at each respective site. Across the two community hospitals that are of similar size, between 243-296 beds, there were twenty-four employees that served as *patient experience ambassadors*. All *patient experience ambassadors* used iPads with FaceTime & Zoom to facilitate the virtual visits. The programs were identical except that one hospital offered service five days a week and the other provided service seven days a week.

There was a two-day orientation process that included an in-depth overview of personal protective equipment (PPE), scripting and iPad training, documentation, hands-on shadowing and training. Personal protective equipment

training included a donning and doffing and N95 fit testing that was provided by nursing education and employee health. The Director of Patient Experience provided special scripting that promotes connection and support. The *patient experience ambassadors* regularly used active listening, conversation engagement and empathy. iPad and application training included how to operate an iPad and navigate through the video conferencing applications, FaceTime and Zoom. The *patient experience ambassadors* shadowed the process to witness application of the concepts discussed.

To facilitate a virtual visit, the patient advocate and *patient experience ambassadors* identified potential candidates that would benefit from the service through a structured employee referral process where frontline employees such as physicians, nurses, case managers, social workers, etc. would refer the patient and/or family to the patient experience ambassador team. The program established a direct family request line where employees and families could call to request the service and/or speak with the *patient experience ambassadors* directly. Once the patient experience team was notified, a *patient experience ambassador* was deployed to schedule and facilitate a virtual visit at the bedside. Before the virtual visit, the *patient experience ambassador* tested the call to ensure that there was connectivity. Once this step was confirmed to be operational, the *patient experience ambassador* connected the patient and family member. The duration of the virtual visit was approximately between five to forty minutes. Most virtual visits were facilitated by one *patient experience ambassador*; however, in the early stages of the program, the *patient experience ambassadors* used a team approach to support one another physically, doing a PPE crosscheck, and emotionally, in difficult emotion-provoking situations such as end-of-life circumstances.

Methods

The present study used a descriptive correlational design. Participation was voluntary and anonymous. A convenience sample of patients and family members who were 18 years or older, able to read and verbally communicate in English or Spanish and who utilized the virtual platforms were recruited through a telephone conversation. Every patient who participated in the program had an opportunity to participate in the research.

Subjects provided their preferred survey transmission method, either mail or e-mail and the preferences were equally distributed. The study was approved by the Institutional Review Board of the health system in the national epicenter. Data was collected from July to September 2020 and analyzed from the paper and electronic surveys using Minitab 19 (Minitab Inc., State College, PA).

The variables defined for the study were reported satisfaction with improving connectedness with your loved one; providing an adequate alternative to the limited hospital visitation policy; providing emotional support to your loved one; experience with the *patient experience ambassador* assigned to you and overall rating. For families whose experience included end-of-life virtual visits, two additional questions were asked regarding whether the program provided peace and closure and whether they would recommend the program. The variables were measured using a Likert – type scale ranging from 4 = excellent, 3 = good, 2 = fair, 1 = poor. Descriptive statistics were calculated for each question as well as overall and data was segmented by hospital and whether the *Connect* program facilitated an end-of-life visit or not. Moods Median was used to test for differences in the populations, as the data was not normally distributed (Table 1).

The overall response rate was 24.5% (N= 49). Sixty-five percent of the respondents represented Hospital A and 35% Hospital B. The average age of the patient population was 70 years of age with a range of 21 to 95 years. 81% of the patients tested positive for COVID-19, 40% were intubated and end-of-life visits accounted for 31% of the overall responses. The people who participated in virtual visits to patients were largely family members with 55% representing adult children, 19%

spouses, 11% siblings, 4% parents and the rest were extended family members and significant others. The majority of visits were facilitated using FaceTime (77%) and Zoom (18%) while the remaining were audio calls (5%). Overall scores were calculated for all patients and all questions (Mean = 3.267, SD 0.1039, Range 3.12 – 3.37).

The mean for Q1 “The *Connect* program improved connectedness with your loved one” was 3.245 SD 0.902 indicating a good degree of satisfaction with a statistically significant difference by end-of-life visits vs. other (p= 0.015). The mean for Q2 “The *Connect* program provided an adequate alternative to the limited hospital visitation policy during the COVID-19 pandemic” was 3.122 SD 1.073 indicating a good degree of satisfaction with a statistically significant difference by end-of-life visits vs. other (p = 0.046). The means for Q3 “The *Connect* program provided emotional support to our loved one” and Q4 “I was satisfied with my experience with the *patient experience ambassador* assigned to my visit” were 3.224 SD 0.848 and 3.375 SD 0.914 respectively indicating a good degree of satisfaction. There was no difference by end-of-life visits vs. other (p = 0.207 and p = 0.176) for these two questions. For Q5 “How would you rate the *Connect* program?” the mean was 3.367 SD 0.929 indicating a good degree of satisfaction with a statistically significant difference by end-of-life visits vs. other (p = 0.028). If virtual visits were for end-of-life situations, participants

Table 1. Effectiveness of the *Connect* program which provided virtual visual and emotional to patients and families during the COVID–19 crisis

Question	Hospital A mean	Hospital A median	Hospital B mean	Hospital B median	Hospital A & B mean	Hospital A & B median	End-of-life vs. Other	Hospital A vs. Hospital B
Q1 - The <i>Connect</i> program improved connectedness with your loved one.	3.281	3.500	3.176	3.000	3.245	3.000	p = 0.015	p = 0.556
Q2 - The <i>Connect</i> program provided an adequate alternative to the limited hospital visitation policy during the COVID-19 pandemic.	3.250	4.000	2.882	3.000	3.122	3.000	p = 0.046	p = 0.073
Q3 -The <i>Connect</i> program provided emotional support to our loved one.	3.219	3.000	3.235	3.000	3.224	3.000	p = 0.207	p = 0.703
Q4 - I was satisfied with my experience with the patient experience ambassador assigned to my visit.	3.419	4.000	3.294	4.000	3.375	4.000	p = 0.176	p = 0.867
Q5 = How would you rate the <i>Connect</i> program?	3.406	4.000	3.294	4.000	3.367	4.000	p = 0.028	p = 0.970
Q6 - The <i>Connect</i> program brought you peace and closure with your loved one.	2.667	3.000	2.400	3.000	2.930	3.000	n/a	p = 0.819
Q7 - To what extent would you recommend the <i>Connect</i> program to family for end-of-life situations?	2.800	4.000	2.400	3.000	3.125	3.500	n/a	p = 1.0
Overall score for all patients and questions					3.267	3.250		

were asked two additional questions to address those specific needs. The mean for Q6 “The *Connect* program brought you peace and closure with your loved one” was 2.930 SD 1.033, and the mean for Q7 “To what extent would you recommend the *Connect* program to family for end-of-life situations?” was 3.125 SD 1.088. All families and significant others virtually visiting were satisfied with the program; however, the results suggest that there were existing opportunities in end-of-life experiences.

Discussion

The results of this study suggest that the *Connect* program was successful in facilitating connection with families and caregivers; however, those participating in end-of-life situations needed more support. There are existing satisfaction differences based on whether the visit was social or end-of-life. Significant others that participated in an end-of-life call rated the program as less satisfactory than those who participated in a social call.

The COVID-19 pandemic disrupted usual experiences of grief.³ Unexpected death is a marked feature of coronavirus-related death, and this feature of bereavement can lead to maladaptive coping and difficulty adjusting. These bereavement experiences are compounded by the fact that most families will not have been permitted to say their goodbyes in person.³ For bereaved individuals, funerals and burials were postponed or held remotely, often without presence of family or the possibility of the warm embrace from a loved one.³ Furthermore, it was found that there are existing differences in the data between social calls and end-of-life visits for the questions “The *Connect* program improved connectedness with your loved one” and “the *Connect* program provided an adequate alternative to the limited hospital visitation policy during the COVID-19 pandemic.” Families and other virtual visitors that dealt with the emotional aftermath of an end-of-life experience had lower levels of satisfaction than those who participated in social interactions. It is possible that these differences were as a result of the disrupted usual experience of grief. While research cannot yet report on psychological processing of end-of-life situations during social isolation of the COVID-19 pandemic, one can reasonably extrapolate that many are dealing with higher levels of anxiety and depression during this uncertain time. These likely contribute negatively to the quality and satisfaction of an end-of-life virtual visit.

There were several limitations to this program, such as resource dependency in the form of staff and the population selected to participate in the satisfaction survey. Staff recruitment was challenging. Many available furloughed staff did not want to put themselves at risk of exposure and emotional consequences. Health care clinicians are often trained to put aside their own feelings and emotions to put patient well-being and care first.⁴

During a time of a crisis, healthcare providers sharing last moments via video conferencing places an emotional and psychological burden on them.³ There is also a social legacy in disaster-related deaths, like in this pandemic. Collective grief, as seen in situations of high-profile deaths and disaster situations is a recognized phenomenon, with shared mourning through bonding with strangers who have undergone a similar bereavement.³ As a result, not all recruited *patient experience ambassadors* committed to the full duration of the program due to the emotional challenges.

Another limitation is one aspect of the population that was selected to participate in the satisfaction survey. The satisfaction survey was only given to adults but does not represent the effects COVID-19 had on how this survey could have helped the children of some of these family members.

Technology is playing an increasingly important role in enhancing the patient and family connection. This innovative program provided multi-factorial benefits and intensely significant experiences for the patients, families, and staff. It capitalized on the increased bandwidth of furloughed staff to support frontline healthcare providers by decreasing workload and upholding employment status. The study, however, did not focus on the experiences of the *patient experience ambassadors*. The project team is further investigating the impact of the program on the ambassadors. While there weren't many differences between the results of Hospital A and Hospital B, this program can be tailored, adapted and implemented to the needs of any acute-care hospital.

Conclusion

The purpose of this study was to evaluate the effectiveness of this unique patient experience response program and to improve family/caregiver satisfaction during the COVID-19 pandemic. The difference noted in end-of-life situations taught us that these virtual visitors needed more emotional support. Although this program was implemented in two separate geographic locations and staff, it was executed effectively at both hospitals. The fact that there weren't major differences in responses for most questions on the survey speaks to the robustness of the program.

Based on the results of the satisfaction survey that highlights the benefits of the *Connect* program, a transition plan was embedded into current operational processes to provide patients and families access to social virtual visits during the period of limited hospital visitation. In light of the continued COVID-19 pandemic, the project team is creating a plan based on the data collected in this study to optimize lessons learned into a modified patient experience response plan.

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