Revenue cycle performance is reviewed in detail at weekly meetings led by the CEO. Additionally, regular meetings are being held to analyze the status of the backlog in Medicaid applications; present at these meetings are representatives from CCHHS, Cook County, the Governor’s office, the Illinois Department of Healthcare and Family Services, and the Illinois Department of Human Services.

In January 2012, the System realized $40.9 million in retroactive payment adjustments as a result of alterations proposed by CCHHS and accepted by HFS to rate methodology calculations. An additional $8.5M in retroactive payments as a result of these adjustments is anticipated to be paid on February 28, 2012. This second group of payments relates to past outpatient activity.

<table>
<thead>
<tr>
<th></th>
<th>Gross</th>
<th>Net or payment (cash) received</th>
</tr>
</thead>
<tbody>
<tr>
<td>January payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Provident and Stroger Hospitals)</td>
<td>$83,048,660</td>
<td>$40,884,855</td>
</tr>
<tr>
<td>February payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Oak Forest)</td>
<td>$6,657,987.02</td>
<td>$3,277,727</td>
</tr>
<tr>
<td>*(Stroger Hospital Outpatient)</td>
<td>*$10,685,345.10</td>
<td>*$5,260,395</td>
</tr>
<tr>
<td>Total Rate Retro</td>
<td>*$100,391,992.12</td>
<td>*$49,422,977</td>
</tr>
</tbody>
</table>

*Although CCHHS already received notice of payment for Feb 28th this is an estimate of the retroactive rate portion - the retroactive rate payment amount to be confirmed by the State.*
1115 WAIVER

With President Preckwinkle we recently concluded a series of briefings with members of the Illinois General Assembly regarding the 1115 Waiver request, and the necessary enabling legislation. The proposed legislative language has been drafted. The waiver document has been widely disseminated and we have responded to numerous stakeholder inquiries. Among others, I or my team have met with and briefed the Illinois Primary Healthcare Association, Maryjane Wurth and Illinois Hospital Association staff, the Metropolitan Chicago Healthcare Council (MCHC) Policy and Advocacy Council, a large group of local FQHC’s and community clinics, several hospital CEO’s, and others; further outreach is planned. An 1115 Waiver Steering Committee has been established and meets weekly with three working groups reporting. The implementation workgroups are Care Management, Empanelment/Registry and Administration and are progressing. We are currently responding to a request of HFS to provide that department with staff to lead on this project - there is a particular focus being given to eligibility screening/enrollment potential options. Our initial meeting with CMS, HFS, and CCHHS is scheduled for February 24th, at 10:00 a.m.

OAK FOREST HEALTH CENTER

The Capital Committee continues to make progress in the planning of the Oak Forest Health Center. On February 10th committee members along with clinical stake holders toured a radiology center which offered assistance in mapping out patient flow and layout for the ground floor of the OFHC. The presentation to the Board of Directors for the design of the Oak Forest Health Center has been moved up from the April 27th Board Meeting to the March 29th Board Meeting. The Immediate Care Center will move to the New “E” Building on February 25th. Also, the OFHC Volume Statistics Dashboard is now posted on the health center’s page on the new CCHHS website and will be updated monthly.

PUBLIC HEALTH UPDATE

The Cook County Department of Public Health in partnership with the CPPW (Communities Putting Prevention to Work) team held the final session of the Change Institute on February 14, 2012 in Alsip, Illinois to acknowledge the work of the 38 Model Communities grant recipients in implementing policy, system and environmental strategies to make “healthy choices” available to improve the health status of residents. Strategies ranged from plans to develop walking paths and mass-transit to increasing healthy food options and physical activity in schools. The participants highlighted their strategies
through presentations and poster sessions and emphasized a commitment to sustaining these initiatives beyond the funding cycle.

SCHWARTZ ROUNDS

The Schwartz Center for Compassionate Care was founded in 1995 by Kenneth Schwartz who died of lung cancer. The mission of the Center is to promote healthcare so that patients and their professional caregivers relate to one another in a way that provides hope to the patient, support and nurturing to caregivers and sustenance to the healing process. Schwartz Center Rounds is one of the programs offered by the Center. The Rounds provide an interdisciplinary and interdepartmental forum where caregivers discuss difficult emotional and social issues inherent in patient care. The Rounds discussion focuses on a specific patient case. A panel of multidisciplinary caregivers describes their experience caring for the patient and the impact it had on them. This is followed by a facilitated discussion among attendees. These rounds differ from clinical or management rounds in that they address the ethical, psychological, and emotional concerns that arise during the patient’s illness, not the medical issues. The Rounds serve to nurture the caregivers in a safe and confidential forum.

Stroger Hospital’s first Schwartz Center Rounds was held in September 2011. Since then Schwartz Rounds have been held monthly and thus 6 sessions have been held that have been very well attended by various disciplines consisting of physicians, RNs, social workers, occupational /physical therapists, lab and clerical workers. Benjamin Mba, MD, MRCP (UK), FACP, FHM is the organizer and driving force behind this activity and I want to thank him for his efforts and for bringing this great learning tool to our system.

For your information attached is an article titled The Schwartz Center Rounds: Evaluation of an Interdisciplinary Approach to Enhancing Patient-Centered Communication, Teamwork, and Provider Support by Beth A. Lown, MD, and Colleen F. Manning, MA which provides an evaluation of the impact of such rounds at other institutions. Also, the New York Times article, Well: Sharing the Stresses of Being a Doctor by Pauline W. Chen, M.D., regarding the subject, is also attached.
NEW WEBSITE

In the beginning of February we launched our new website www.cookcountyhhs.org. The new website is aimed at providing public information for patients, employees, and the public at large. When you log on, you will find basic information about accessing our services, locating our facilities, finding a job or how to do business with CCHHS as well as profiles about our elite medical staff and reports of our committee and board meetings. There is also a news section which highlights upcoming events including a health observance calendar that highlights what we are doing throughout the system toward keeping our patients healthy. This is just the start of a new look and feel to our on-line presence and I encourage everyone to stay connected to CCHHS.

I would like to thank Marisa Kollias our Interim Director of Public Relations for undertaking this project that was developed at an accelerated pace and completed on time and under budget.
The Schwartz Center Rounds: Evaluation of an Interdisciplinary Approach to Enhancing Patient-Centered Communication, Teamwork, and Provider Support
Beth A. Lown, MD, and Colleen F. Manning, MA

Abstract

Purpose
To assess the impact of Schwartz Center Rounds, an interdisciplinary forum where attendees discuss psychosocial and emotional aspects of patient care. The authors investigated changes in attendees’ self-reported behaviors and beliefs about patient care, sense of teamwork, stress, and personal support.

Method
In 2006–2007, researchers conducted retrospective surveys of attendees at six sites offering Schwartz Center Rounds (“the Rounds”) for ≥3 years and prospective surveys of attendees at 10 new Rounds sites that have held ≥7 Rounds.

Results
Most of the retrospective survey respondents indicated that attending Rounds enhanced their likelihood of attending to psychosocial and emotional aspects of care and enhanced their beliefs about the importance of empathy. Respondents reported better teamwork, including heightened appreciation of the roles and contributions of colleagues. There were significant decreases in perceived stress (P < .001) and improvements in the ability to cope with the psychosocial demands of care (P < .05). In the prospective study, after control for presurvey differences, the more Rounds one attended, the greater the impact on postsurvey insights into psychosocial aspects of care and teamwork (both: P < .05). Respondents to both retrospective and prospective surveys described changes in institutional culture and greater focus on patient-centered care and institution-specific initiatives.

Conclusions
Schwartz Center Rounds may foster enhanced communication, teamwork, and provider support. The impact on measured outcomes increased with the number of Rounds attended. The Rounds represent an effective strategy for providing support to health care professionals and for enhancing relationships among them and with their patients.


The effort to foster effective communication among health care providers and with patients and families is a significant challenge in our complex health care systems. Patients, providers, and policy makers understand its importance, however, and with good reason. High-quality interpersonal relationships, communication, and “whole-person” knowledge of patients have been correlated with improvements in clinical and functional status.
support.25 Few opportunities exist to enhance relationships and communication among all members of multidisciplinary health care teams, to teach the advanced communication skills needed in our complex health care environments, and to create supportive environments in which all can learn from each other.

The Schwartz Center Rounds provide such opportunities. Initiated in 1997 by members of the Kenneth B. Schwartz Center and piloted at Massachusetts General Hospital (Boston, Massachusetts), “the Rounds” are now established in more than 186 sites across the United States. The goals of the Rounds are to improve relationships and communication with patients and among providers and to enhance providers’ sense of personal support. More background information on the Rounds can be found on the center’s Web site (http://www.theschwartzcenter.org). They offer a safe forum in which providers can share their experiences, dilemmas, joys, concerns, and fears (both for their patients and for themselves). The Rounds are held in diverse environments, including academic medical centers, community hospitals, outpatient practices, community health centers, and nursing homes. Participants and learners from various disciplines and professions attend, in numbers ranging from 35 to 200 at each site. The Rounds are one-hour, case-based, interactive discussions held monthly or bimonthly and led by a physician and/or a professional facilitator. Each session begins with a brief presentation of a patient (or family) case by members of the health care team who cared for the patient. This presentation introduces multiple perspectives on selected psychosocial topics. Audience members and the presentation team participate in the facilitated group discussion that follows.

The Rounds address a wide range of important topics rarely discussed elsewhere.26 These topics include the management of team conflict, stories of hope and miracles, instances when providers become patients, the impaired professional, the impact of patient violence toward providers, instances when cultural or religious beliefs impair providers’ ability to communicate, the impact on providers of making a mistake, humor and healing, and many others.

Because no studies had been done to evaluate the outcomes of the Rounds, the Schwartz Center commissioned just such a study in 2006–2007. The goals of the study were to assess the impact of the Rounds on self-reported changes among attendees in their beliefs about patient care, their behaviors during health care interactions, their participation in teamwork, and their sense of stress and personal support. Researchers also gathered participants’ reports of changes in institutional practices and policies that the participants attributed to issues raised at the Rounds.

Method

Evaluation design and survey procedures

The evaluation included two major components: analysis of retrospective surveys at “experienced” Rounds sites (i.e., where the Rounds had been in operation for at least three years) and analysis of prospective (pre/post) surveys of attendees at “new” sites both as Rounds were first implemented and after each site had held Rounds seven or more times. The six experienced Rounds sites included five hospitals in the Northeast and one in the Midwest. Between summer 2006 and summer 2007, participants identified by Rounds coordinators received an e-mail request to participate and a Web link to the electronic survey. Researchers also performed semistructured interviews at five of these sites with 44 participants, including providers, Rounds leaders and facilitators, and hospital administrators.

Between fall 2006 and winter 2007, the pre/post survey was sent to providers at 10 hospitals across the country as those hospitals were initiating Rounds. Participating hospitals included six in the Northeast, two in the Midwest, one in the South, and one in the West. Pre-Rounds data collection was staggered to occur as new sites began holding Rounds. The Web link to the electronic pre-Rounds survey was sent to health care professionals identified by Rounds leaders as those who would know about or would be invited to attend Rounds. Post-Rounds data collection occurred after Rounds were held at least seven times at each site. The dates and titles of all of the Rounds that had occurred at each hospital during the study period were listed on each hospital’s post-Rounds survey. Providers who participated in the study indicated which Rounds sessions, if any, they had attended.

We sent providers three reminders in an attempt to increase the rates of response to each survey. The institutional review boards of all 16 participating hospitals reviewed and approved the research procedures and measures, and we obtained written (electronic) informed consent from all study participants.

Measures

We constructed our surveys to investigate three domains: (1) insights into the psychosocial and emotional aspects of clinical care on patient interactions, (2) teamwork, and (3) support for providers. The three domains were identified through the use of a Logic Model27 of the Schwartz Center Rounds and by consultation with program stakeholders. Each of the three outcomes was measured by having caregivers indicate their degree of agreement with a set of related statements or by having caregivers indicate the frequency with which they experienced specific feelings about their work. In most cases, the statements required caregivers to respond on a six-point rating scale; the possible responses ranged from “strongly disagree” to “strongly agree.” The section of the survey on insights into care included seven items adapted with permission from the Jefferson Scale of Physician Empathy developed by Hojat and colleagues.28 The section on support for providers included items excerpted and modified from the Perceived Stress Scale of Cohen and colleagues.29 Program stakeholders, including a sample of Rounds leaders, reviewed the measures for face validity.

Statistical analysis

Responses to 15 statements about patient interactions were highly correlated (Cronbach coefficient: 0.88). We called this set of items the Patient Interaction Scale. Responses to nine questions about teamwork also were highly correlated (Cronbach coefficient: 0.88). We called this set of items the Teamwork Scale. The items in both scales are shown in Appendix 1.
Using these scales, we calculated a Patient Interaction score and a Teamwork score for each participant in the pre/post surveys. The scores were based on respondents’ average responses to the items in each scale. We used regression analysis to assess whether exposure to Rounds explained the outcomes of interest. There was a great deal of variability in the Rounds attendance of survey respondents, which provided us with natural comparison groups. Besides examining Rounds attendance, we explored the influence of professional discipline; the participants’ years of experience, age, gender, and race/ethnicity; and the presence of other opportunities to discuss the psychosocial and emotional aspects of care. However, these variables were generally not predictive of higher postsurvey scores.

For the retrospective analysis, we used one-way analysis of variance to evaluate whether exposure to Rounds explained the outcomes of interest. We calculated the significance of changes in perceived stress by using two-tailed t tests.

Results

Survey response rates

To estimate overall average Rounds attendance at the six sites, we calculated the midpoint of attendance ranges reported by Rounds leaders at each experienced site. Out of an estimated 413 potential respondents, 256 responded to the retrospective survey, for an estimated average response rate of 62%. We sent the prospective pre-Rounds survey to potential attendees identified by Rounds leaders (as described in Methods). Only those who responded to the pre-Rounds survey (n = 399) received the post-Rounds survey. The overall response (or retention) rate for the pre/post survey was 56% (n = 222).

Respondents

We assessed respondents’ age, gender, race/ethnicity, discipline, and years of professional practice to ascertain the demographic characteristics of caregivers who attend the Rounds. Most of the respondents were experienced caregivers; 43% of the retrospective respondents and 51% of pre/postsurvey respondents had been professionals for more than 20 years. Their average age was 46 to 49 years. Most of the respondents to both the retrospective and the pre/post surveys described themselves as white (90% and 88%, respectively) and female (78% and 82%, respectively). Respondents to the retrospective and the pre/post surveys were nurses (38% and 51%, respectively), physicians (21% and 19%, respectively), social workers (18% and 5%, respectively), clergy (6% and 5%, respectively), or other (17% and 20%, respectively).

Table 1

<table>
<thead>
<tr>
<th>Changes</th>
<th>Attendance frequency: No.</th>
<th>Item response: Mean (SD)†</th>
<th>F‡</th>
<th>P value§</th>
</tr>
</thead>
<tbody>
<tr>
<td>I try harder to attend to patients’ nonverbal cues and body language</td>
<td>Infrequent: 113</td>
<td>4.40 (1.25)</td>
<td>4.078</td>
<td>.045</td>
</tr>
<tr>
<td></td>
<td>Frequent: 137</td>
<td>4.71 (1.17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have more compassion for patients and families</td>
<td>Infrequent: 113</td>
<td>4.37 (1.29)</td>
<td>4.884</td>
<td>.028</td>
</tr>
<tr>
<td></td>
<td>Frequent: 136</td>
<td>4.71 (1.10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel more energized about my work</td>
<td>Infrequent: 113</td>
<td>4.36 (1.31)</td>
<td>4.994</td>
<td>.026</td>
</tr>
<tr>
<td></td>
<td>Frequent: 137</td>
<td>4.71 (1.13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have new strategies for handling patient situations</td>
<td>Infrequent: 113</td>
<td>4.35 (1.19)</td>
<td>5.802</td>
<td>.017</td>
</tr>
<tr>
<td></td>
<td>Frequent: 137</td>
<td>4.69 (1.04)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am more comfortable discussing sensitive issues with patients and their families</td>
<td>Infrequent: 113</td>
<td>4.27 (1.16)</td>
<td>4.438</td>
<td>.036</td>
</tr>
<tr>
<td></td>
<td>Frequent: 136</td>
<td>4.56 (1.04)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

‡ “Frequent” attendees came to Rounds five or more times in the last year. “Infrequent” attendees came fewer times.

§ Responses to each question were measured on a scale from 1 (strongly disagree) to 6 (strongly agree).

F The F statistic is the mean square for the factor divided by the mean square for the error.

§ Calculated by one-way analysis of variance between groups attending frequently and groups attending infrequently.
patient care before attending the Rounds. In the prospective presurvey, the average score on the Patient Interaction Scale was 5.01 out of 6, and the average score on the adapted Jefferson Scale of Physician Empathy was 5.33 out of 6. When we controlled for any presurvey differences, regression analysis showed that the greater the number of Rounds attended, the higher the postsurvey Patient Interaction score ($P < .05$).

In addition, in the prospective study’s postsurvey, administered after Rounds had occurred seven or more times at each site, we asked prospective study respondents to rate how strongly they agreed or disagreed with four statements about any changes in their patient interactions that specifically resulted from their attending the Rounds. We found that the greater the number of Rounds a person attended, the greater the impact on that person’s insights into psychosocial aspects of care ($P < .01$), focus on the effects of illness on patients’ lives and families ($P < .05$), and compassion ($P < .05$). Figure 1 illustrates these findings.

### Impact on teamwork

We measured teamwork among providers by exploring the following areas in both retrospective and pre/post surveys: appreciation for the roles of colleagues from one’s own and other disciplines, communication with colleagues about both clinical and psychosocial aspects of care, cooperation and coordination with colleagues, openness to expressing thoughts and concerns about patient care with colleagues, willingness to offer and receive support from colleagues, feelings of being alone, and a sense of belonging to a patient care team. Nearly all retrospective survey respondents indicated that Rounds had improved their participation as part of a team (Table 2). In particular, respondents had a heightened appreciation of the roles and contributions of colleagues from other disciplines and improved communication about both psychosocial issues and clinical issues.

In the prospective study’s presurvey, the average score on the Teamwork Scale was 5.29 out of 6. In the prospective study’s postsurvey, the greater the number of Rounds attended, the higher the postsurvey Teamwork score (after control for any presurvey differences).

### Table 2

**Retrospective Survey of Improvement in Teamwork as a Result of Schwartz Center Rounds Attendance at Experienced Sites, 2006–2007 (N = 245–248)**

<table>
<thead>
<tr>
<th>Area of improvement in teamwork</th>
<th>Degree of improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all or only a little: No. (%)</td>
</tr>
<tr>
<td>Appreciation of roles/contributions of colleagues from other disciplines</td>
<td>18 (7)</td>
</tr>
<tr>
<td>Appreciation of roles/contributions of colleagues from your discipline</td>
<td>27 (11)</td>
</tr>
<tr>
<td>Improved communication with colleagues about psychosocial issues</td>
<td>26 (10)</td>
</tr>
<tr>
<td>Improved communication with colleagues about clinical issues</td>
<td>36 (15)</td>
</tr>
<tr>
<td>Openness in expressing thoughts, questions, feelings about patient care with colleagues</td>
<td>31 (13)</td>
</tr>
<tr>
<td>Willingness to offer or receive support from a colleague</td>
<td>35 (14)</td>
</tr>
<tr>
<td>Cooperation/coordination with colleagues in patient care</td>
<td>28 (11)</td>
</tr>
<tr>
<td>Your sense of belonging to a caregiver team</td>
<td>30 (12)</td>
</tr>
<tr>
<td>Feelings of being alone in your work with patients</td>
<td>60 (24)</td>
</tr>
</tbody>
</table>

*Data from these two categories were collapsed because of the small number of rating responses within each category.*
(P < .05). In addition, when we asked prospective study respondents to rate how strongly they agreed or disagreed with three statements about any changes in their perceptions about their colleagues and their interactions that specifically resulted from their attending the Rounds, we found that the greater the number of Rounds a person attended, the greater the impact on that person's appreciation of colleagues' roles and contributions (P < .05), communication with colleagues (P < .01), and teamwork (P < .01) (Figure 2).

Semistructured interviews with participants at experienced sites showed that Rounds helped providers get to know one another and enabled them to put themselves in each other's place by hearing about their perspectives and experiences. One participant said, "I've gotten to know more people, and we can talk outside of Rounds as well. I think it is fostering good communication among teams." In addition to getting to know one another, caregivers gain a deeper understanding of their colleagues' challenges. Another participant said, "I truly have a higher level of respect for what [my] colleagues do and what they have to endure."

The Rounds enhance a sense of connection and shared purpose. One participant said, "You get a sense of solidarity and camaraderie because many people hold the same priorities." They also offer opportunities to model humility and to learn from others. Another participant said, "[Rounds] gives you permission to say, 'I don't know,' or 'We're still learning.' Schwartz models that capacity to be less all-knowing and to value expertise that isn't medical—that includes connection [and] compassion. It creates a new sense of competency, rather than arrogance."

**Impact on stress and personal support**

Respondents to the retrospective survey compared how often they experienced feelings of stress and an inability to manage the psychosocial and emotional demands of patient care before they began attending Rounds with how often they experienced those feelings at the time of the survey.29 Survey results indicated statistically significant decreases in respondents' perceived stress (P < .001) and statistically significant increases in their ability to cope with the psychosocial demands (P < .05) and emotional difficulties (P < .01) of work after they attended Rounds, as compared with those ratings before they began to attend Rounds. There was, however, no significant change in respondents' confidence in their ability to handle difficult psychosocial aspects of care.

Most of the respondents to the prospective study's postsurvey (administered after their institutions had conducted seven or more Rounds) indicated that they felt more supported, less stressed, and less isolated after attending Rounds, although we did not find statistically significant changes in these domains. However, the more Rounds attended by pre/poststudy respondents, the greater the perceived impact of Rounds on these domains (Table 3).

**Institutional outcomes**

Fifty-one percent of retrospective and 40% of pre/postsurvey respondents observed changes in practices or policies within their departments or institutions since the initiation of Rounds. Participants at experienced sites were also asked this question during the semistructured interviews. All comments fell into four categories: unique and profound contribution, teamwork, patient-centered approach to care, and specific institutional outcomes.

The comments indicate that Rounds provide an opportunity for dialogue among providers that is otherwise largely unavailable. Such dialogue has the potential to change institutional culture. One participant said, "Rounds are a place where people who don't usually talk about the heart of the work are willing to share...their vulnerability, to question themselves. Rounds are an opportunity for dialogue that doesn't happen anywhere else in the hospital." Another said, "I don't think there are standard operating procedures that have changed...[I]t's more the culture [that has changed]." There should be a complete package of care that addresses the psychological, social, and spiritual aspects of care in addition to the medical—that should be the standard.

Respondents and interviewees emphasized the impact of Rounds on teamwork and communication across professions. One interviewee said, "The Rounds have given us the opportunity to open up a dialogue within our various clinics." Another said, "When Rounds started, we weren't in multidisciplinary teams, and I think Rounds fostered that movement." They also commented on...
having gained a sense of “the big picture” of patient care in their institutions and how they fit into it: “The mosaic . . . is more clear, instead of [your] being in your own encapsulated compartment.”

Respondents, especially those at newer Rounds sites, commented on their departments’ adoption of a more patient-centered approach to care. One said, “There are more patient care conferences to coordinate care [in] difficult situations.” Another mentioned, “There is more of a focus on what is best for the patient whenever we are contemplating changes in policies, procedures, or unit processes.”

Respondents also described institutional outcomes, including greater use of palliative care services and specific initiatives to improve patient care and provider support. One respondent said, “The number of days before the palliative care team is consulted has decreased since the Rounds.” An interviewee at an experienced site said, “We have been able to set up, with a group of nurses, an intervention in our [intensive care unit]. The standard of care is now that two nurses [rather than one] get to meet and know all patients with bad prognoses. This idea came from topics at Schwartz Rounds.” Another said, “One of the docs who is an anesthesiologist has formed a group to give support to people who are responsible for medical errors. . . . He presented his case a few years ago at Rounds, and this was a catalyst for starting the group.”

Table 3

<table>
<thead>
<tr>
<th>Changes</th>
<th>Attendance frequency: No. *</th>
<th>Item response: Mean (SD)†</th>
<th>F‡</th>
<th>P value§</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel more supported in work with patients</td>
<td>One-time: 25</td>
<td>4.32 (1.11)</td>
<td>3.108</td>
<td>.048</td>
</tr>
<tr>
<td></td>
<td>Infrequent: 80</td>
<td>4.53 (1.35)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequent: 48</td>
<td>5.00 (1.17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel less stressed in work with patients</td>
<td>One-time: 25</td>
<td>3.64 (1.44)</td>
<td>4.133</td>
<td>.018</td>
</tr>
<tr>
<td></td>
<td>Infrequent: 80</td>
<td>4.16 (1.40)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequent: 45</td>
<td>4.58 (1.08)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel less isolated in work with patients</td>
<td>One-time: 25</td>
<td>3.76 (1.27)</td>
<td>4.225</td>
<td>.016</td>
</tr>
<tr>
<td></td>
<td>Infrequent: 80</td>
<td>4.30 (1.40)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequent: 47</td>
<td>4.70 (1.20)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* “One-time” attendees came to Rounds one time during the study period. “Infrequent” attendees came two to five times. “Frequent” attendees came six or more times.
† Responses to each question were measured on a scale from 1 (Strongly disagree) to 6 (Strongly agree).
‡ The F statistic is the mean square for the factor divided by the mean square for the error.
§ Calculated by one-way analysis of variance between groups.

Discussion
We describe here the evaluation of an educational forum that enhances communication with patients and families and among health care professionals while building the sense of support that professionals need to sustain themselves in their work. The Rounds foster several domains of the “patient-centeredness” that is desired by patients and family members, including a focus on understanding the patient as a whole person within a unique context and understanding the patient’s experience of illness.31,32 Respondents in our retrospective study reported greater insight into the psychosocial and emotional aspects of illness and care, a greater likelihood that they would consider the effects of illness on patients and families, and enhanced empathy (measured by a well-validated scale)—all as a result of their attending Rounds.

Attending the Rounds enhanced participants’ understanding of the perspectives and challenges of colleagues, as well as of interdisciplinary communication. The qualitative data suggest that the Rounds provide a forum in which to experience a sense of connection and to reinforce a sense of shared purpose. These findings suggest that the Rounds can foster teamwork; attitudes toward teamwork are important because they can affect performance.33,34 Effective teams require open communication and mutual respect for all members and their contributions.35 Communication is often stymied, however, by professional hierarchies, the difficulty of speaking up across authority gradients,36 discrepancies in perceptions about the presence or absence of collaboration,37,38 and differences in preferences for professional hierarchies.39 The Rounds provide attendees with a glimpse into the day-to-day professional lives of coworkers across disciplines and professions. By providing attendees with opportunities for dialogue, not just about patient care but also about their own experiences and the complexities of relating to one another, the Rounds may have the potential to initiate collaboration and to loosen hierarchical power structures.

The majority of pre/postsurvey respondents reported that Rounds attendance improved their sense of support and decreased their stress and sense of isolation. Retrospective respondents reported significant improvements in these areas after they began attending the Rounds. The burgeoning literature on stress and burnout attests to the significance of these problems among health care workers, students, and trainees.40–44 Occupational stress and burnout affect providers’ quality of life, which may result in absenteeism and staff turnover, which, in turn, affect service delivery, patient satisfaction, and institutional economics.45–47 Limited evidence supports work-directed interventions to reduce stress, general symptoms, and burnout.48 The sources of stress and burnout include conflict with patients and coworkers and the difficulties
inherent in caring for chronically or terminally ill patients. The Rounds address these issues, and they may be a helpful component of longitudinal interventions to reduce work-related stress.

Most respondents in the poststudy of the prospective study endorsed the impact of Rounds on their insights into illness, patient-centered focus, teamwork, and stress. However, we did not observe significant changes from the presurvey to the postsurvey in perceived empathy, impact on patient interactions, teamwork, or stress among these respondents. This lack of change may be due to at least two factors: the high levels of initial endorsement of these attributes by respondents in the presurveys and the length of time the Rounds had been in existence. The Rounds had been implemented for three or more years at retrospective sites, but for only one year to 18 months at pre/post sites. The average number of Rounds attended at pre/post sites was 4.5 sessions.

Educational and organizational efforts take time to change participants’ attitudes and behaviors. We do not know the optimal number of Rounds sessions needed to effect such changes, but we cannot exclude the possibility that continued Rounds attendance over a longer period may facilitate such changes. Indeed, we observed a significant association between the number of Rounds attended and the Patient Interaction Scale and Teamwork Scale in both retrospective and pre/post studies—the more Rounds attended, the greater the impact. Furthermore, the greater the number of Rounds attended by pre/poststudy respondents, the greater the perceived impact of Rounds on feelings of being supported, less stressed, and less isolated.

This study had some limitations. Because Rounds sites do not keep master lists of attendees, we could not calculate precise response rates. Self-reported behaviors cannot be assumed to correlate with actual behaviors. Comparison of the impact of Rounds on attendees’ and nonattendees’ actual behaviors, patient satisfaction, clinical outcomes, teamwork performance measures, and burnout would be of interest, but, as with any educational intervention embedded within complex systems, such an effect would be difficult to attribute solely to Rounds. The impact of the duration of Rounds on measured outcomes may be clarified by extended pre/post studies in the future.

Conclusions
This study shows the impact of a longitudinal forum that fosters interdisciplinary communication, teamwork, and support. These issues are vitally important to patients, providers, health care organizations, and policy makers. The Rounds represent an important addition to educational and organizational efforts to enhance a sense of shared purpose and connection in the practice of medicine and the effective care of patients. Future studies to examine their impact on measures of quality and safety will be of interest.

Acknowledgments: The authors wish to thank Marjorie Stanler from the Kenneth B. Schwartz Center for her contribution to the development of survey questions, study design, and overall supervision of its implementation. The authors also acknowledge the Schwartz Center Rounds leaders at all of the participating sites for their contributions to this work. Finally, the authors recognize the study team at Goodman Research Group, Inc., including Michelle Acker, Emik Pressman, Laura Houseman, and Irene F. Goodman, for their assistance in designing and implementing the evaluation of the Schwartz Center Rounds.

Funding/Support: The Kenneth B. Schwartz Center provided funding to Goodman Research Group, Inc. to conduct this study.

Other disclosures: Dr. Lown is a member of the Schwartz Center Board of Directors. Colleen Manning is an employee of the Goodman Research Group, Inc., Cambridge, Massachusetts.

Ethical approval: This study received approval from the following institutional review boards and committees: Committee on Clinical Investigations, Beth Israel Deaconess Medical Center, Boston, Massachusetts; Partners Human Subjects Research Committee, Brigham and Women’s Hospital, Boston, Massachusetts; Institutional Review Board, Brockton Hospital, Brockton, Massachusetts; Indiana University–Purdue University Indianapolis Institutional Review Board, Indiana University Cancer Center, Indianapolis, Indiana; Johns Hopkins Medicine Institutional Review Board, Johns Hopkins–Sidney Kimmel Comprehensive Cancer Center, Baltimore, Maryland; Lawrence Memorial Hospital Research Committee, Lawrence Memorial Hospital, Medford, Massachusetts; Partners Human Subjects Research Committee, Massachusetts General Hospital, Boston, Massachusetts; Institutional Review Board, Mayo Clinic, Jacksonville, Florida; Institutional Review Board, MetroWest Medical Center, Framingham, Massachusetts; MidMichigan Medical Center–Midland Institutional Review Board, MidMichigan Medical Center, Midland, Michigan; Atlantic Health System Institutional Review Board, Overlook Hospital, Summit, New Jersey; Institutional Review Board, Roswell Park Cancer Institute, Buffalo, New York; Institutional Review Board, Scripps Mercy Hospital, San Diego, California; Subjects Review Board, University of Rochester Medical Center, Rochester, New York; Virtua Health Institutional Review Board, Virtua Health–Memorial Hospital, Mount Holly, New Jersey; Institutional Review Board, West Michigan Cancer Center, Kalamazoo, Michigan.

Disclaimer: The Schwartz Center was not involved in the analysis or interpretation of study data.

Previous presentation: Some of the results of this study were presented as an abstract at the American Academy on Communication in Healthcare, Teaching and Research Forum, October 18, 2008, Madison, Wisconsin.

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Appendix 1

A Complete List of the Items Contained in the Patient Interaction Scale and the Teamwork Scale Administered to Schwartz Center Rounds Attendees in Both Retrospective and Prospective Surveys, 2006–2007

The Patient Interaction Scale: Insight into the psychosocial and emotional aspects of patient care (Cronbach $\alpha = .88$)

- I am comfortable discussing tough/sensitive nonclinical issues with patients and their families.
- I have sufficient ideas/strategies for handling patient situations.
- I have compassion (sharing in the suffering of others) for patients and their families.
- I feel energized about my work with patients.
- I try to understand what is going on in patients’ minds by paying attention to their nonverbal cues and body language.
- I try to imagine myself in patients’ shoes when providing care to them.
- I show emotion when responding to a patient’s expression of feelings.
- I consider the effects of illness on the personal lives of my patients.
- I consider the effects of illness on my patients’ families.
- I try not to be hurried during my time with patients.
- I make a point to ask my patients about their interests, profession, and background.
- I share personal information with patients when it is appropriate.
- I consider what I know about a patient’s coping style before deciding how to deliver bad news.
- I focus on my body language and other nonverbal communications.
- I try to review and communicate test results quickly to alleviate patient anxiety.

The Teamwork Scale: Insight into aspects of working with colleagues and being a member of a team (Cronbach $\alpha = .88$)

- I appreciate the roles and contributions of colleagues from disciplines other than my own.
- I appreciate the roles and contributions of colleagues from my own discipline.
- I have good communication with colleagues about nonclinical aspects of patient care.
- I have good communication with colleagues about clinical aspects of patient care.
- I cooperate/coordinate with colleagues on behalf of patients.
- I am open to expressing thoughts, questions, and feelings about patient care with colleagues.
- I am willing to offer support to or receive support from a colleague.
- I feel alone in my work with patients.
- I have a sense of belonging to a caregiver team.
One afternoon, a doctor friend whose clinical skills and bedside manner I've long admired called wanting desperately to talk about her day. Exasperated, and feeling as if she had no one to turn to at work, she reached out to me, her friend.

Earlier that day, a transplant patient had threatened to stop taking one of his medications. Proud of his looks, he had become despondent when the drug made his gums swell. “He thought he looked like a freak,” my friend said.

But he needed the drug to keep his body from rejecting the transplanted organ, so my friend tried to reason with him. When that didn’t work, she began bargaining, then pleading and cajoling. The more he refused, the more frustrated she got. To her, swollen gums seemed like a small price to pay for a lifesaving transplant, and she found herself growing increasingly angry with the patient.

“All those ideals about empathizing with patients and respecting their choices went flying right out the window,” she said. She had thought about asking a colleague at work for advice but feared she would be judged, even blamed. “Everyone is ready to tell us to be caring and compassionate, but it’s really hard sometimes, trying to do to the right thing all alone.”

Studies have shown that health care that respects patient values and preferences influences how well patients do. Statistics show that such compassionate care can improve control of diabetes, increase patient adherence to treatment recommendations, decrease the use of costly diagnostic testing and lower hospitalization readmission rates for ailments like heart attacks and pneumonia.

But the mounting evidence has also led to a flood of new mandates, how-to tips, scorecards and reimbursement policies linked to the new standards. And there is no shortage of experts eager to explain it all and to remind clinicians to, well, be compassionate.

The enthusiasm reflects excellent intentions, of course. The problem is that when faced with a complicated case that falls outside of the relatively simplistic boundaries of the irreproachable truisms, caregivers are almost always on their own. That professional isolation — and the moral distress that goes with it — has contributed to alarming levels of professional burnout.

But one organization has been working to change that by quietly focusing where others have not: on supporting caregivers in their everyday clinical work.
Inspired by the experiences of Kenneth B. Schwartz, a Boston health care lawyer who died of cancer in 1995 at the age of 40, the Schwartz Center for Compassionate Healthcare has for the last 15 years run a program known simply as Schwartz Rounds. Held on a monthly or bimonthly basis in hospitals, nursing homes, community health centers and academic medical centers across the country, these rounds, or meetings, are an opportunity for clinicians to discuss emotionally challenging cases or issues in their work.

Led by a trained facilitator, the rounds attract up to 200 doctors, nurses, social workers and other caregivers and employees. There is a strict code of confidentiality. Typical topics include cases in which a clinician and patient can no longer communicate effectively because of differing religious views, instances in which a caregiver makes mistakes and situations in which patients or their family members become violent with caregivers.

The discussions that ensue are often emotional. But instead of focusing on blame, discussion leaders work to transform these stressful moments into an opportunity for clinicians from all disciplines to encourage and support one another. “With problems like these, people usually just end up pointing fingers,” said Dr. Stephen Nalbach, a resident in neurosurgery at Brigham and Women’s Hospital in Boston. “Schwartz Rounds is like a conversation where we get to debrief and learn from others and try to do better, instead of just moving on and forgetting.”

While early critics might have been skeptical about the effect of these meetings, a recent study in the journal Academic Medicine has shown that clinicians who attend Schwartz Rounds feel significantly less stress and are better able to cope with the demands of their work. The more frequently they attend rounds, the more easily they discuss sensitive issues with their patients.

What’s more, they feel energized about their work and better equipped to come up with new strategies for handling difficult patient situations. Institutional culture has been shown to improve as well, with about half of all participants citing a greater focus on patient-centered and team-based care at hospitals that hold Schwartz Rounds.

The change even trickles down to the language of the workplace. “At some centers, ‘Schwartz’ has become a verb,” said Julie Rosen, executive director of the Schwartz Center. “To ‘de-Schwartz’ means to lose one’s compassion, and to ‘Schwartz it’ means to add conviction and compassion to a job.”

Offering these rounds requires a significant commitment from both the center and the more than 200 hospitals that currently hold the rounds. The cost for the first year, not including the time and effort of on-site clinicians who must step away from their work to attend or those involved in the planning of each meeting, is approximately $15,000 per institution. The Schwartz Center, which relies primarily on philanthropic sources for its own operations, generally pays a large part of these initial costs, but thereafter each site shoulders most of its own expenses while the center provides ongoing support in the form of evaluations, regular visits and handouts and other materials.

Despite these expenses, the center is continuing to expand the program. An additional 31 hospitals, including Emory University Hospital, Geisinger Medical Center and Stanford University Hospital, have joined the program this year. The center has also begun working with
hospitals in Britain, where six centers now hold Schwartz Rounds.

In an essay he published shortly before he died, Mr. Schwartz described the relationships he had with several of his caregivers during his final months of life. Struggling to come to terms with leaving behind a wife and 3-year-old son, he wrote that the “acts of kindness — the simple touch from my caregivers — have made the unbearable bearable.”

“If I have learned anything,” he continued, “it is that we never know when, how or whom a serious illness will strike. If and when it does, each one of us wants not simply the best possible care for our body but for our whole being.”

His legacy has made that possible for all of us, patients and caregivers.