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**Patient-Defined Plan of Care Goals to Increase Patient Satisfaction and Communication:
A Benchmark Study**

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NURS 5382: Capstone

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Executive Summary

Over the last two decades, patient-centered care has been identified as a core principle for healthcare (McKeown et al., 2023). Patient-centered care has been shown to reduce overall healthcare costs, improve patient outcomes, and increase patient satisfaction (Figueroa et al., 2016; Köberich et al., 2016; McKeown et al., 2023; Araki, 2019; Morgan & Yoder, 2012). Although patient-centered care is universally recognized as an essential aspect of healthcare, there is no universally defined definition of what it is or how to implement it (Rassouli, et al., 2020).

While working as a bedside nurse with acutely ill cancer patients, it became very evident that patients were not actively involved in the daily decisions regarding their plan of care. There is a paternalistic nature of healthcare, where the care plan is dictated to the patient; ‘today, you will have test XYZ or procedure ABC.’ Nurses have become more task-oriented and less patient-centered. Perhaps this results from a society that has moved more towards texting versus actively talking and engaging in conversation. Due to the lack of communication, studies have shown that goal concordance between patients, nurses, and physicians can be as low as 20% to 28% (Ellis, et al., 2019; Figueroa, et al., 2016).

Patient-centered communication empowers people to participate actively in their daily goals. It provides a platform for a more holistic approach to medicine. During the Covid-19 pandemic, an elderly patient with terminal cancer was becoming increasingly isolated, confused, and depressed. The nurse asked the patient, ‘What is the most important thing I can help you with today?’ After being isolated for over a week at Christmas, the patient wanted permission to go downstairs and see the holiday decorations. Despite the lockdown, the nurse received permission and facilitated the trip. After the patient returned, the nurse asked her how she was

doing, and she said, “I finally feel like a human again.” Over the next two days, the patient became more alert, and her health improved enough so that she could be released home with hospice care.

Research has shown that patient-centered care and goal concordance can have significant financial implications for healthcare. More importantly, patient-centered care can positively impact a patient’s emotions and well-being. This empowerment can help patients to “feel like a human again” and become active participants in decisions regarding their care.

Patient-Defined Plan of Care Goals to Increase Patient Satisfaction and Communication: A Benchmark Study

This benchmark study will provide simple, concrete steps to improve patient-centered care in inpatient hospital units. It will facilitate communication between patients and staff and empower them to partner in their care.

Rationale for the Project

Patient-centered care is an ambiguous idea discussed extensively in healthcare in the United States and internationally. Instead of discussing the concept broadly, this project will provide specific steps to help nurses better include patient-centered care objectives as part of the daily plan of care formulation.

This project will address the following PICOT question: (P) In adult inpatient-cancer patients (P), do person-centered communication strategies that reflect patient-defined plan of care goals (I) compared with standard care (C) increase patient satisfaction and communication scores (O) at eight weeks after implementation (T)?

Nurses spend more time with patients than anyone else on the healthcare team. Due to this exposure, nurses are ideally suited to implement patient-centered care strategies. Studies have shown that nurses have higher levels of job satisfaction if they incorporate individualized plan of care goals for their patients (Castellà-Creus et al., 2019). Most nurses genuinely want to help their patients; however, one of the barriers identified in studies is a lack of time to implement patient-centered care (Castellà-Creus et al., 2019; Jerofke-Owen & Bull, 2018). This barrier can be overcome by keeping the project protocols simple, providing adequate training, and minimizing the time needed to implement patient-centered choices.

Studies have shown that most patients, if given the opportunity, overwhelmingly want to be involved in their daily plan of care decisions (Araki, 2019; Jerofke-Owen & Bull, 2018; Morgan & Yoder, 2012). Some patients may be too sick to participate in the plan of care choices, while others may be unwilling to do so (Castellà-Creus et al., 2019; Jerofke-Owen & Bull, 2018).

Patients are not required to participate. This project allows them to participate and empowers patients by allowing their voices to be heard. If patients are too sick to participate or decline to participate, family members can act as surrogates to assist with the plan of care goal formulation.

Literature Synthesis

Patient-centered care has been discussed in the literature for decades, yet a standard, concise definition of the concept is elusive (Morgan & Yoder, 2012; Rassouli et al., 2020). A search was conducted of the academic databases PubMed, CINAHL Complete, and the Cochrane Database of Systematic Reviews (CDSR) using patient-centered care, person-centered care, goal concordance, and goal discordance to explore this topic. This review identified various themes that promote patient-centered care and goal concordance.

Patient-centered care and goal concordance have been shown to lower healthcare costs, improve patient outcomes, and increase overall patient satisfaction. (Figuerola et al., 2016; Köberich et al., 2016; McKeown et al., 2023; Araki, 2019; Morgan & Yoder, 2012). Although goal-concordant care that includes patient-centered communication is ideal, studies have shown that there is often a disconnect between patients, caregivers, nurses, and physicians (Dalal et al., 2019; Figuerola et al., 2016; Sanders et al., 2018). This poor communication can lead to goal discordance, resulting in poor patient outcomes, lower overall satisfaction, more extended

hospital stays, and increased costs (Constand et al., 2014; Dalal et al., 2019; Figueroa et al., 2016; Kwame & Petrucka, 2021).

One aspect of patient-centered care discussed in the literature is empowering patients through open communication between the hospital staff, patients, and their family members (Jerofke-Owen & Bull, 2017; Constand et al., 2014; Epstein et al., 2016). This open communication strategy can lead to a shared decision-making process, where patients can better communicate their desires to the hospital staff (Köberich et al., 2016; Marbach & Griffie, 2011; Jerofke-Owen & Bull, 2017; Morgan & Yoder, 2012; Tomaselli et al., 2020).

Open communication assists nurses in identifying patient-specific goals and preferences so that the patient's plan of care can be individualized to their needs (Marbach & Griffie, 2017; Castellà-Creus et al., 2019; Kwame & Petrucka, 2021). A randomized control study showed that using the electronic health record (EHR) to track patient-specific goals led to higher goal concordance levels between patients and staff (Dalal et al., 2019). Other studies identified how patient-centered communication positively impacted patient empowerment and goal concordance (Castellà-Creus et al., 2019; McKeown et al., 2022; Ortiz, 2021; Morgan & Yoder, 2012).

There are perceived barriers to implementing patient-centered goals in the plan of care. In multiple studies, nurses have identified time as one of the significant objections to including patients in the goals of care formulation (Castellà-Creus et al., 2019; Jerofke-Owen & Bull, 2017; Rassouli et al., 2020). Lack of nurse training on patient-centered communication strategies as well as training on how to customize plans of care in the EHR were two other perceived barriers to implementing a patient-centered plan of care goals (Castellà-Creus et al., 2019; Jerofke-Owen & Bull, 2017; Rassouli et al., 2020; Araki, 2019).

Over the last twenty years, there have been minor improvements in the perceptions of patient-centered communication among adults in the United States (McKeown et al., 2023). In order to move forward, nurses must be provided with the tools to improve their understanding of patient-centered communication and their roles in empowering patients (Kwame & Petrucka, 2021; Morgan & Yoder, 2012). This can be achieved through proper training on patient-centered care techniques, simple workflows that incorporate the EHR into the plan of care documentation, and a movement away from communication that is task-oriented to communication that is more holistic and person-centered (Kwame & Petrucka, 2021; Jerofke-Owen & Bull, 2017; Castellà-Creus et al., 2019; Epstein et al., 2017).

Project Stakeholders

Critical stakeholders for this project include patients, their family members and caregivers, bedside nursing staff, and nursing managers. Extended project team members include doctors, social workers, case managers, and other staff members who can assist patients in accomplishing their plan of care goals. The bedside nursing staff will be directly involved in implementing the project and evaluating its immediate objectives, as well as evaluating the effectiveness and impact of the project on daily operations. Nursing managers will be involved in analyzing the project's impact on HCAHP scores (Appendix E) and budgetary implications.

Implementation Plan

The project will occur in a 16-bed, inpatient adult medical oncology unit. The patient population consists of solid cancer tumor patients who either have cancer or had cancer in the past and are being treated as survivors. The average length of stay on the unit is 6.7 days, and the census is at capacity daily. The only time rooms are vacant on the unit is if a room must go into maintenance. According to institutional data, the demographic profile for the hospital is 76.48%

White, 6.97 % Black, 1.42% Asian/Pacific Islander, 0.38% American Indian/Native American, and 0.92% other, with 6.58% listed as unknown (Wu et al., 2016). 7.26% of the patients are of Hispanic origin (Wu et al., 2016). 58.5% of the patients are from Texas, 38.5% are from other states, and 3% are international patients (Wu et al., 2016).

The project will be implemented over 15 to 18 weeks (Appendix B). The base timeline for implementation has some variability built into the schedule to accommodate presentation and approval by the QI board for the hospital. Additionally, the QI board may ask for changes to the project and request it be resubmitted. A total of one to four weeks is allotted for the QI board approval process.

Once the project is approved, unit staff will be trained in patient-centered care communication strategies and goal concordance via an online training module. The training will take place over two weeks to provide ample time for the team on day and night shifts to complete. A “Yellow Huddle” will be used where team members sign off on the expectations of the project requirements. The Yellow Huddle will outline the requirement of tracking a daily patient-specific goal on the patient’s whiteboard and in the electronic health record (Appendix C).

After training is complete, the project will officially begin on the unit. Patients are not required to participate but are given the opportunity to provide input on their plan of care goals. A process is in place to outline what staff should do if patients do not want to participate or lack the capacity to participate (Appendix D). If family members are present, they will be given the opportunity to participate.

During shift huddle-ups, charge nurses will remind employees to complete the daily tasks associated with the project and encourage team members. At the start of the shift, the patient’s

primary nurse will educate the patient on what the plan of care entails and then ask the patient for input. The patient's plan of care goal(s) will be documented on the patient's whiteboard so all team members can see it throughout the day and during the night shift. The primary nurse will also enter the patient's goal into Epic (Appendix C). During management rounds, the charge nurse and/or nurse manager will ask the patient about progress in meeting their daily plan of care goal and then discuss progress with the team. The night nurse will re-evaluate the plan of care goal with the patient and continue to help them with progress to meeting the goal. A similar process will occur each day, allowing new goals to be entered or continue working towards the original goal.

Ideally, the nursing staff will coordinate care with other disciplines to help the patient achieve their plan of care goals. For example, if the patient's goal is better pain control, the nurse can reach out to the medical staff to strategize ways to improve the patient's pain control. Depending upon the goal, other team members, including physical therapists, nutritionists, social workers, and case managers, should be consulted.

The active phase of the project is scheduled for a total of 8 weeks. The total number of potential participants in the study is approximately 133. This number was calculated by taking the study length of 56 days multiplied by the total number of beds (16), divided by the average length of stay for the unit (6.71), to determine the approximate number of potential participants over the project timeframe.

The evaluation phase of the project will occur for four weeks after the implementation phase is completed and will focus on the use of Epic to chart patient-specific goals, relevant HCAPHS scores, and feedback from the nurses on the unit through a survey.

Timetable/Flowchart

Due to time constraints with the approval process, the project will not be implemented and will serve as a benchmark study. The timetable for the project is variable due to the requirement of getting approval from the QI board. If amendments to the plan are required for approval, it will elongate the preparation phase of the project.

There are two flowcharts included with the paper. Appendix B outlines a proposed project timeline from approval to evaluation. Appendix D summarizes the daily workflow for nurses participating in the project.

Data Collection Methods

Data will be collected in a pre and post-intervention strategy. The pre-test data can be calculated using the same period on the unit, except one year prior, and act as a control group. The experimental group will consist of patients on the unit during the project period. Data collection will include four elements:

- Scores from select HCAHPS survey questions
- Use of patient-specific goals field in Epic
- Total number of patients on the unit during the project period
- Length of hospital stay

HCAHP scores will focus on specific questions dealing with the nursing staff, overall hospital rating, and understanding of care (Appendix E). The specific questions that will be included for the project evaluation include:

NURSING COMMUNICATION

- During this hospital stay, how often did nurses treat you with courtesy and respect?

- During this hospital stay, how often did nurses listen to you carefully?
- During this hospital stay, how often did nurses explain things in a way you could understand?

HOSPITAL RATING

- Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
- Would you recommend this hospital to your friends and family?

UNDERSTANDING YOUR CARE

- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left.

There are three placeholders in Epic for the patient-specific plan of care goals, including:

- Anxieties, fears, or concerns
- Individualized care needs
- Patient/family-specific goals (include timeframe)

Nurses will be instructed to use the third placeholder in Epic (Appendix C) for tracking patient/family-specific goals for this project.

The final two data elements collected include the total patient population and the average length of stay. This data can be determined by pulling information from the Epic database.

Evaluation

The project will be evaluated for effectiveness using a pre and post-test evaluation. Descriptive statistics can be used to compare the control versus experimental groups. Demographic and clinical data for both periods will be addressed to see if the groups are similar. The average age, the proportion of subjects of each sex, length of stay, reason for hospitalization, and the proportion of subjects with related co-morbidities should be determined.

The percentage of participation will be determined by dividing the total number of patients on the unit by the number of patients with data entered in the Epic placeholder (Appendix C) for patient-specific goals versus patients with a null value for the Epic placeholder.

HCAHPS scores (Appendix E) will be evaluated for improvement (Health Services Advisory Group, 2023). HCAHPS scores are distributed quarterly, so the evaluation should include scores from the eight-week project period and four weeks after to allow patients enough time to submit the surveys.

The overall length of hospital stay should be reviewed for both periods. The control versus the experiment group will be evaluated to determine if the project impacted the overall length of stay.

The final phase of the evaluation will be to survey nurses from the unit to see their feelings regarding the project's impact on improving patient-centered communication and goal concordance. Demographic data will be included in the survey to evaluate patterns based on age, time as a nurse, and sex. The anonymous survey will be conducted using SurveyMonkey or a similar online tool using a 5-point Likert Scale. The survey will include the following questions:

1. I am satisfied with the training I received to facilitate patient-centered communication.
2. I understand what goal concordance means.
3. I felt comfortable asking my patients about the daily plan of care goals.

4. I used the patient's whiteboard to track their daily goals and preferences.
5. I used Epic to track my patient's daily goals and preferences.
6. I involved other team members (physical therapists, doctors, case managers, etc.) to help my patient with the plan of care goal.
7. I have enough time in my day to involve the patients in the decisions regarding their care plans.
8. How likely will you continue involving your patients in formulating their daily care plan?

Limitations to the project include the small sample size of participants due to unit size and the limited duration of the project. There are significant limitations to analyzing the HCAHPS scores and developing a cause-and-effect relationship with the intervention, as the scores come as aggregate totals, limiting the ability to minimize data from where confounding variables may have impacted the scores.

Cost Benefit Analysis

The project's overall cost is minimal as it involves training employees while they are already at work. The training can be streamlined to be completed during the regular workday and reinforced through simple activities and outreach to the nursing and hospital staff.

HCAHPS communication scores can significantly impact an organization's bottom line. Low HCAHPS scores limit reimbursement levels from Medicare. Low scores can also impact the organization by lowering its reputation with consumers in the community, impacting their hospital choices. A patient who scores a hospital poorly on HCAHPS will be less likely to come back to that hospital for future treatment. Additionally, research has shown a direct relationship between patient satisfaction scores and their likelihood to file malpractice claims (Stelfox et al., 2005).

Another area to explore for potential financial gain is the patient's length of stay. A shorter average length of stay will increase availability for other patients to come to the hospital, minimizing the need to place the hospital on diversion. The shorter length of stay may increase the hospital census over the course of the year.

Studies have shown that patients are more satisfied when patient-centered care is implemented (Figuerola et al., 2016; Köberich et al., 2016; McKeown et al., 2023; Araki, 2019; Morgan & Yoder, 2012). Increased patient satisfaction may lead to less stress for the nurses caring for the patients. Additionally, studies have shown that nurses who incorporate patient-centered care strategies into their practice have increased job satisfaction, which potentially could lead to less turnover (Castellà-Creus et al., 2019).

Discussion of Results

As a pilot study, the project is a starting point for exploring concrete ways to implement patient-centered communication strategies that encourage direct patient input in their daily care plan. The project's primary goal is to have nurses ask the critical question often left out, "What can I do to help you today?" or "What goals would you like to accomplish today?"

Once the nursing staff gets into a habit of including patients in their daily care plan, the next step will be to refine how the information is documented and communicated to the rest of the healthcare team. The current placeholder in Epic for patient-specific goals is buried deep within multiple forms that are only seen by bedside nurses. Eventually, there needs to be a more dynamic placeholder for this communication so that it can be seen electronically by anyone accessing the patient's chart in Epic.

Many possible studies can be conducted from the data collected on patient-specific care choices. The patient-centered care data in Epic can be sorted to determine patterns and

frequencies. If items appear frequently, the hospital staff can design strategies to help all patients on the chosen topic, improving the patient experience and positively affecting HCAHPS scores.

Another primary goal of this project is to turn the patient's whiteboard into a dynamic, two-way communication device where goals and messages are shared with patients, nursing staff, physicians, and extended healthcare team members. The nursing staff can use the whiteboard in patients' rooms to reflect their involvement in the daily plan of care. Currently, team members do not consistently use the whiteboard. Simple goals or phrases may be documented such as "Welcome to unit XYZ." or "Call don't fall." These goals remain static during the entire duration of the patient's stay.

Due to the time constraints of the academic calendar and the process for project approval by the quality improvement board, this project was created as a benchmark study versus a capstone project.

Conclusions/Recommendations

Goal concordance is seriously compromised between patients, nurses, and physicians (Dalal et al., 2019; Figueroa et al., 2016; Sanders et al., 2018). This study was designed to increase goal concordance and empower patients to take a more active role in their daily plan of care. HCAHPS scores were selected to determine project effectiveness out of convenience.

Ideally, a survey tool should be designed to measure the validity and reliability of patient-centered communication's impact on patient satisfaction levels and goal concordance. If a proper survey tool is devised or found in the literature, it will be possible to develop multiple studies to see their impact on pre and post-test goal concordance and patient satisfaction levels.

The project's primary goal is to increase patient participation through more robust involvement of nurses. Through training and practice, nurses will become better at asking

questions and encouraging patient involvement. These patient choices should be communicated to the extended healthcare team through the electronic health record and the proper use of the patient whiteboard.

Patient-centered care does not have to be a vague topic often discussed but seldom implemented. Patients can be more involved in the decisions affecting their daily care plan through simple, concrete steps. Nurses spend more time with the patients than any other team member. They are ideally suited to leading this dynamic change that may provide financial incentives for the hospital and increased patient satisfaction levels.

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Appendix A Evidence Table

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
Castellà-Creus, M., Delgado-Hito, P., Casanovas-Cuellar, C., Tàpia-Pérez, M., & Juvé-Udina, M. (2019). Barriers and facilitators involved in standardised care plan individualisation process in acute hospitalisation wards: A grounded theory approach	Grounded theory approach developed by Strauss and Corbin	Qualitative Study + interviews + direct observation + chart reviews + focus groups	39 nurses 3 hospitals	Barriers + Routines acquired in hospital wards + tradition of narrative records + lack of knowledge + limited interest Facilitators + holding clinical care sessions + use of standardized care plans and interface in terminology	Use of grounded theory that clearly identified both barriers and facilitators .	Open, axial and selective coding until data saturation was reached. EQUATOR guidelines for qualitative research (COREQ) were applied.	Nursing routines may hinder POC customization. Nurses become task-oriented and are required to complete specific tasks in a timely manner. Tasks may not reflect PCCG. NPR reduces the time available for PCCG. Nurses may not be technically savvy enough to document PCCG in the EHR or do not know how to find standardized POC templates that can be modified. Patient complexity was viewed as a	USPSTF grade: Good Strengths: + use of multiple types of data collection, multiple hospitals, and different types of units + sample of nurses from different levels of experience, as well as permanent and agency nurses. Weakness: + study conducted in Spain, differences may exist in hospital care and nurse training Level VI: evidence from a single descriptive or qualitative study

Legend: USPSTF = United States Preventive Services Task Force, CCS = clinical care sessions, IT = information technology, SCP = standard care procedure, PCC = patient centered care, EHR = electronic health record, QS = qualitative study, RCT = randomized control trial, PS = prospective study, I = intervention, PT = patient, CL = clinician, POC = plan of care, HRG = Haberle recovery goal, MRH = main reason for hospitalization, TS = tests scheduled, PS = procedures scheduled, MC = medications changed, CP = consults planned, TOD = time of discharge, DPC = discussion with patient or clinician, BCI = board certified internists, LOS = length of stay, PI = private insurance, RCT = randomized control study, APPC = active patient participation coding, VR = responding to patients emotions (Verona VR-CODES), PTCCI = informing patients of prognosis and treatment choices, PTCCF = framing patients prognosis and treatment choices, PPSM = prerandomization phase sample means, MIC = medical ICU, ONC = oncology unit, ICS = individualized care scale, SC = Smoliner scale, IzEP = instrument to assess nursing care delivery systems, PCQ = person-centered climate questionnaire, P-CIS = patient-centered inpatient scale, PSNCQQ = patient satisfaction with nursing care quality questionnaire, SF-36 = short form 36, FIM = functional independence measurement. POC = plan of care, CCS = clinical care sessions, NPR = nurse-to-patient ratios, PCCG = patient-centered care goals, SPOC = standardized plans of care, GC = goal concordance

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				+ nurses expertise and willingness			hindrance to PCCG. Management involvement or lack of involvement affects the nurse's use of PCCG. Nurses document PCCG on paper during handoff but not the EHR. CCS helps nurses with PCCG. EHR training increases use of PCCG. SPOC facilitates use of PCCG through modification.	
Constand, M. K., MacDermid, J. C., Dal Bello-Haas, V., & Law, M. (2014). Scoping	N/A	Scoping Review Database search 1990 to 2013 Medline, CINAHL, and	101 articles total 19 met inclusion criteria: 13 review articles	IV = Patient centered care models/frameworks DV = communication, partnership,	The variables were consistently confirmed in articles and are	Data extracted by lead author and confirmed by second author Content analysis	Although no consensus PCC framework was found in the various studies and articles, the three DVs of communication,	USPSTF grade: Good Strengths: + breadth of search using multiple terms and databases + timeframe included approximately 13 years of publications

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review of patient-centered care approaches in healthcare		EMBASE. Keywords: “patient-centered care,” “client-centered care,” “framework,” and “model” to identify relevant studies.	4 QS 1 RCT 1 PS	and health promotion	thus viewed as relevant.	See table 3	partnership, and health promotion were identified in each study. An empirical framework is needed for future studies in PCC and goal concordance. This framework should include the three DVs as part of the eventual PCC empirical model.	Weaknesses: + No clear definition of PCC is understood, making it difficult to determine what it is and how to measure it + only one RCT found Level V: evidence from systematic reviews of descriptive or qualitative studies
Dalal, A. K., Dykes, P., Samal, L., McNally, K., Mlaver, E., Yoon, C. S., Lipsitz, S. R., & Bates, D. W. (2019). Potential of an electronic health record-	N/A	Pre-Post interventional study	Pre-I 457 total eligible PT Post-I 283 total eligible PT In random order	IV PT and CL online portal DV Concordance between PT and CL of: HRG MRH TS PS	Goal concordance is a good indicator of PCCG implementation. This is one of the few RCT found in	A generalized estimating equations z-test Mean concordance scores for overall POC and individual POC elements	See table 3 in article.	USPSTF grade: Good Strengths: + statistically significant findings from pre and post-intervention for HRG and MRH Weaknesses: + small sample size at single facility

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integrated patient portal for improving care plan concordance during acute care			approached Pre-I and Post-I 55 participated in interviews Post-I 46 participated in interviews	MC CP TOD DPC	the literature with PCCG and goal concordance. The study showed statistical significance.	Structured POC interview instrument 2 BCI independently assessed and scored all POC elements and averages were determined		+ patient portal enrollment independent from study may be biased as patients had longer LOS and PI Level II: evidence obtained from well-designed RCT
Epstein, R. M., Duberstein, P. R., Fenton, J. J., Fiscella, K., Hoerger, M., Tancredi, D. J., Xing, G., Gramling, R., Mohile, S., Franks, P., Kaesberg, P., Plumb, S., Cipri, C. S., Street, R. L.,	N/A	RCT	Cluster RCT at community and hospital-based clinics in western New York and California. 265 patients	IV Patient training DV APPC VR PTCCI PTCCF	This study is relevant as it shows that interventions to improve PCCG with physicians, patients, and their caregivers increase overall	Transformed 4 component scores to z scores based on PPSM 4 z-scores averaged to form the primary outcome Wald-type tests from prespecified	The composite communication score showed a significant intervention effect (estimated adjusted intervention effect, 0.34; 95% CI, 0.06–0.62; P = .02)	USPSTF grade: Good Strengths: + intervention included training for physicians, patients, and their caregivers + statistically relevant results + facilities in New York and California Weaknesses: + this study focused on physicians instead of nursing interventions

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Shields, C. G., Back, A. L., Butow, P., Walczak, A., Tattersall, M., & Venuti, A. (2016). Effect of a patient-centered communication intervention on oncologist-patient communication, quality of life, and health care utilization in advanced cancer.			194 caregivers 38 physicians participated		GC for cancer patients.	mixed-effects linear regression models Generalized estimating equations for binary outcomes QOL trajectories were performed using the terminal decline model (TDM)		+ only two study sites + only one office visit was recorded + study focuses on GC for end-of-life trajectory for patients with terminal cancer versus GC throughout the treatment plan Level II: evidence obtained from well-designed RCT
Figuerola, J. F., Schnipper, J. L., McNally, K., Stadel, D., Lipsitz, S. R.,	N/A	Quantitative research study	Adult patients admitted to MICU or ONC for greater	IV – goal concordance DV – Haberle recovery goal across	This is a critical study as it validates GC between	Validated questionnaire given to physician, primary nurse,	Poor GC. Identical recovery goal between patient, nurse, and physician = 20.2%	USPSTF grade: Fair Strengths: + standardized instrument, HRG + simplicity of design

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& Dalal, A. K. (2016). How often are hospitalized patients and providers on the same page with regard to the patient's primary recovery goal for hospitalization?			than 48 hours 1,436 patients eligible 181 patients participated		physicians, nurses, and patients	and patient, included HRG Completed questionnaire from all three interviewees = 109	Concordance between physician and nurses = 39.4% Total discordance (each selected a different goal) between all three: 29.4%	Weaknesses: + static demographics of patients + 2 inpatient services at single facility + possible selection bias + data collected at only one time point in the patient's admission Evidence VI: evidence from a single descriptive or qualitative study
Jerofke-Owen, T., & Bull, M. (2017). Nurses' experiences empowering hospitalized patients	N/A	Qualitative research study	Nurses employed at 4 different hospitals 34 nurses: 33 female 1 male	IV – acute care nurses empowering patients DV + facilitators + barriers	The variables are essential indicators for GC and PCCG	Four focus groups, audio recordings were transcribed to allow for data analysis Data was coded manually by two researchers,	Themes identified: + establish therapeutic relationship + fostering communication + providing education + respecting patient autonomy + engaging support systems	USPSTF grade: Fair Strengths: + use of participants from four facilities Weaknesses: + poor representation of male nurses, with only one out 34 participants + focus groups using purposive sampling

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						and results were reconciled Data grouped into themes and examined for consistency and specificity	+ lifting spirit/giving hope + conflicting information regarding POC + lack of time + fear and anxiety over unfamiliar environments and routines	+ 97% of participants were Caucasian Level VI: evidence from single descriptive or qualitative study
Köberich, S., Feuchtinger, J., & Farin, E. (2016). Factors influencing hospitalized patients' perception of individualized nursing care: a cross-sectional study	N/A	Quantitative research study Cross-sectional study	606 patients 20 different hospital units 5 different hospitals	IV Patient's perception of individualized PCC DV + individual factors affecting + organizational factors influencing it	Ultimately it is the patient's perception that determines if PCG is met	German version of ICS Smoliner scale IzEP Data coded and entered in IBM SPSS version 22 Applied hierarchical linear model with two levels Calculations made with HLM 7	+ the longer patient is in the hospital, the more they perceive PCC + patients in better health perceive their care to be more PCC + perceived individualized care is positively associated with shared decision-making	USPSTF grade: Fair Strengths: + Multilevel models able to separate the influence of hospital units and patients on perceived individualized care + 20 different hospital units in 5 hospitals Weaknesses: + demographics based on German healthcare system

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								+ cross-sectional studies only provide snapshot Level IV: evidence from a well-designed case-control and cohort studies
Marbach, T. J., & Griffie, J. (2011). Patient preferences concerning treatment plans, survivorship care plans, education, and support services	N/A	Qualitative study	40 cancer survivors	IV Survivors' personal experiences with receiving cancer treatment DV + educational information + treatment plan + survivorship care plan + patient support	Each of the DVs is important to consider for PCCG. This is the first study that explores survivorship POC goals.	Thematic analysis Data saturation was reached with four significant themes identified	Themes identified: + educational information: anger and confusion + treatment plan: anger and confusion, lack of understanding, goal discordance, better understanding in clinical trials; nurses play primary role in development, delivery, and clarification of plans of care + survivorship care and planning:	USPSTF grade: Fair Strengths: + specific themes identified across each focus group Weaknesses: + small sample group all from same area + 4 focus groups Level VI: Evidence from a single descriptive or qualitative study

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							wanted formal written document outlining follow-up, testing, surveillance + patient support: emotional support lacking, desire for more spiritual support, support groups/mentorship	
McKeown, L., Hong, Y. A., Kreps, G. L., & Xue, H. (2022). Trends and differences in perceptions of patient-centered communication among adults in the US	N/A	Quantitative study Cross-sectional survey	National Cancer Institute's Health Information National Trends Survey (HINTS) Data from cross-sectional survey conducted in 2011, 2014,	IV PCC scores Epstein's six PCC core functions DV Key sociodemographic groups	This is a critical study that uses a different type of scale, Epstein's six PCC functions, to analyze trends over several years	two-stage stratified sampling design across all cycles (2011, 2014, 2017, 2020) measured with a validated scale that captures, PCC score determined by averaging 7 questions from questionnaires	Scores showed slight improvement: 2011 – 77.45 2014 – 78.67 2017 – 79.64 2020 – 80.33 Involved in decisions sub-score of “always” 2011 – 51.91% 2014 – 54.71% 2017 – 52.81% 2020 – 57.21%	USPSTF grade: Good Strengths: + nationally representative sampling method + data collected over multiple time points spanning many years + large sample size Weaknesses: + HINTS survey used multiple administration cross-sectional design and is not repeated measures

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			2017, 2020 Sample size ranged from 3335 to 3865					<p>design tracking same subjects + responses are subject to self-report bias + HINTS is not a longitudinal design and data are independently sampled + participant limitations with the HINTS data that can skew results toward US populations who have high socioeconomic status + this is a physician study versus a nursing study, however, patient's perceptions of PCC still are applicable</p> <p>Level IV: evidence from well-designed case-control and cohort studies</p>

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Morgan, S., & Yoder, L. H. (2012). A concept analysis of person-centered care.	Walker and Avants's method of concept analysis	Review	CINAHL, Medline, PubMed, and Cochrane Review searched using terms: "individualized-care," "person-centered care," "patient centered care," "client-centered care," and "resident centered care." Focus on adult population	Concept analysis: + person-centered care + patient-centered care + individualized care + client-centered care + resident-centered care	Strong focus on patient-centered care terms from studies representing varying levels of evidence.	Empirical referents were provided to measure PCC from the perspective of the person receiving care	+ Definition of PCC: holistic (bio-psychosocial-spiritual) approach to delivering individualized care in a respectful manner that promotes participation and communication, empowering the patient + Antecedents: vision and commitment, organizational attitudes and behaviors, shared governance + Consequences: improved quality of care, increased satisfaction with care, improved health outcomes	USPSTF grade: Good Strengths: + breadth of search + inclusion of 50 different studies + international perspective that may be farther along than US Weaknesses: + article was published in 2012, so information is dated Level V: evidence from systematic reviews of descriptive and qualitative studies

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			> or = to 19 years of age, narrowed to total of 50 articles used for analysis				+ Empirical referents: PCQ, ICS, P-CI, PSNCQQ, SF-36, FIM + Model case provides an exemplar of the concept of PCC	
Rassouli, M., Zamanzadeh, V., Valizadeh, L., Ghahramanian, A., & Asghari, E. (2020). Limping along in implementing patient-centered care: qualitative study	Zhang and Wildermuth's method of content analysis	Qualitative descriptive study	Face-to-face interviews conducted with 21 nurses working in teaching hospitals in Iran	IV – PCC DV + effective communication + careful care of distinct needs + valuing the patients and their rights	These are three variations of major variables seen across multiple studies.	From interviews, 5 field notes were collected, data analyzed using the Zhang and Wildermuth method of content analysis, Sampling continued until data saturation was reached, criteria	Themes discovered: + effective communication + care of distinct patient needs, patients as individuals + valuing patients and their rights + holistic approach to care + PCC is not formalized and occurs in an ad-hoc manner	USPSTF grade: Fair Strengths: + builds on themes and foundations of earlier works in PCC Weaknesses: + Study conducted in Iran, so cultural and healthcare differences may exist + Nurses reported not having enough time to spend on direct care + potential for self-report bias

Legend: USPSTF = United States Preventive Services Task Force, CCS = clinical care sessions, IT = information technology, SCP = standard care procedure, PCC = patient centered care, EHR = electronic health record, QS = qualitative study, RCT = randomized control trial, PS = prospective study, I = intervention, PT = patient, CL = clinician, POC = plan of care, HRG = Haberle recovery goal, MRH = main reason for hospitalization, TS = tests scheduled, PS = procedures scheduled, MC = medications changed, CP = consults planned, TOD = time of discharge, DPC = discussion with patient or clinician, BCI = board certified internists, LOS = length of stay, PI = private insurance, RCT = randomized control study, APPC = active patient participation coding, VR = responding to patients emotions (Verona VR-CODES), PTCCI = informing patients of prognosis and treatment choices, PTCCF = framing patients prognosis and treatment choices, PPSM = prandomization phase sample means, MIC = medical ICU, ONC = oncology unit, ICS = individualized care scale, SC = Smoliner scale, IzEP = instrument to assess nursing care delivery systems, PCQ = person-centered climate questionnaire, P-CIS = patient-centered inpatient scale, PSNCQQ = patient satisfaction with nursing care quality questionnaire, SF-36 = short form 36, FIM = functional independence measurement. POC = plan of care, CCS = clinical care sessions, NPR = nurse-to-patient ratios, PCCG = patient-centered care goals, SPOC = standardized plans of care, GC = goal concordance

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
						proposed by Guba and Lincoln was used to ensure rigor. These criteria included credibility, conformability, transferability, and dependability		Level VI: evidence from a single descriptive or qualitative study
Tomaselli, G., Buttigieg, S. C., Rosano, A., Cassar, M., & Grima, G. (2020). Person-Centered care from a relational ethics perspective for the delivery of	N/A	Scoping Review	Scoping review of literature searching PubMed, Medline, and Scopus from 2008-2018 using multiple keywords	IV – PCC DV – relational ethics actions and perspectives	The use of ethical perspectives in PCC provides another tool to review the concept and provide foundations for	23 articles were selected for review; content analysis was conducted to identify and compare main features of PCC and relational ethics; articles were reviewed, and data was	+ matches and congruence between PCC and relational ethics + patient as unique person, partner, and co-creator of POC + close relationship between ethics and PCC principles, including knowledge, mutual	USPSTF grade: Good Strengths: + analyzes PCC from an ethical perspective. + thorough search with detailed inclusion criteria Weaknesses: + subjectivity of reviewers + lack of language pluralism as majority of

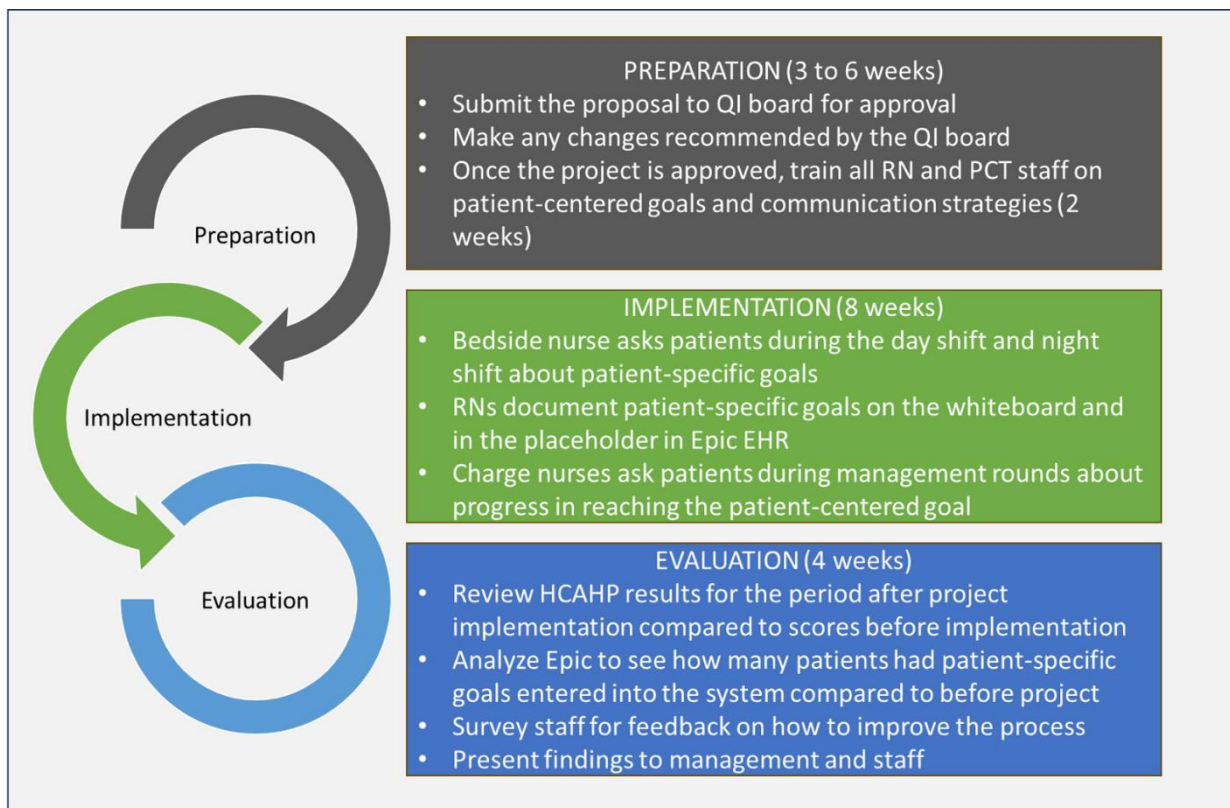
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Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
high quality and safe healthcare: A scoping review					improvement	extracted using data extraction form	respect, and engagement + PCC held to a higher-level ethical approach as patient becomes partner in care and co-creator	<p>studies were conducted in English + studies may have been missed if they did not fall into three databases used + PCC approaches may be different in other countries, as well as between public and private healthcare systems</p> <p>Level V: evidence from systematic reviews of descriptive and qualitative studies</p>

Legend: USPSTF = United States Preventive Services Task Force, CCS = clinical care sessions, IT = information technology, SCP = standard care procedure, PCC = patient centered care, EHR = electronic health record, QS = qualitative study, RCT = randomized control trial, PS = prospective study, I = intervention, PT = patient, CL = clinician, POC = plan of care, HRG = Haberle recovery goal, MRH = main reason for hospitalization, TS = tests scheduled, PS = procedures scheduled, MC = medications changed, CP = consults planned, TOD = time of discharge, DPC = discussion with patient or clinician, BCI = board certified internists, LOS = length of stay, PI = private insurance, RCT = randomized control study, APPC = active patient participation coding, VR = responding to patients emotions (Verona VR-CODES), PTCCI = informing patients of prognosis and treatment choices, PTCCF = framing patients prognosis and treatment choices, PPSM = prerandomization phase sample means, MIC = medical ICU, ONC = oncology unit, ICS = individualized care scale, SC = Smoliner scale, IzEP = instrument to assess nursing care delivery systems, PCQ = person-centered climate questionnaire, P-CIS = patient-centered inpatient scale, PSNCQQ = patient satisfaction with nursing care quality questionnaire, SF-36 = short form 36, FIM = functional independence measurement. POC = plan of care, CCS = clinical care sessions, NPR = nurse-to-patient ratios, PCCG = patient-centered care goals, SPOC = standardized plans of care, GC = goal concordance

Appendix B

Project Timeline



Appendix C

Epic Placeholders for Patient-Centered Care Goals

Epic Placeholder for Patient-Specific Goal

Patient-Specific Goal (Individualized) ⓘ

Expected end: 9/30/2023 ⓘ

Flowsheets

Time taken: 10/4/2023 ⓘ 1443 ⓘ Responsible

Patient Specific Goal

Anxieties, Fears or Concerns

Individualized Care Needs

Patient/Family-Specific Goals (Include Timeframe)

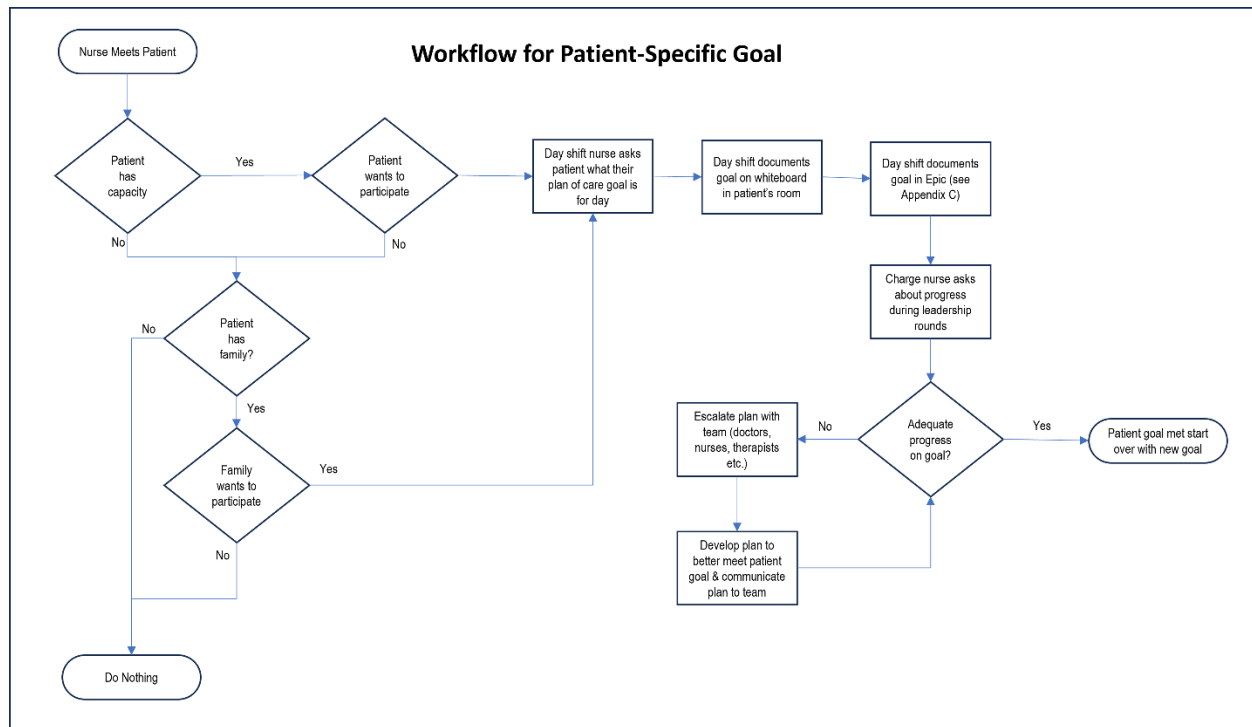
to have more strength in extremities at discharge taken 6 days ago

↑ Previous ↓ Next ✕ Cancel

Patient-specific goals entered here in Epic EHR

Appendix D

Nurse Workflow for Patient-Specific Goals



Appendix E

HCAHPS Survey Questions for Analysis

HCAHPS Survey Questions for Analysis

Your Care from the Nurses

- During this hospital stay, how often did nurses treat you with courtesy and respect?
- During this hospital stay, how often did nurses listen to you carefully?
- During this hospital stay, how often did nurses explain things in a way you could understand?

Overall Rating of the Hospital

- Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
- Would you recommend this hospital to your friends and family?

Understanding Your Care

- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.