

LETTERS TO EDITOR

In Reference to “Changes in Patient Satisfaction Related to Hospital Renovation: The Experience With a New Clinical Building”

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We complement Dr. Siddiqui et al. on their article published in the *Journal of Hospital Medicine*.¹ Analysis of the role of new physical environments on care and patient satisfaction is sparse and desperately needed for this high-cost resource in healthcare delivery. A review of the original article led us to several observations/suggestions.

The focus of the study is on perceived patient satisfaction based on 2 survey tools. As noted by the authors, there are multiple factors that must be considered related to facilities—their potential contribution to patient infections and falls, the ability to accommodate new technology and procedures, and the shifting practice models such as the shift from inpatient to ambulatory care. Patient-focused care concepts are only 1 element in the design challenge and costs.

The reputation of Johns Hopkins as a major tertiary referral center is well known internationally, and it would seem reasonable to assume that many of the patients were selected or referred to the institution based on its physicians. It does not seem unreasonable to assume that facilities would play a secondary role, and that perceived satisfaction would be high regardless of the physical environment. As noted by the authors, the transferability of this finding to community hospitals and other settings is unknown.

Patient satisfaction is an important element in design, but staff satisfaction and efficiency are also significant elements in maintaining a high-quality healthcare system. We need tools to assess the rela-

tionship between staff retention, stress levels, and medical errors and the physical environment.

The focus of the article is on the transferability of perceived satisfaction with environment to satisfaction with physician care. Previously published studies have shown a correlation with environments and views from patients' rooms with reduced patient stress levels and shorter lengths of stay. Physical space should not be disregarded as a component of effective patient care.²

We are committed to seeking designs that are effective, safe, and adaptable to long-term needs. We support additional research in this and other related design issues. We hope that the improvements in patient and family environments labeled as “patient focused” will continue to evolve to respond to real healthcare needs. It would be unfortunate if progress is diverted by misinterpretation of the articles findings.

References

1. Siddiqui ZK, Zuccarelli R, Durkin N, Wu AW, Brotman DJ. Changes in patient satisfaction related to hospital renovation: experience with a new clinical building. *J Hosp Med*. 2015;10(3):165–171.
2. Ulrich RS, Zimring CP, Zhu X, et al. A review of the research literature on evidence-based healthcare design. *HERD*. 2008;1(3):61–125.

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The Authors Reply “Changes in Patient Satisfaction Related to Hospital Renovation: The Experience With a New Clinical Building”

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We thank Mr. Zilm and colleagues for their interest in our work.¹ Certainly, we did not intend to imply that well-designed buildings have little value in the efficient and patient-centered delivery of healthcare. Our main goal was to highlight (1) that patients can distinguish between facility features and actual care delivery, and poor facilities alone should not be an excuse for poor patient satisfaction; and (2) that

global evaluations are more dependent on perceived quality of care than on facility features. Furthermore, we agree with many of the points raised. Certainly, patient satisfaction is but 1 measure of successful facility design, and the delivery of modern healthcare requires updated facilities. However, based on our results, we think that healthcare administrators and designers should consider the return on investment on the costly features that are incorporated purely to

improve patient satisfaction rather than for safety and staff effectiveness.

Referral patterns and patient expectations are likely very different for a tertiary care hospital like ours. A different relationship between facility design and patient satisfaction may indeed exist for community hospitals. However, we would caution against making this assumption without supportive evidence. Furthermore, it is difficult to attribute lack of improvement of physician scores in our study because of a ceiling effect. The baseline scores were certainly not exemplary, and there was plenty of room for improvement.

We agree that there is a need for high-quality research to better understand the broader impact of healthcare design on meaningful outcomes. However, we are not

impressed with the quality of much of the existing research tying physical facilities with patient stress or shorter length of stay, as mentioned by Mr. Zilm and colleagues. Evidence supporting investment in expensive facilities should be evaluated with the same high standards and rigor as for other healthcare decisions.

Reference

1. Siddiqui ZK, Zuccarelli R, Durkin N, Wu AW, Brotman DJ. Changes in patient satisfaction related to hospital renovation: experience with a new clinical building. *J Hosp Med.* 2015;10(3):165–171.

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In Reference to “Managing Superutilizers—Staying Patient Centered Is the Solution”

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The development of complex care plans at our institution is challenging, and the editorial by Drs. Li and Williams¹ characterizes some of our concerns as well. We agree that there are risks of care plans becoming overly paternalistic. In our process, we attempt to engage patients in the development of their care plans, with varying degrees of success. For example, we continue to engage patients in overcoming access issues, including housing and transportation, and to gather input in pain-management strategies. The level of patient involvement depends greatly on the reasons for their utilization and their level of engagement. In some cases we have even gone beyond the patient to incorporate social networks and caregivers. The patient-centered approach to which Drs. Li and Williams refer may work well in populations that have traditional support systems, high medical liter-

acy, and high levels of patient engagement, but for our particular superutilizer population, there has often been little interest in interacting with the healthcare system in a traditional fashion. Despite this, we, like Drs. Li and Williams, feel it is an important element that should not be ignored and continue to seek opportunities for patient engagement in our care plan process.

Reference

1. Li J, Williams M. Managing superutilizers—staying patient centered is the solution. *J Hosp Med.* 2015;10(7):467–678.

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The Authors Reply “Managing Superutilizers—Staying Patient Centered Is the Solution”

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We appreciate the study’s authors acknowledging the importance of patient engagement. Nonetheless, we are disappointed by their statement that the “patient centered approach... may work well in populations that have traditional support systems, high medical literacy and high levels of patient engagement, but for our particular super utilizer population, there has often been

little interest in interacting with the health care system in a traditional fashion.” To us, this paternalistic attitude of “we know what’s best for them,” does not equate with “what might work best for you?” Patients lacking common social supports, inadequate insurance, and suffering from low health literacy may be unable to interact with the healthcare system in a “traditional”