The Many Facets of Excellence
Dear Colleague:

The drive toward excellence in patient-centered care is a continuous journey, fueled in large part by patients’ perceptions of the quality of care they receive and their satisfaction with the care experience. Organizations that set their sights on this goal understand that achieving it requires a relentless focus on improvement.

As strategic partners in this journey, we at Press Ganey embrace the tremendous responsibility of ensuring that every patient’s voice is heard. We are committed to promoting a culture of high-quality, high-value health care by collecting, analyzing and communicating volumes of actionable data and by constructively engaging physicians and employees in improvement efforts informed by this data.

The essential factors in the pursuit of excellence include:

- Properly positioning the health system “brand” of mission, quality, safety and the patient experience
- Developing and consistently communicating a clear strategic vision
- Engaging top leadership, medical staff and employees in the endeavor
- Encouraging patient and family involvement at multiple levels
- And systematically measuring and meeting patients’ needs

Through attention to these factors, many of our partner organizations have been able to achieve phenomenal gains in patient-experience measures. Lifetime Health Medical Group, a New York-based medical practice group in New York, saw a nearly 50% relative improvement in its mean percentile “Likelihood to Recommend” score in the course of one year. Amazingly, the mean score on this measure for the group’s urgent care centers rose from 36.2 to 82.4 during that period (page 25).

And at The Ohio State University Wexner Medical Center, the organization’s “Overall Hospital” ranking, which hovered around the 25th percentile in 2006, has since topped the 80th percentile thanks in large part to a targeted initiative to improve leadership engagement and foster accountability, as well as a culture that promotes continuous process improvement (page 19).

As the excellence “bar” continues to rise, we must all continue to move with it by defining new and better ways of doing things. Never has the need been greater to get the most value out of everything we do, and never has the role of teamwork been more critical. Creating a system of high-quality, equitable health care requires the efforts and commitment of all stakeholders.

Patrick T. Ryan
CEO
“Perfection is not attainable. But if we chase perfection, we can catch excellence.”

Vince Lombardi was referring to success on the gridiron, but the iconic coach’s words are just as applicable to health care. In fact, “chasing perfection” is what stakeholders in the health care industry are being challenged to do as they strive to deliver patient-centric care in the era of health care reform.

Driven by the demand for continuous improvement across diverse measures of quality, safety and value, health care leaders are diving deep into their organization’s performance data to transform every facet of the patient experience.

“The minute we start thinking that we are ‘good enough’ in any given area is precisely when something will arise that will let us know that there is no such thing as ‘good enough,’” Dr. Ernest Mazzaferri, medical director of The Ohio State University Wexner Medical Center’s Richard M. Ross Heart Hospital, said in an interview for this issue of Partners (“The Many Facets of Excellence,” page 14).

Excellence in health care is clearly a moving target—but one that is within range for organizations that commit to its pursuit.

Diana Mahoney
Editor-in-Chief
**Surgical Readmissions May Be Quality Surrogate**

Nearly one in seven patients hospitalized for a major surgical procedure is readmitted within 30 days of discharge, although the readmission percentages vary based on the surgical volume and mortality rates of individual hospitals, according to a study of national Medicare data.

Hospitals with high surgical volume and low surgical mortality have lower rates of surgical readmission than other hospitals, Dr. Thomas C. Tsai and his colleagues from Harvard University, Brigham and Women’s Hospital and the Veterans Affairs Boston Healthcare System reported in the September 18 issue of the *New England Journal of Medicine*.

To gain insight into variation in rates of readmission after major surgery and the relationship between the rates at a given hospital and other markers of surgical care quality, the researchers calculated 30-day readmission rates after hospitalization for coronary artery bypass grafting, pulmonary lobectomy, endovascular repair of abdominal aortic aneurysm, open repair of abdominal aortic aneurysm, colectomy and hip replacement. They conducted bivariate and multivariate analyses to assess the relationships between readmission rates and various quality measures, including adherence to surgical process measures based on Hospital Quality Alliance (HQA) surgical care scores, procedure volume and mortality.

For the six index procedures, there were 479,471 discharges from 3,004 hospitals, and the median risk-adjusted composite readmission rate at 30 days was 13%.

“In a multivariate model adjusting for hospital characteristics, we found that hospitals in the highest quartile for surgical volume had a significantly lower composite readmission rate than hospitals in the lowest quartile, at 12.7% compared with 16.8%,” the authors wrote. Among hospitals with the lowest surgical mortality rates, the median composite readmission rate was significantly lower than hospitals with the highest mortality rates, at 13.3% vs. 14.2%, while high adherence to reported surgical process measures was only marginally associated with reduced readmission rates, at 13.1% for the highest quartile and 13.6% for the lowest quartile. “Patterns were similar when each of the six major surgical procedures was examined individually,” they wrote.

It’s possible that the higher-volume, lower-mortality hospitals have lower readmission rates because those hospitals “have the systems and processes in place to protect surgical patients from some of the outcomes that might lead to readmission,” Tsai said in an interview.

The findings are important from a policy perspective, according to Tsai. The Centers for Medicare & Medicaid Services (CMS) currently bases its readmission penalty program on readmissions for medical conditions (heart failure, heart attack and pneumonia), “yet the evidence from the medical side does not show a clear relationship between hospital quality and readmission rates,” he said. “Our study identified a link on the surgical side.”

Because reducing hospital readmission rates is an important clinical and policy priority, according to Dr. Tsai, “the findings are good news for policy makers and the public health community as a way to reduce health care spending and improve outcomes for surgical patients.”

**Nation’s Health Tab to Climb under ACA**

The Affordable Care Act (ACA) is expected to add 0.1% in health care spending per year through 2022, which translates to a $621 billion increase to the nation’s health care tab over the next decade, according to an annual estimate of health spending trends.

In 2012, health care spending grew 3.9%, to $2.8 trillion, and is expected to stay under 4% in 2013, which is in line with
the low rate of growth seen over the past few years, according to a report by economists in the CMS Office of the Actuary published in the September 18 issue of Health Affairs.

The sluggish spending is not attributable to the ACA, the authors said. Rather, it is a consequence of larger trends, according to CMS economist Gigi Cuckler. “What we’ve seen over the past 50 years is that when the economy shrinks, so does health spending. When the economy recovers, health care spending increases.”

The spending hike is not likely to match the pre-recession levels, Cuckler said in a press briefing, noting that from 2012 to 2022, the average annual growth in health spending, which was 7.4% from 1990 to 2006, is expected to reach only 5.8%.

By 2014, the economists project spending will increase to 6.1%. Because the newly insured patients under ACA will be younger than the current insured population and will be less likely to require hospitalization, the spending increases will be higher for physician services and prescription drugs, according to Cuckler.

Specifically, overall spending on physician services is projected to increase 7% in 2014, compared to slightly less than 5% in 2012 and approximately 4% in 2013. If Congress allows the scheduled 25% reduction in physician payment rates as mandated by the Medicare Sustainable Growth Rate formula to go into effect in January, the 7% projection will drop to less than 5%, the economists noted.

While the nation’s overall health spending for Medicare services is expected to slowly increase through 2022 as the aging population increases both enrollment and per-enrollee spending, limited growth in fee-for-services payment increases will restrain Medicare spending. Additionally, if the recommended spending targets defined by the ACA’s Independent Payment Advisory Board (IPAB) are adopted as planned beginning in 2015, spending will be further restrained, they stated.

**HHS Releases Meaningful Consent Tools**

Federal health officials have developed an online resource to help medical practices explain to patients how their health information will be exchanged electronically with hospitals and other providers and to secure their consent for doing so.

The U.S. Department of Health and Human Services (HHS) launched the "As patients become more engaged in their health care, it is vitally important that they understand more about various aspects of their choices when it relates to sharing their health in the electronic information exchange environment," ONC Chief Privacy Officer Joy Pritt said in a statement.

The ONC pilot project tested the use of tablet computers to inform patients about the options available to them when they consider whether to electronically share their health information through an HIE.

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**Patient Consent for eHIE**

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**Meaningful Consent Overview**

Electronic health information exchange (eHIE) — the way that health care providers share and access health information using their computers — is changing rapidly. One way some providers share and access information is through a third-party organization called a health information exchange organization (HIE). As eHIE increases, patient trust in HIEs must be ensured and patients may more frequently be asked to make a "consent decision." This consent decision concerns the sharing and accessing of the patient’s health information through an HIE for treatment, payment, and health care operations purposes. Consent decisions may allow patients to determine the following, depending on the eHIE taking place:

- If their health information will be released,
- Under what circumstances the release will take place (e.g., any time or emergencies only?), and
- by whom (e.g., health care providers? HIE?).

Providers may choose to offer one or a combination of the following general types of consent policies (PDF - 71K):

- Opt-in — Default is that patient health information is not shared. Patients must actively express their consent to share.
- Opt-out — Default is for patient health information to automatically be available for sharing. Patients must actively express their desire to not have information shared if they wish to prevent sharing.

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**Quick Links**

What is Meaningful Consent?
What Do I Need to Know To Implement Meaningful Consent?
**INDUSTRY NEWS**

**ACP Issues Clinical Care Blueprint**

In a position paper titled “Principles Supporting Dynamic Clinical Care Teams” published in the September 17 issue of *Annals of Internal Medicine*, the American College of Physicians (ACP) states that advanced practice nurses and other providers can play a significant role on the clinical care team, but always with physician leadership.

“Internists are particularly well qualified to care for adults with complex illnesses and diagnostic challenges,” said ACP President Dr. Molly Cooke in a statement. “Depending on their specific clinical needs and circumstances, however, patients might appropriately be seen by other members of the clinical care team, with physicians being available for referrals or consultation as needed.”

The blueprint offers an example of a patient with advanced diabetes and other chronic conditions, suggesting that internists might refer the patient to an advanced practice nurse on the team who is an experienced diabetes patient educator. The nurse practitioner would work with the patient to facilitate a care management program, while the internist would have overall responsibility for the patient’s clinical care.

Advanced practice registered nurses and physicians assistants can typically provide wellness and preventive care services as well as care that can be delivered through a well-defined treatment algorithm for single, well defined problems, such as hypertension or hyperlipidemia, the authors wrote.

Importantly, all members of the care team must be clear with patients about their skills and training, especially those providers who use the title “doctor,” but who are not MDs, the authors stressed. “Because patients view the term ‘doctor’ as being synonymous with ‘physician’ when used in a health care setting, it is incumbent on all health care professionals with a doctoral degree other than JMD or DO to clarify that they are not physicians when using the term ‘doctor’ in the patient care setting.”

Although the make-up of clinical care teams may vary depending on specialty, clinical setting and the talents of individual team members, most teams should include physicians, advanced practice nurses, other registered nurses, physician assistants, clinical pharmacists and other health care professionals, the authors wrote.

Most important, however, clinical care teams must be built on a “culture of trust, shared goals, effective communication and mutual respect for the distinct skills, contributions and roles of each member,” the authors stated. Toward this end, medical training programs should spend more time teaching providers how to work as part of a team, and policymakers should keep team-based care in mind with respect to changes to the health care payment system. While the current fee-for-service system does not promote coordinated care, new models, such as bundled payments and accountable care organizations, are more amenable to team-based approaches, they wrote.

“Regulatory and payment policies must be aligned with and support team-based care models rather than creating barriers,” Dr. Cooke said in the ACP statement.

**Proposed FQHC Rule Would Increase Medicare Payments in Underserved Areas**

As required by the ACA, CMS has issued a proposed rule to establish a prospective payment system for Federally Qualified Health Centers (FQHCs) under Medicare Part B beginning October 1, 2014.

Medicare currently pays FQHCs, which are generally required to treat patients regardless of their ability to pay, based on reasonable costs and subject to established payment limits for covered services that are provided to Medicare beneficiaries. The Affordable Care Act requires that the new Medicare PPS account for a number of factors, including the type, intensity and duration of services provided in this setting, without payment limits that exist under the current system.

FQHCs will be transitioned to the new payment system throughout fiscal year 2015. The move to the new system “will help even more patients get care in federally supported health centers,” CMS Administrator Marilyn Tavenner said in a press briefing. “The services provided by these centers help ensure patients get important primary and preventive care that lowers costs and improves health outcomes.”

Under the proposed rule, Medicare will pay FQHCs a single encounter rate per beneficiary, per day for all services provided. The rate will be adjusted for geographic variation in costs and for the higher costs associated with furnishing care to a patient that is new to the health center or is receiving a comprehensive initial Medicare visit. There is no change to the FQHC covered services for beneficiaries, and the system will continue to cover the same services that Medicare has paid for in the past.

The proposed rule, which CMS developed in close collaboration with the Health Resources and Services Administration (HRSA), includes adjustments to the Clinical Laboratory Improvement Amendments that would give CMS more discretion in enforcing proficiency testing referral rules. Additionally, rural health clinics would be allowed to contract with non-physician practitioners.

If implemented, the rule would increase Medicare payments to FQHCs for services provided to Medicare beneficiaries in medically underserved areas by approximately 30%.

The proposed rule was published in the September 23 *Federal Register*, with comments accepted through November 18.
Unit-Level Safety Culture Linked to Productivity, Patient Outcomes

A strong safety culture at the nursing unit level is associated with improved patient outcomes, increased staff productivity and lower staff turnover rates, a study has shown. As such, safety culture is an important factor in the quest to advance patient safety and eliminate hospital-acquired conditions, the study authors wrote in the July/August issue of the *Journal for Healthcare Quality*.

The report, titled “Safety Culture Relationships with Hospital Nursing Sensitive Metrics,” explores the relationships between staff perceptions of safety culture and ongoing measures of hospital nursing unit-based structures, care processes and adverse patient outcomes based on Press Ganey scores for 37 nursing units at nine California hospitals. The researchers measured safety culture perceptions six months prior to the collection of nursing-sensitive measures of hospital performance safety at the unit level, the authors wrote.

“Significant relationships were found with reported falls and process measures for fall prevention,” the authors wrote. Additionally, “multiple associations were identified with [safety culture] and the structure of care delivery.” Specifically, skill mix, staff turnover and workload intensity demonstrated significant positive relationships with the safety culture of the organizations.

Safety culture was an important factor to understand the quest to advance safe patient care, the authors wrote. “When senior leaders prioritized a safety culture, patient outcomes may have improved with less staff turnover and more productivity,” they reported, underscoring the business case for investing in patient safety systems to provide reliably safe care. “These findings have affordability and quality implications for hospital leadership,” they concluded (*J Healthc Qual* 2013; 35(4): 61-74).

Intervention Enhances Docs’ Communication about Meds

A physician-targeted educational session can improve physician–patient communication about newly prescribed medication, a study has shown.

In a controlled clinical trial of patients in three primary care practices, reported in the *Annals of Family Medicine*, investigators analyzed the effect of a pilot intervention designed to help physicians convey important medication-related information to their patients.

The intervention consisted of a one-hour interactive educational session encouraging physician communication surrounding five basic elements regarding a new prescription—discussion of medication name, purpose, directions for use, duration of use and side effects – as well as a handout listing the five elements, according to Dr. Derjung M. Tam of the University of California–Los Angeles and colleagues.

The study’s main outcome measures were the five-point Medication Communication Index (MCI) assessed by qualitative analysis of audio-recorded interactions and patient ratings of physician communication about new prescriptions.

The investigators reviewed the interactions of 27 physicians prescribing 113 medications to 82 of the 256 patients enrolled in the study. The mean MCI for medications prescribed by physicians in the intervention group was 3.95, which was significantly higher than that for medications prescribed by control group physicians, the authors wrote. Specifically, counseling about three of the five MCI components was significantly higher for medications prescribed by physicians in the intervention group, as were patients’ ratings of new medication transfer. In both the intervention and control groups, higher MCI scores were associated with better patient ratings about information regarding new prescriptions.

“Further work is required to assess whether improved communication stimulated by the intervention translates into better clinical outcomes,” the authors wrote (*Ann Fam Med* 2013; 11:28-36).
Many Hospitalizations Are Avoidable, Say Primary Care Doctors

More than 40% of hospitalizations stemming from ambulatory-care sensitive conditions (ACSCs) could be avoided with effective preventive care and disease management, according to a survey of primary care physicians reported in the Annals of Family Medicine.

Investigators conducted semi-structured interviews with 12 primary care physicians from 10 primary care clinics regarding 104 hospitalizations of 81 patients with ACSCs at high risk of re-hospitalization. Of the 104 hospitalizations, 43 (41%) were considered potentially avoidable by participating physicians, wrote lead author Dr. Tobias Freund of University Hospital in Heidelberg, Germany, and colleagues.

During the interviews, the cause of hospitalization fell into five principal categories: system-related, such as the unavailability of ambulatory services; physician-related, such as sub-optimal monitoring; medical, such as medication side effects; patient-related, such as delayed help seeking; and social, such as lack of social support, the authors reported. Among the causes of unavoidable hospitalizations according to the physicians were comorbidities and medical emergencies.

“Strategies to avoid these hospitalizations may target after-hours care, optimal use of ambulatory services, intensified monitoring of high-risk patients and initiatives to improve patients’ willingness and ability to seek timely help, as well as patients’ medication adherence,” the authors wrote (Ann Fam Med 2013; 363-370).

Safety of EHR-Enabled Work Systems Must Be Checked

Hospitals and health systems must employ proactive monitoring strategies to detect new, unexpected electronic health record (EHR)-related errors, according to health services researchers at Baylor College of Medicine. Doing so builds resilience into EHR-enabled clinical work systems through the ability to continuously prevent, detect, mitigate or ameliorate hazards or incidents that might otherwise preclude the organization’s ability to provide safe and effective care, Dr. Hardeep Singh and colleagues wrote in BMC Medical Informatics and Decision Making.

The authors have begun a multi-phase program to develop and validate a set of proactive self-assessment tools that will identify EHR-related work system risks and vulnerabilities before harm occurs. The first phase of the project will be the development of self-assessment guides that clinicians and health care organizations will be able to use to evaluate certain high-risk components of their EHR-enabled systems.

“Based upon previous work, current literature, and expert opinion, we have
Jillian Michaels, Celebrity Wellness Coach, Joins NCC Keynote Roster

Jillian Michaels, a leading health and fitness guru who also is a wellness coach on TV’s hit show *The Biggest Loser*, will join Former Secretary of State Hillary Rodham Clinton and Dr. Atul Gawande as a keynote speaker for the 2013 National Client Conference (NCC) held November 18-20 in Orlando, Florida.

Michaels has successfully coached millions of people facing personal health challenges to harness their potential and live their best lives. Her inspirational messages resonate with patients and caregivers alike. Audiences nationwide draw from her belief that fulfillment starts from within, by finding one’s passions and connecting with them.

This year’s conference theme, “A Voice for Every Patient,” recognizes the importance of giving every patient, physician and employee the opportunity to be heard in order to improve the overall patient experience.

A Model for Success

A *Harvard Business Review* article co-authored by Press Ganey Chief Medical Officer, Dr. Thomas H. Lee and lead author Michael Porter, a renowned authority on competitive and business strategy, proposes a strategic model for improving health care that requires restructuring how health care delivery is organized, measured, and reimbursed.

In the article, titled “The Strategy That Will Fix Healthcare,” the authors address many challenges facing health care providers and propose a model to help organizations succeed within this complex environment. The model comprises six interdependent components (see page 24), one of which is the patient voice, which together shift the health care industry to a high-value delivery system.

Improvement Portal Enhancements

Press Ganey recently released Improvement Portal enhancements that make it easier for organizations to identify, share and act on targeted performance improvement opportunities.

Among the enhancements, the Performance Scorecard provides visually concise views of performance, allowing organizations to quickly pinpoint their standing on key performance areas and drill down to the provider, unit, or specialty level. Additionally, new emailing and scheduling features in Quick Reports allow organizations to quickly monitor, share and manage improvement reports.

For more information, visit the Improvement Portal page on the Press Ganey website (http://www.pressganey.com/ourSolutions/improvementPortal.aspx).
Modeling Excellence through Innovation

The CEO of Geisinger Health System is bringing to fruition a century-old vision to “make my hospital right; make it the best.”

By Diana Mahoney

What does it take to keep an “engine of innovation” running smoothly? A visionary leader who recognizes great ideas and a team of individuals working together to help bring them to fruition.

Such is the well-oiled machine that is Geisinger Health System under the leadership of President and Chief Executive Officer Glenn D. Steele Jr., MD, Ph.D.

Geisinger is one of the nation’s leading fully integrated health services organizations, comprising 44 community practice sites, 3 hospitals, 3 emergency departments, multiple ambulatory care campuses, 4 ambulatory surgery centers and 12 retail-based and worksite clinics serving 2.6 million residents throughout 44 counties in central and northeastern Pennsylvania. It also owns a health insurance plan that covers approximately 448,000 people.

Lauded as a role model for health care reform, Geisinger consistently delivers exceptional patient care—at costs far below the national average, a feat that Steele attributes to multiple drivers, including innovation, strategic integration, collaboration and investment in patient-focused health information technology.

Since joining the Danville, Pennsylvania-based organization in 2001, Steele has been a guiding force in Geisinger’s $180 million investment in cutting-edge health care technology, including the deployment of a fully integrated electronic health record (EHR) across the organization.

During his tenure, Steele’s focus has been steadily fixed on waste reduction and value re-engineering. “It’s generally accepted in the health care industry that around 40% of the care that is provided today is unnecessary and possibly even harmful. It almost doesn’t matter where you aim, you’re going to find something to fix,” he said in an interview with Partners.

Toward this end, Steele has overseen the implementation of multiple initiatives designed to restructure roles and responsibilities and redesign workflow to provide quality care, improve value and reduce costs.

One such effort, the Geisinger Accelerated Performance Program (GAPP), was launched in 2009 as a leadership-engagement platform for improving clinical and operational performance. Specifically, the approach applies management science to all of the organization’s business, administrative and clinical practices as they relate to care, workflow, process, personnel and resources. Since its implementation, GAPP has led to millions of dollars in savings.

Additionally, the organization’s ProvenCare portfolio of evidence-based quality and efficiency programs, which address both acute and chronic conditions, redesigned care processes for high-volume diagnosis-related groups (DRGs) with an eye toward delivering coordinated bundles of evidence-based best practices. To date, ProvenCare has led to significant improvements in clinical outcomes and provider adherence to established guidelines.

For coronary artery bypass surgery, for example, clinical workgroups established a bundle of 40 evidence-based practices and designed improved workflow processes. Information technology staff hardwired each element of the bundle into the EHR through templates, order sets and reminders, and the team developed a “patient compact” to engage patients as partners in their care.

As a result of these efforts, adherence to the evidence-based practice bundle increased from 59% at baseline to 100% after four months and remained at or close to that level, according to data provided by Geisinger. The positive changes were reflected in clinical outcomes as well. In-hospital mortality decreased from 1.5% to zero; the number of patients who experienced complications decreased from 38% to 30%; and 30-day readmissions decreased from 6.9% to 3.8%. Additionally, the number of patients discharged to their homes increased by 10%.

Results such as these, and the programs that have facilitated them, have earned Geisinger recognition as a national model for health care delivery under reform. And they have earned Steele his reputation as an innovator with an eye toward excellence who is ready to lead the charge.

For this issue of Partners, Steele shared his thoughts on Geisinger’s excellence journey to date and what it will take to keep the innovation wheel spinning in the years to come.

Partners: How do you define excellence at Geisinger?

Dr. Steele: Over the past several years, Geisinger Clinical Enterprise and Geisinger Health Plan have worked together to achieve a set of four ambitious strategic priorities in the pursuit of continued excellence: quality, innovation, market expansion and securing the legacy. Our determination to achieve these goals has led to a culture and proven results that elicit both national and international inquiry and acclaim. The evidence speaks for itself: reduced mortality rates, improved outcomes and reduced readmissions due, in large part, to ProvenCare programs for acute episodic care and prevalent
chronic diseases, advanced medical home and transitions of care, the investment of a couple of billion dollars since 2002 into new facilities and technology and national recognition from the National Committee for Quality Assurance, Becker’s Hospital Review and other national organizations and media outlets.

We are proud to be a model high-performance health system. This means creating a continuum of care with an emphasis on value—keeping costs down and quality up and working with payers to tie payment to outcomes. Our focus on affecting population health becomes not just a good community benefit but a path to organizational success. To that end, we’ve carefully built strong relationships with other providers in the region—and throughout the country—and hold clinical research and continuous learning as priorities.

Key to this accomplishment is the motivation and teamwork of everyone who is part of what we call the Geisinger family.

**Partners:** What are some of the strategic priorities for pursuing/achieving excellence across the enterprise?

**Dr. Steele:** Our system-wide integration of the extensive electronic health record system has been a top priority.

Additionally, we believe it’s critical to stay close to the community to continue to succeed here. That means doing everything we can to ensure strong governance and professional leadership for the 2.6 million residents across the 44 counties we serve in central and northeast Pennsylvania.

That commitment extends to our governing board. For example, our board has added a number of directors with a national perspective on health care. The result has been a stimulating mix of ideas and perspectives which contributes positively to our success.

**Partners:** As one of the “most wired” health care organizations in the country, how does Geisinger’s investment in technology play into the quest for excellence?

**Dr. Steele:** Seamless communication of information is critical. Our significant investment in technology contributes to our ability to develop programs, such as Proven Care and Proven-Health Navigator [the medical home model] that improve care and provide increased value for populations of patients and for individual patients.

The deployment and optimization of electronic health records is essential to the fundamental change in our clinical delivery model. From here, we have created a system where everything we do
as providers goes into a database, and we find out whether there is a deviation from the expected outcome—for a single patient and for some subpopulations of patients. That information is critical to driving real-time clinical decision making.

In addition, we use a variety of telemedicine technologies to expedite communication and diagnosis and to provide care close to where our patients live. Two-way interactive technology allows physician-to-physician consultations or “virtual visits” between physicians and patients, and real-time patient monitoring in more than 70 physically disparate sites in 44 Pennsylvania counties.

Additionally, we use “store-and-forward” technology, which enables digital images and associated information, including photos, diagnostic images, lab results and patient records, to be securely transferred from one location to another. Our eICU program allows us to partner with Geisinger and non-Geisinger hospitals throughout our region to bring the benefits of advanced critical care to the communities we serve.

What’s more, our EHR, which is an Epic system, provides many non-Geisinger physician practices with portals into the electronic records of shared patients. That way, when we take care of patients together, our non-Geisinger partners know in real time what is happening to their patients.

**Partners:** What have been and continue to be some of the challenges of operating an organization as large and complex as Geisinger under health care reform?

**Dr. Steele:** One of the major challenges of transitioning from fee-for-service as our basic reimbursement alignment to population health risk that looks and feels a lot like capitation.

During the drive to pass health reform in 1993 and 1994, we were told as a society that you had to choose between quality and cost reduction. I think we’re coming to believe now that in many areas, where you find high utilization and high cost, you also find low quality. And so if you re-engineer care in those particular areas, or focus on those particular populations, you get increased quality, better care and lower costs.

We’re very proud of what we’ve done with the extra value this has created, and we have invested it back into the clinical enterprise. And, we’re going to continue to innovate. If you believe the RAND data, that somewhere between 40% and 45% of what we do in health care either is not helpful or may be hurtful to those we serve, there is a lot of value that can be extracted and redistributed. The rate-limiting step is going to be the structure of the provider and insurance markets at large—both predominantly focused only on price-per-unit of work.

As Medicare Advantage gets less reimbursement, we are feeling the difference. Now, you have to understand that even before the Medicare Modernization Act was passed in 2003, we were doing fine with our equivalent of a Medicare Advantage plan. After the enactment of that law, we were able to move into markets that we were not in before, and we were able to use what was obviously a significant increase in reimbursement to undertake the innovations that we’ve described.

The other, more general challenge, is whether—outside of the Centers for Medicare & Medicaid Services—the commercial payers are going to be able to change their business model. Right now, the business model in insurance is a financial arbitrage model. They make money off of the difference between what they collect in premium dollars and what they pay out in claims. What we want to drive toward is insurance companies

“We know that our heritage of excellence, quality and innovation is grounded in and contingent on the personal and professional well-being of our employees.”
Partners: Doing better financially if their members do better in their health status over time. This would force a fundamentally different relationship between payer and provider and help move away from a price-per-unit-of-work conversation.

Over the years, we have had health systems from around the globe approach us to learn how to do what we are doing. We are now scaling and generalizing our experience, skill, technology and innovation and making it widely available through xG Health Solutions.

Partners: In an enterprise as diverse and complex as Geisinger, how do you make sure that the values of the organization are communicated to and represented by every individual within the organization, from the flagship hospital to community practices to retail-based clinics?

Dr. Steele: We have focused on re-engineering and standardizing the process. You know, we have all these arguments about geographic variations in care, but the fact is, there is unjustified variation even in how we do things in a given hospital with a single group of physicians taking care of the same kinds of problems in different patients. There is no excuse not to start re-engineering care. We preach this consistently.

We are committed to our employees, the Geisinger family. We know that our heritage of excellence, quality and innovation is grounded in and contingent on the personal and professional well-being of our employees. We stay focused on ensuring that we provide employees with the knowledge, incentives and resources necessary to live healthy and active lives. We listen closely and learn how we can help them do their jobs better. That translates to offering opportunities for learning and knowledge sharing, recruiting the best and brightest professionals and developing and sustaining world-class formal education programs. I spend at least 25% of my time interacting with as many of our front-line Geisinger family members as I can.

Partners: Geisinger has been touted as a model for value in health care and as being ahead of the health care reform curve. To the degree that innovation requires risk, is there room, within the increasingly stringent health care reform legislation, for risk taking, and if not, what does that mean for innovation?

Dr. Steele: Geisinger has a longstanding culture of working to meet challenges. We are driven by Abigail Geisinger’s vision of wanting our region to have the best health care, and we’ve embraced constant change as the way to achieve that. Innovation is a constant reality for us.

But you cannot innovate without the freedom to fail, to learn from failure and to keep moving ahead. I’ve been blessed with a board that understands that taking chances is part of achieving a vision. We understand that change is not a choice; it’s a necessity in today’s environment.”
We found that in order to re-engineer health care to better serve patients and keep costs under control, we had to do everything differently. We had to start by demonstrating that we could re-engineer from a focus on procedures to a focus on outcomes that reflect better, patient-centered care. Years ago we were advised to sell our health plan/insurance company. Instead, we repositioned it to be our partner—and that has fueled our innovation model. In addition, our health plan now has contracts with many providers, not just Geisinger. Our model has proven itself and we are now able to reach out into markets outside of Pennsylvania such as West Virginia, Delaware, Maine and New Jersey.

**Partners:** Along these same lines, if “failure is a stepping stone to greatness,” what have been some of the failures that have fueled Geisinger’s greatness?

**Dr. Steele:** When I came to Geisinger, all the pieces were here—clinical integration and the insurance element in the health plan. But, what we have been working toward is using the clinical enterprise/insurance relationship, we call it the sweet spot, to pilot population health innovations in an environment where there isn’t a winner or a loser. If we re-engineer care and our patients do better in our structure, it doesn’t matter if the provider or payer side gets the financial benefit.

We think it’s great that there are opportunities within the Affordable Care Act (ACA) to do rapid-cycle innovation, which we have been pushing for a while. There is nothing wrong with CMS demonstration projects or with randomized clinical trials, but we don’t have enough time to learn through these processes as the cost trajectory and patient demand go up as millions become newly insured. We believe that many aspects of the Geisinger experience are scalable and generalizable throughout the health care system in the United States, and that the way our country pays for and delivers health care nationally needs to move to something that looks a bit more like Geisinger in a relatively short period of time.

For example, when we have a conversation with our non-Geisinger payers about us as a provider, the conversation starts and ends with a negotiation over the amount of money that we will be reimbursed for each unit of work. That contrasts with the conversation that we have between our providers and our own insurance company, which starts with this: “Let’s look at a high-utilizing, high-cost group of patients, and let’s see what the optimum outcomes for them would be. And if we can agree on what that optimum outcome should be, let’s then back out what the appropriate incentives would be to get there.” So, that’s a totally different framing of the conversation, and I think that’s what is going to have to happen at the national level.

**Partners:** How does the pressure to reduce costs affect the pursuit of excellence at Geisinger?

**Dr. Steele:** It fuels our engine of innovation. It helps us to find new and better ways to innovate and develop new models of care. Continuous innovation has been the most energizing aspect of what we have done at Geisinger—to figure out how to create a machine for continuous innovation without putting our entire business at risk, and without assuming that every one of our innovations is going to work. Finding a way to do this on a national scale is a big challenge.

**Partners:** What is on the horizon for Geisinger in terms of the excellence journey?

**Dr. Steele:** “Transforming the Future” is the strategic imperative that leads our vision and drives every action and initiative at Geisinger Health System. There isn’t one template for excellence. I hope that we continue our journey in myriad ways—at Geisinger and beyond.

We will continue to test new ways of giving care in a more efficient manner and focus on creating more of a value proposition in health care delivery and financing. Every member of the Geisinger family will focus on extracting cost and creating value for the folks we serve and stay committed to; ensuring fiscal responsibility and appropriate use of resources; achieving annual operating goals; continuing to develop plans and tactics around our three strategic priorities (quality and innovation; market leadership; and personal and professional well-being of the Geisinger family); and remaining loyal to our commitment to Abigail Geisinger’s original vision: “Make my hospital right; make it the best.”
The Many Facets of Excellence

Health systems are employing a broad spectrum of data-driven strategies to foster continuous improvement in patient-centered care

By Diana Mahoney

Before getting the nod to move forward with an expansion project that would add 450,000 square feet to the Nemours/Alfred I. duPont Hospital for Children in Wilmington, Delaware, the architects who designed the $260 million addition faced some tough questions from a highly discerning hospital council.

The inquiries varied: “Why are the rooms laid out that way?” “Will there be enough space to play?” and “Where will visitors sit?” A few were accompanied by sketches illustrating alternate visions. And all of them were posed by children and teens – some of whom had been patients of the facility themselves at one time. Although their voices were small, the message they delivered was anything but: If the project doesn’t work for children, then the project doesn’t work.

In this spirit, the architects answered each question and addressed every concern. They understood that approval by the hospital’s Youth Advisory Council (YAC), along with that of Family Advisory Council (FAC), was vital to the success of the multimillion dollar endeavor, which would feature a five-story expansion with private patient rooms.

“The design of the Nemours expansion was a truly collaborative project. Our team worked closely with hospital leadership to develop a comprehensive master plan aimed at transforming health care for the region’s children. We were inspired by the hospital’s Family and Youth Advisory Councils’ input to create an experience that puts the family first while bringing caregivers closer to patients,” said Ed Huckaby, Senior Project Designer and Pediatric Practice Leader at FKP Architects.

Family and patient involvement at Nemours is not reserved for the “big” projects, such as the Delaware expansion, which will be open for patients in 2014, and the Nemours Children’s Hospital in Orlando, Florida, which opened in 2012.

“The Youth Advisory Council does everything from helping with design projects to taste-testing items that will be on the menu,” said Mariane Stefano, Vice President of Service and Operational Excellence. As the voice of the hospital patients, YAC members advocate for changes that will optimize hospital policies, services and programs for families across the nonprofit organization, which in addition to the two children’s hospitals includes major pediatric specialty and primary care clinics in Delaware, Florida, Pennsylvania and New Jersey.

Similarly, the FAC, which comprises family members who have experience with the health system in both inpatient and outpatient settings across various specialties, meets regularly to contribute to the development and enhancement of family-centered care, said Jim Burrows, Director of Service Excellence at Nemours.

Formerly the parent co-chair of the FAC, Burrows was hired by the organization in 2012. His unique perspective as a parent of a critically ill child receiving care at Nemours combined with his FAC leadership success and his professional service-related experience in the banking industry made him an ideal candidate for bridging any gaps between outside-looking-in and inside-looking-out perspectives on how families can be incorporated into all aspects of the care process to improve their experience. “This includes participation in family-centered rounds, nursing shift changes, hospital committee meetings such as Quality and Safety, and continuous improvement activities,” he said.

Nemours’ emphasis on patient and family input is fundamental to the organization’s commitment to achieving patient-centered excellence across the enterprise, as is the ability to collect and analyze outcome data and make strategic decisions based on the analyses.

“Excellence in patient- and family-centered care is our ‘True North,’ and we use our quality and patient-experience measures to help guide us,” Stefano said. In terms of metrics, “our goal, as defined by our CEO, is to be in the top fifth percentile ranking for select quality and patient-experience measures system-wide.”

Certain pockets of the organization have already achieved 95th percentile ranking, Stefano said. To build on those successes and improve in areas that have not yet reached the mark, “we started a journey of continuous improvement at Nemours about a year and a half ago and have adopted Toyota’s Lean methodology for our improvement work,” she said.

“Our aspirational goal is perfect care,” Stefano said. “We understand that we will never achieve 100% perfection, just like Toyota understands that they’ll never get to zero defects in their manufacturing. The idea is that you set the goals to be aspirational so that you are always looking at ways you can improve what you’re doing to meet patient and family needs.”
The implementation of eSurvey methodology fits perfectly into Nemours’ continuous improvement model, Stefano said, noting that the organization has deployed Press Ganey’s eSurvey across its medical practice, emergency departments and outpatient ancillary services sites and is moving toward inpatient and ambulatory surgery implementation. “Like other organizations, we use our Press Ganey data to help pinpoint where we need to focus our attention in each of our facilities. Using eSurvey allows us to react much more quickly to situations. It certainly helps us with the number of surveys we collect, so there’s more data integrity and staff buy-in.”

In monthly meetings with all of the leadership teams at all of the Nemours’ campuses, “we review the Press Ganey data at a high level and we talk about what strategies are being deployed,” said Stefano. “If performance is dipping in any area, we are aware of it quickly.”

One of the primary benefits of eSurvey to the organization is the early insight it provides for trend spotting, Burrows said. “If you see something go in the wrong direction for one month, you don’t necessarily react and change it, but you know to keep your eye on it,” he explained. “If it starts to become a trend, that’s when you circle back and say, ‘Okay, we need to reverse this.’”

One powerful example of how family and patient-experience analytics can drive operational strategy came after a few months’ worth of data suggesting that performance on the housekeeping side was stalling. “ Obviously, managers can go out and talk to these folks and see what’s going on, but at the end of the day, what really made a big difference to the housekeeping staff was hearing from the families themselves,” Burrows said. “We brought in a panel of family members to speak to the housekeeping staff about how the impact these employees had on the families’ experience went beyond just cleaning the room. A lot of families appreciated having someone other than a physician or nurse to talk to, even if it was just to say ‘hello’ or offer a word of support or encouragement.”

The experience was “remarkably well received” by the staff, said Burrows. “We learned that part of what was happening was that housekeeping staff often kept from interacting, because they didn’t want to disturb the family members. They just wanted to clean the room and blend into the background,” he said. “They needed to hear from families that it was okay to talk to them.”

Since the intervention, “Our scores on the ‘Courtesy of Housekeeping Staff’ measure have been rising,” said Stefano. Even though it is premature to identify this as a consistent trend, “it does validate to the housekeeping staff that they are an important part of the care team, and that their efforts truly matter.”

Importantly, performance metrics at Nemours are not considered in a vacuum. “We make it clear that excellence is not about a number. It’s about creating that experience for patients and families. That is something that everybody here embraces. The survey responses tell us how we’re doing and where we want to go,” said Burrows.

In some ways, as a pediatric organization, Nemours had a head start with respect to patient-centered care. “In pediatrics, the focus on patient-centered care has been around a lot longer than it has in the adult world, so it’s something we’re very accustomed to,” said Stefano.

On the other hand, the performance bar is higher, Burrows said. “As an adult, if you tell me that I am going to need surgery for something, I can accept that much more easily than if you tell me that my daughter’s going to need surgery. All of a
sudden, my world is being taken away from me. There’s a certain loss of control, and as a parent, that’s a bad feeling,” he said. “The care team must always maintain that perspective: not only do we treat the child, but we treat the family.” Every employee must recognize that and rise up to meet the challenge in every interaction, he said.

Another challenge is maintaining top-tier performance over time, particularly in the face of industry pressures to reduce costs and shift care models. “We haven’t gotten to the point where we have been able to sustain results at the highest level, so that’s what we’re trying to achieve with the continuous improvement work,” Stefano said. “If we work hard at trying to streamline our processes—improve flow and reduce waste—that will allow our care providers more opportunity to spend time with patients and families to do what we think will add value under very tight budget targets.” Regardless of what happens externally in the health care industry, however, “our laser focus on the patient and family experience never falters,” she said.

A similar mentality is driving operational shifts in health systems across the country. “It’s about creating a culture that puts patients first every day,” said Dr. Ernest Mazzaferri, Medical Director of The Ohio State University (OSU) Wexner Medical Center’s Richard M. Ross Heart Hospital and co-chair of the organization’s Patient Experience Council.

Since 2006, “Overall Hospital” scores at OSU Wexner Medical Center have risen dramatically from the lower 25th percentile to consistently within the 80th to 85th percentiles, and occasionally in the 90th percentile or higher for certain service lines and units. Even so, said Mazzaferri, “I don’t think we will ever be satisfied with our numbers because the goal is to constantly strive to get better. If you call me in two years and we are consistently in the 95th percentile, I will still say we’re not ‘there’ yet. Nobody is going to create a situation where they are always doing it right. But it is very possible to create a culture in which we consistently look for ways to improve what we do every day.”

When it comes to improving daily processes to meet patients’ needs, “we collect as much data as we can because it helps identify areas in which we can continually make this a better place for our patients,” Mazzaferri said. “But it’s not just about the numbers. If one month we’re in the 90th percentile, that is great, and it deserves a pat on the back, but we can’t go crazy, because the next month we could dip. It’s about doing this every day and looking for trends over time. For us, the data we get from various sources are most valuable as a springboard into discussion and action.”
To that end, patient experience data for the entire organization—which includes a medical school, six hospitals, a unified physician practice, a network of primary and specialty care practices, as well as multiple research centers and laboratories—is reviewed by leadership monthly. Additionally, patient satisfaction scores for the previous month are always available on the health system intranet. “The data are available, and that is really important,” Mazzaferri said, “but the question is, ‘are we doing a good enough job utilizing the data?’

“A few years ago, the CEO of our medical center, Dr. Steven Gabbe, made this a priority. He started bringing together the physicians and multidisciplinary leadership to address the low patient satisfaction scores,” said Mazzaferri. “For the past three or four years, we’ve met with this group, and we have been identifying issues slowly and trying to focus on certain areas and then bringing in best practices.”

Once the issues have been isolated and best practices have been identified, “we start bringing it out to the floor, and even though it’s on the dashboard, we say, okay, let’s highlight some things that we are not doing well, such as ‘Quiet.’ If you look at the Ross ‘Quiet’ scores, we’re up in the 78th percentile,” Mazzaferri said. “It’s taken awhile, but leadership has learned how to engage the front-line staff to utilize the data in the best way possible and identify best practices among our six hospitals, because we really have separate business units.”

As the awareness and understanding of the available data proliferates, so does the faith in its validity among the front-line caregivers. “Evidence of this can be seen in our scores. Our scores are better because we’ve identified where our problems are. You have to have faith in the data to be able to make changes based on that, and we have made changes,” Mazzaferri said. “Having said that, there are some data points that folks are not completely comfortable with, such as ‘Physician Communication’ on the inpatient side.

“When you’re an inpatient, you will likely interact with multiple physicians during your stay, so the response can be a reflection of all of them,” Mazzaferri said. “It’s okay when that metric is assigned to a service or service line, but it’s difficult to reconcile when it’s assigned to an individual.”

To help clarify ambiguity on that metric, according to Jessica Halley, senior data manager, “we are able to start tapping into the comments that patients provide on the surveys. It lets us drill down a little more to identify opportunities on the side of individual people to congratulate for the lasting impression that they left, but then also on the flip side, to highlight deficiencies when someone is called out specifically.”

Although the data and the comments “are right there in everyone’s face on our dashboard,” said Mazzaferri, “the challenge is getting everyone to use the information. This is an issue of accountability as much as anything.” The communication responsibility belongs to the leadership of each facility to address individual issues with the respective division directors, he said. In the same way that high-performing individuals should be recognized for their efforts, “the leaders know that if there are people in their group who are in the lowest quartile, or lowest 10th percentile, that has to be addressed. Not only is it publicly reported data, it’s not good for our patients to have practitioners who are putting anything less than their best foot forward.”

This is a message that comes directly from the top, Mazzaferri said. “We have breakfast meetings with Dr. Gabbe on a regular basis to recognize high performing physicians, and we are about to roll out a program to meet with low-performing physicians.”

The fact that the CEO believes these performance issues are important enough to take an hour out of his day “sends a strong message,” Mazzaferri said, as does the fact that he is a physician speaking with physicians. “He understands the pressures and the challenges. The high performers are obviously honored to be recognized by Dr. Gabbe as their leader, but also as a colleague.”
The low-performing physicians are currently being engaged in one-on-one conversations with physician leaders regarding improvement opportunities, Mazzaferri said. “These conversations will be structured in such a way to say, ‘Look, we understand there are barriers. What can we do to help you? What will make this better?’”

Targeting specific groups within a system in this way can help improve the whole organization, Mazzaferri explained. For example, “although there will always be a bottom 10% in every program, the goal for us is to move that bottom 10% up above the 50th percentile. If we can move that group up into that percentile, we will still have our large percentage of high performers, and that will move our metric higher.”

Similarly, targeting the areas and individuals who are scoring just below top box can have tremendous value. “When we look at our scores, for example, when we focus on the HCAHPS Overall Hospital Rating question, the percentage of patients that score somewhere between a 7 and a 10, it’s well over 90% of our patients. What we want is to move those scoring 7 and 8 into the 9 and 10 bucket,” said Halley. “We’ve started communicating that. It’s a powerful message to say, ‘We don’t have incredibly dissatisfied patients. We will get more value out of focusing on that group of 7s and 8s who are more or less happy, because it will not take much to boost them up.’”

While it makes sense to focus on those 7s and 8s rather than “the rare bottom scores from a few unsatisfied patients who we will not be able to appease no matter what we do, when individual providers are consistently receiving low scores, we have to take action,” said Mazzaferri. “We have to hold physicians to a higher standard. The physicians who are getting 7s and 8s on a 10-point scale are in the game, but there is absolutely no reason why we should accept the very low-performing physicians or employees. When you’re an employee here, you need to behave the way we expect you to behave, and that’s by putting patients first. At the end of the day, that’s what we are about. We need to make sure that everybody believes in that message.”

When Mary Nash, PhD, RN, took over as Chief Nurse Executive at The Ohio State University Wexner Medical Center, she carried with her an important principle she learned during the years she held the same title at a different health care organization: accountability.

“The CEO of that organization routinely met with all of the departments and services that were not meeting their targets. So the goal was to never be called to a meeting in the penthouse because that meant you were not meeting your numbers,” Nash said. “By doing this, what he was saying to everyone was, ‘You are accountable for your performance.’

“When I came to OSU in 2006 and was handed the responsibility for patient experience improvement, I was surprised that the organization’s patient satisfaction scores were so low, hovering around the 25th percentile,” she said. “When I started inquiring about the process that was in place to work on this stuff, it was soon apparent to me that there were a lot of little committees that would meet, but it was mostly a ‘come if you can’ kind of thing.”

For the first systemwide gathering she arranged, meeting invitations went out to the CEOs of each hospital and practice in the system. Although the meeting was well attended, “it soon became apparent to me that the CEOs were not there. Instead, they delegated the responsibility to someone else in their area. That was my first ‘aha’ moment.”

Rather than continue with the meeting, she told those who were in attendance the success of the patient-experience efforts rested on leadership engagement, and suggested that the only way the efforts would be successful was if leadership made it a priority.

“I believe that this is important enough to an organization that it cannot be delegated. The responsibility rests with the highest level executive of the enterprise for which patient experience data is being collected to make the time to understand, consider and act on the data,” she said. “It’s a well-understood business principle that what the boss pays attention to is what gets done.”

Nash’s point was well taken. “All of a sudden, the message came down from the CEO of the health system: ‘Get there.’ And they did,” she said. “Once they got there, they realized how important it was to be present and active. If you role-model change, change will happen.”

Since that time, the OSU Wexner Medical Center patient satisfaction scores have topped the 80th percentile. “I can’t attribute that solely to leadership engagement, but it is a fundamental component of an effective strategy,” said Nash.
The Pursuit of Excellence: High Performance Environments

To maximize the value of health care for patients, many organizations are embracing “change to become good.”

By Sharon Worcester
Excellence in health care delivery can feel like a moving target under reform legislation. And while the most effective strategies for pursuing excellence can vary at any given time by organization, department, unit, provider and even patient, keeping the target in range for all stakeholders requires innovation, adaptability, persistence and a certain amount of risk taking.

It also requires focusing the organization’s attention firmly on the bull’s-eye: the maximization of value for patients, according to Dr. Thomas H. Lee, Chief Medical Officer at Press Ganey. That is, “organizations must achieve the best possible outcomes at the lowest possible cost,” he said. “Health care is at a point of discontinuity where things are moving from a system organized around transactions – what doctors do – to one that is organized around meeting patients’ needs as efficiently as possible,” Lee said. “The goal of health care is not to reduce health care spending; it is to help people, and to do so as efficiently as possible.”

Central to this concept is the development of high-performance environments. Toward this end, organizations are making fundamental strategy shifts and identifying unique and effective practices to achieve continuous incremental improvement across multiple domains, much like that dictated by the Lean methodology, which steers improvement efforts to where they will have the biggest impact. One of the most powerful Lean tools is the Japanese philosophy of Kaizen, which translates literally to “change to become good.”

One Kaizen-inspired tool that has been broadly adopted by health care organizations to effect long-term “change to become good” is the daily huddle – time each day that teams come together to work through their plan-do-check-act (PDCA) cycle. Although simple in concept, the huddle is a departure for managers and their teams, many of whom have never been engaged in daily improvement efforts. In that regard, the huddle represents a more disciplined and, ultimately, more effective way of working.

At Advocate Health Care in Illinois, the general huddle concept has been applied to help ensure Advocate employees always keep safety top of mind and to prevent any unintended harm to patients. Managers hold “safety huddles” at a designated time each day to review safety-related events that have arisen in the previous 24 hours, and to look ahead to identify any particular safety issues that might be anticipated, such as staffing shortages, unique work load issues, or unusual cases, according to Dr. Lee Sacks, Executive Vice President and Chief Medical Officer at the 12-hospital not-for-profit health care delivery system in Chicago and the central region of the state.

The huddles also provide an opportunity to follow up on any open issues identified at prior safety huddles. “We didn't invent this,” Sacks said, explaining that safety huddles have long been used by the military and have been used in various other industries and organizations. “More than a year ago, while working on updating Advocate’s Safety Strategic Plan, we looked at several leading organizations, and one of the things we came across was the safety huddle.”

Now, the hour from 8 to 9 a.m. is designated as a meeting-free period across the entire health system, during which the 15- to 20-minute daily safety huddle is held, Sacks said. The practice was implemented earlier this year after extensive training of the leadership, and quickly was expanded from a Monday to Friday practice to include weekends and holidays.

“We take care of patients every day, and it is important to address safety every day. The safety huddle is a chance for leaders to come together, get a report from their team to assess what happened and communicate with participants.”

Dr. Lee Sacks
Executive Vice President and Chief Medical Officer,
Advocate Health Care
noting that a simple survey conducted about six weeks after implementation demonstrated strong buy-in, with 91% to 97% of respondents agreeing or strongly agreeing that the safety huddles provide valuable information, improve patient safety, improve awareness of unintended harm that is occurring, allow resolution of issues more quickly and are worth the time spent. “I think everyone saw it as a tool to resolve issues quickly,” he said.

A strong indicator that the short-term goal of improved reporting is being met is the fact that error reporting is up 27% year-to-date, said Dr. Sacks. “This is very encouraging,” he said, particularly because previous survey data indicated a problem with error reporting. While leadership felt that the culture supported reporting without being punitive, most front-line caregivers felt threatened and were hesitant to report errors.

“It certainly raised concern that a lot of events weren’t being reported. The fact that reporting has increased by double digits appears to confirm that,” Dr. Sacks said.

The long-term goal of the safety huddle practice is to eliminate harm, and while it is too early to evaluate this outcome, “capturing short-term safety events certainly has the potential to make a difference,” said Dr. Sacks.

The value of the huddle as an improvement tool also has been recognized by leaders at Henry Ford Health System, who included the practice as one component of a large-scale effort to promote accountability, transparency and communication across the system’s 1,200-member Henry Ford Medical Group, five hospitals, Health Alliance Plan (a health insurance and wellness company), Henry Ford Physician Network, a 36-site ambulatory network and many other health-related entities throughout Detroit and Southeast Michigan.

The effort began in March 2011 with the development of a corporate Customer Engagement Department. Members of the customer engagement team were charged with the construction of a multi-faceted, system-wide customer service framework based largely on the Malcolm Baldrige Quality Award Criteria for Performance Excellence, according to Courtney Stevens, Manager of Customer Engagement and Service Improvement at Henry Ford.

“We followed a framework for a service culture centered on our vision for Henry Ford Health System, which is ‘transforming lives and communities through health and wellness – one person at a time,’” Stevens said. “Around June of 2011, we had a leadership meeting, and we put forth mandates to strive for in the coming years.”

That same year, the health system received a Malcolm Baldrige National Quality Award in recognition of its innovative efforts to improve patient care and reduce unintended harm, as well as its “No Harm” campaign promoting zero-defect, no excuses approach to health care outcomes, according to Stevens.

One component of the effort was an evidence-based model comprising standard questions and conversation triggers for communicating with patients and their families as well as with each other. The technique is a powerful way to communicate with people who are feeling nervous and vulnerable. By following the stepwise approach, staff can make sure patients understand
what is happening to them and what to expect, with the goal of minimizing anxiety and improving the overall experience, Stevens said.

The “customer engagement journey” also included leadership rounding on patients and employees on a regular basis. Additionally, a new set of system standards of excellence was developed.

“These were not just expectations; performance management was based on meeting these standards,” Stevens said.

As noted, a huddle concept was also rolled out. Much like the “safety huddle” employed at Advocate, the Henry Ford approach involved a department-based practice of setting aside a specific time to share system- and department-level messages.

“They then rolled out incentives tied to results, including service and patient satisfaction results,” Stevens said. “At the end of 2011, we started what we called ‘world-class experience training’ for first-impression employees, including Clinical Service Representatives, unit desk clerks and valet attendants—all the people who have first contact with patients.”

Beginning in 2012, that training was extended to all staff, and a rounding system was established that included standard rounding at the same time each day. Following a “best practices sharing visit” at UCLA Hospital, a system-wide rounding system was established that included standard system rounding on the same day and at the same time. Later that year, a physician version of the stepwise communication concept was rolled out, along with a leadership rounding process, she said.

In June 2012, the mandates were reiterated at another all-leadership meeting, and later that year, the world-class service training was expanded with specific tools and processes for leaders to improve coaching and accountability. “By December, we had trained more than 24,000 employees on the world-class service communication and experience program,” Stevens said.

The program, which provides a framework—but allows flexibility for each department to “put its own spin on it”—continues to evolve based on feedback and changes in the health care environment. Today, the leadership rounding program is still going strong. Wednesday afternoons are set aside as meeting-free. Rounding takes place during any 90-minute time frame within that period, Stevens said.

Also, the communication protocol has been incorporated into new employee training and physician on-boarding to make sure new employees have the same base training as long-term employees, and refresher courses are in development.

“We continue to use our data and metrics to share information. We’re very transparent with employees and leaders about how we are doing with respect to patient satisfaction and with the new CMS requirement, so we continue to keep those in front of our leaders,” she said.

For example, “huddle boards” – bulletin boards used solely for communicating goals, metrics and outcomes – are placed in each department and encompass everything from employee and customer engagement data to quality and other department initiatives. “These have helped with communication and allow staff to monitor progress on a daily basis,” said Stevens.

The customer engagement journey also involves a number of pilot initiatives, including a program involving phone calls to patients within 24 to 72 hours of discharge to check on them and answer any questions they may have, Stevens said.

So far, the effort to create a world-class service culture at Henry Ford is paying off.

“As a system, our main customer engagement goal for this year is a top box score of 78.8 on the ‘Likelihood to Recommend’ patient satisfaction question,” said Stevens. “Based on our monthly and rolling three-month scores, we are getting close, and have improved from the December 2012 score of 74.5. This year, our flagship hospital in Detroit – Henry Ford Hospital – hit their highest score in two years, so we are definitely seeing improvement throughout the system,” she said.

The efforts by organizations like Advocate and Henry Ford are evidence of the recognition on
Achieving the goal of maximizing value for patients requires an overarching strategy that involves the development of a high-performance environment that seeks to provide patients with true value, according to Press Ganey Chief Medical Officer Dr. Thomas H. Lee.

In an article in the October issue of *Harvard Business Review*, Lee, along with Michael E. Porter, the Bishop Lawrence University Professor at Harvard University, describe this strategy as a “value agenda” that will require a complete restructuring of the ways that health care delivery is organized, measured, and reimbursed.

Lee and Porter describe six “interdependent and mutually reinforcing” components they view as necessary for the development of high-performing systems that lead to a high-value health care delivery system:

1. **Organization into Integrated Practice Units, or IPUs.** IPUs represent dedicated multidisciplinary teams of clinical and nonclinical personnel who provide the “full care cycle,” including treatment of related conditions and complication for a given condition. One example is diabetes care that addresses related eye and kidney disorders. This type of approach refers to something more than simply co-locating relevant providers and staff at the same building; rather, it is a restructuring of care delivery.

2. **Measurement of Outcomes and Costs for Every Patient.** Measuring results in health care leads to improved outcomes; measuring results for individual patients will lead to improved value for individual patients. “The only true measures of quality are the outcomes that matter to patients,” Lee and Porter explained.

3. **Use of Bundled Payments for Care Cycles.** Neither global capitation nor fee-for-service directly rewards improving the value of care. Conversely, well-designed bundled payment—such as payment that covers the full care cycle for acute conditions, the overall care for chronic conditions for a defined period, or primary and preventive care for a defined patient population—directly encourages teamwork and high-value care.

4. **Integration of Care Delivery Systems.** Multisite care delivery systems are often loose confederations of largely stand-alone units that duplicate service rather than integrate care delivery. The integration of systems to eliminate the fragmentation and duplication of care and to optimize the types of care delivered in a given location represents a huge opportunity for improving value, the authors wrote.

5. **Expanded Geographic Reach.** Substantially increasing value on a large scale requires that superior providers for particular medical conditions serve far more patients, and extend their reach through strategic expansion of excellent IPUs, according to Lee and Porter, who note that geographic expansion is about improving value—not just increasing volume.

6. **Development of an Enabling Information Technology Platform.** This sixth component of the value agenda powerfully enables components 1–5 and helps those components work with one another, enable measurement and new reimbursement approaches, and tie all the parts of the delivery system together. Such a system should be centered on patients, use common data definitions, encompass all types of patient data, allow accessibility of the medical record to all parties involved in care, include templates and expert systems for each medical condition, and allow for simple extraction of information.

Maximizing value through these components requires an open-ended commitment. It is a journey, much like the journey that Advocate Health Care and Henry Ford Health System have undertaken, Lee said.
Making Good on a Promise

With the implementation of an enterprise-wide quality pledge, a New York-based medical practice group saw a 50% improvement in its mean “Likelihood to Recommend” score over the course of one year.

By Sharon Worcester

Anne Ruflin, President of Lifetime Health Medical Group (LHMG), starts every Monday with three of her favorite things: peppermint tea, dark chocolate and a review of patient comments. These days, more often than not, that patient feedback is as refreshing as the tea and as sweet as the chocolate. It reflects the “Patients First” philosophy of the organization, as well as the commitment that employees at every level have made through an innovative “Promise to C.A.R.E.” initiative, which encompasses Courtesy, Attitude, Respect, and Engagement, Ruflin says. But that hasn’t always been the case.

Just two years ago, survey data showed that patient satisfaction was alarmingly low, so the generally positive comments that Ruflin sees now also serve as a weekly reminder of the not-for-profit health system’s remarkable transformation. In 2011, Press Ganey data revealed serious, across-the-board deficiencies in patient loyalty to LHMG—an important measure of patient

“If you give people something to strive for rather than something to avoid, it goes a lot further.”

Anne Ruflin
President, Lifetime Health Medical Group
CASE STUDY

“Part of the compensation for our physicians and mid-level providers is built on whether patients are willing to recommend them to others.”

Elaine Vanderland
Manager, Compliance, Privacy and Ethics, LHMG

satisfaction, and one of the ways the organization defines excellence. “This was a systemic concern affecting every one of our sites,” said Ruflin. In fact, some sites had mean scores in the 40s and 50s, she noted.

The finding was a wake-up call to leadership that the organization’s ability to truly deliver on its brand promise was in jeopardy. Patient loyalty is a critical factor in the LHMG mission, said Ruflin, who joined LHMG in 2010 on the heels of a major restructuring, including a 20% workforce reduction.

Since that time, LHMG—which includes 11 primary care, urgent care and multi-specialty centers between Buffalo and Rochester, New York—achieved a fundamental culture shift that allowed the organization to address systemwide issues that were negatively contributing to the poor patient satisfaction.

“The Press Ganey data really highlighted for us that we had patient satisfaction issues. As we started to really get more into looking at that data, it became clear that we were not performing the way we wanted to perform,” she said, explaining that one of the key indicators of poor patient satisfaction was patient willingness to recommend LHMG to friends and family.

This prompted a closer look at the factors that needed to change in order for patient loyalty to improve.

“We determined that part of the problem was that we did not have consistent standards throughout the organization for how to treat our patients. We had some very high-performing practices and some very low-performing practices; and we had some very high-performing physicians and some very low-performing physicians. So, there was a lot of variation in terms of what was going on internally,” she said. Such variation was a road block to the provision of a consistent patient experience within and across the organization, in all settings and at all levels of care, she explained.

By the end of the second quarter of 2011, executive leadership at LHMG began to formulate an improvement plan, and with Press Ganey’s help, they began to reshape the organization’s culture. The mission was to identify and address key areas
in need of improvement, said Elaine Vanderland, who was Process Change Manager for LHMG at the time and helped to oversee the project.

A number of factors were deemed important for shaping a culture of excellence. Courtesy, for example, was a key factor driving patient satisfaction levels, as evidenced by the survey data. Wait times were another, said Vanderland, who now serves as Manager of Compliance, Privacy and Ethics, but who maintains a role in the ongoing data-driven improvement process.

The approach that LHMG leadership took to address the patient satisfaction problem was detailed and tactical in nature, Ruflin said, explaining that even the simplest things – training receptionists to look up when someone approaches the front desk, and improving communication about wait times, for example – can, and did, make a significant difference.

Patient satisfaction data were carefully and closely monitored, and outcomes were reported monthly to leadership. Because the performance measures were provided so quickly, “we were able to make timely adjustments based on the outcomes,” Ruflin said, noting that the effects were remarkable.

Within a year, from 2011 to 2012, the mean percentile “Likelihood to Recommend” score for the organization as a whole on the medical practice patient satisfaction survey increased from 61.8 to 92.1, representing a nearly 50% relative improvement in mean score and surpassing the goal score of 90 set at the start of the initiative, Vanderland noted. Moreover, dramatic improvements were evident at all 11 LHMG sites, with one site more than doubling its mean score, she said. And while the organization did not set a specific goal for its urgent care centers, the “Likelihood to Recommend” mean score for that area increased from 36.2 in 2011 to 82.4 in 2012.

The Promise to C.A.R.E. model created service standards for addressing the factors that matter to patients based on their feedback. It was designed to allow employees to take ownership of patient satisfaction, and to play a role in improving it. The promise itself is highly visible throughout the organization. In exam rooms and lobbies across all 11 sites, it is emblazoned on posters that have been signed by employees who have pledged to live and work by the attributes.

In addition to employee commitment, the signatures symbolize the organizational belief that excellence can be attained only through the support of every employee, at every level, working toward the common goal of putting patients first, said Ruflin. Promise to C.A.R.E. dovetailed with the “Patients First” principle, and brought the concept to life, she added.

The program was promoted through a celebratory, large-scale rollout, and leadership worked with employees to clarify how the new standards that were built around the promise could be achieved in each individual role.

“From my perspective, it was very important that this not come down as a command from above —that it was a personal commitment that every one of us in the organization could embrace and be accountable for,” Ruflin noted.

That being said, when it came to engagement, senior leadership visibility and commitment was important for ensuring that the entire organization remained focused on the promise. That approach contributed to the success of the initiative by emphasizing the importance of fulfilling the promise from every possible angle. Adherence was incorporated into performance reviews, employee recognition, and even compensation, in some cases.

“Promise to C.A.R.E. was a galvanizing mission that every person felt committed to and felt they could contribute to.”

Anne Ruflin
President, LHMG
“Part of the compensation for both our physicians and mid-level providers is built on whether patients are willing to recommend them to others,” Ruflin explained.

Buy-in to the Promise to C.A.R.E. program was widespread, and the few pockets of resistance that were encountered served to weed out those who couldn’t—or wouldn’t—take ownership of the goals of improving patient satisfaction, Vanderland said. Those people basically felt that patients should be grateful that LHMG will see them at all, because many are uninsured or underinsured, she explained. “And those people did not fit into our new culture,” she said.

For those who did fit into the culture, leadership recognized the importance of addressing morale issues. Employees had to feel supported in their efforts. Given the recent restructuring and workforce reductions, employees were under tremendous strain, Ruflin said.

She credits the supportive, rather than punitive, approach incorporated into the Promise to C.A.R.E. model for much of the success. The flexibility of the model—the ability to react quickly to the data and to individualize the program to specific departments and sites—is also a factor in its success, she said.

“One of the key things I learned through this was that Promise to C.A.R.E. was a galvanizing mission that every person felt committed to and felt they could contribute to,” Ruflin said. “I do think that’s what helped us break through and make the changes.” Importantly, the changes were rolled out in stages. “I never asked everyone to change everything all at once.”

Her message to executive leadership at other organizations facing similar challenges: Stay engaged, and never underestimate the power of a positive message.

“Even if you have a negative problem, approach it in a positive way,” she said. “If you give people something to strive for rather than something to avoid, it goes a lot further.”

Toward this end, each Monday, after reading the patient feedback, Ruflin makes a point to quickly recognize and reward those who have elicited positive feedback—a practice that employees noticed and appreciated right away.

“When they realized I would look at the comments every Monday and would give compliments, it made a difference,” she said. “So we’re on it. Everyone knows I will ask about it and check in on it. This is really a very living process within our medical group.”

Without that relentless focus, it’s unlikely that the transformation would have occurred, she said.

“I think if I were to stop talking about it and stop highlighting it, it wouldn’t be the same. The culture is a mix of the top and all the layers working together, but if the top doesn’t care, nobody else will either.”

Anne Ruflin
President,
LHMG

Across-the-Board Gains
Each of LHMG’s 11 primary care practice sites throughout Buffalo and Rochester, New York, saw significant improvements in patient loyalty from 2011 to 2012, as measured by scores on the “Likelihood to Recommend” Medical Practice mean scores.

<table>
<thead>
<tr>
<th>Site</th>
<th>2011</th>
<th>2012</th>
<th>% Change</th>
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<tbody>
<tr>
<td>Mosher</td>
<td>47.2</td>
<td>66.2</td>
<td>82.6</td>
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<tr>
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<td>40.9</td>
<td>88.4</td>
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<td>West Seneca</td>
<td>59.5</td>
<td>87.9</td>
<td>49.6</td>
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<tr>
<td>Amherst</td>
<td>58.1</td>
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<tr>
<td>Hamburg</td>
<td>62.1</td>
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<td>80.3</td>
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<tr>
<td>Westfall Pediatrics</td>
<td>86.2</td>
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In late spring 2004, my mother needed aortic valve replacement surgery. She’d known it was coming for several years and when the time came, I travelled home to New York so that I could be there and help out as she recovered. We were hopeful that the procedure would be a success, and were confident that she was in good hands. Mom’s surgeon at North Shore Manhasset Hospital, Dr. Alan Hartman, now the chairman of cardiovascular and thoracic surgery at North Shore–Long Island Jewish Health System came highly recommended. He had completed a successful heart surgery on my uncle several years prior. And during my parents’ initial consultation with him for my mother’s surgery, he made a terrific impression.

But we were also nervous. This would be my mother’s third heart surgery, having previously had two bypass procedures, as well as a heart attack and history of angina.

On the morning of my mother’s surgery, Dr. Hartman came into the room with a comfortable reassurance. When he sat down to chat with us, he seemed relaxed and optimistic and genuinely interested in making sure we all knew what was going to happen. I recall that he specifically asked me if I had any questions for him because we had not met previously.

As Dr. Hartman rose to leave, my mother said, almost as an afterthought, “Oh, and also, Dr. Hartman … don’t forget I have a DNR.”

My initial instinct, as a daughter, was that this was not the time to invoke a do not resuscitate order. As someone who studies health care provider interactions, my next thought was that this proclamation was not going to make the surgeon happy, and I waited for the stress to show. Surely, Dr. Hartman would be annoyed that something like a DNR hadn’t been discussed previously or addressed with the nursing staff. I was certain that his mind would be on the surgical schedule and that discussing the DNR implications at this point would create backlog. Mostly, I didn’t want us to be the “difficult” family that created trouble, particularly not before he needed to perform a complex surgery on my mother.

But, Dr. Hartman was neither angry nor annoyed. He didn’t look or act put out, and he didn’t look at his watch. Instead, he paused, and then said, “Well, let’s have a conversation about that.” He sat back down in the chair, leaned back and crossed an ankle over a knee and continued, saying, “Carol, when you say you have a DNR, tell me more about what you mean by that.”
My mother has a doctorate and had been an English teacher for years. She has a gift for explaining things precisely and clearly. But the fear was showing as she searched for the right words. “Well, you know, if something goes really wrong and I have a stroke or something, I don’t want you to do anything courageous … or extreme. It’s ok to let me go.”

Dr. Hartman thought for a minute and then continued very conversationally. “So, in order to give you a new heart valve, we are going to need to stop your heart. Then after we’ve replaced your valve and finished, we’ll restart your heart and ‘bring you back up.’ And the anesthesiologist needs to help me bring you back up. If the anesthesiologist doesn’t feel like he’s allowed to do that, he won’t want us to start the surgery in the first place. Is that what you mean by having a DNR?”

Mom’s response was immediate. “Oh no! I just don’t want something really bad to happen and not be able to do anything for myself.”

At this point in the conversation, I jumped in. “Mom, if you could still do the Sunday New York Times crossword puzzle but you were in a wheelchair, would that be okay with you?”

“Yes,” she said.

“What if you were blind, but could listen to books on tape and the opera? Is that ok?”

Dr. Hartman looked at the two of us and then asked, “Carol, do you feel like your daughter knows what you would want?”

My mother answered with certainty. “Yes, she’s on my health care proxy.”

Quite gently, Dr. Hartman then continued. “Carol, would it be ok with you if we proceeded with the surgery without the DNR and assume for the moment that it will all go well, but that if anything happens I will talk to your daughter and she will make good decisions for you? Would that be all right?”

A definitive “Yes” came from my mom.

The conversation took less than five minutes.

Dad and I then went up to the family surgical waiting room. The hours felt like a really long time. At one point, I checked with the volunteer who had been periodically escorting family members to see their loved ones in the recovery area to make sure we hadn’t missed our names being called. She asked who my mom’s surgeon was, and when I told her it was Dr. Hartman, she smiled and said, “Oh, he’ll come for you. He likes to come get the families himself.”

Sure enough, sometime later, Dr. Hartman appeared in the doorway with a smile and told us that things had gone very well. He walked with us to the post-surgical ICU and stood, leaning comfortably in the doorway, making conversation while we looked at my mom who, though cold and hooked up to a million things, already had better color than I’d seen in a while. I kept getting nervous that we were taking his time, and that surely he needed to be somewhere else. But he seemed to be in no rush and waited until we were ready to leave the room before he went on his way.

That day is very clearly etched in my brain, partly because of the fear, relief and gratitude I felt through the course of the day. But also because I frequently retell parts of the story when I’m talking about what it means to reduce patient suffering and improve patients’ experiences.

I retell the story to highlight the value in health care of appreciative inquiry, which is the concept of reviewing examples of excellence to uncover what made them so successful in order to bring out the best in patient care, quality, safety and interpersonal communication.

In the spirit of appreciative inquiry, Dr. Hartman:

> Ensured we had the information we needed by eliciting questions and asking clarifying questions of his own
> Conveyed a sense of kindness and caring that reduced our anxiety with the situation and created a sense of trust in him
> Used body language to show that he had time for us
> Let the emotional state and needs of my mother, the patient, guide the interaction instead of having his own agenda control the interaction
> Sought to understand the values of my mom and her family before offering options or making recommendations
> Seamlessly navigated an end-of-life conversation by responding to my mom’s concerns, taking into account the planning and structure for decision making she had already put in place
> And helped my mom retain as much control over her situation as possible

In the delivery of health care, that is what excellence looks like.
The Human Side of Excellence

A surgeon advocates for humanistic values in medicine

By Diana Mahoney

“Medical excellence requires human excellence, and the human side of the physician needs to be fed no less than the scientific and technical ones.”

This sentiment, articulated in a recent article by Dr. Richard Gunderman, a correspondent for The Atlantic, and professor of radiology, pediatrics, medical education, philosophy, liberal arts, and philanthropy at Indiana University, touches on a critical but often under-appreciated element in the delivery of quality health care.

“It is about being human,” said Dr. Alan Hartman, chairman of cardiovascular and thoracic surgery at North Shore–Long Island Jewish Health System and associate professor at Hofstra North Shore–LIJ School of Medicine. “Health care has to be delivered on a personal level. The standard for us, as physicians, has to be to provide the type of care we expect for ourselves or our families. Nothing less.”

In everyday practice, this means “doing your due diligence of providing good care, paying attention to details, and most importantly, communicating—with the patient, with the family, and with other providers involved in the patient’s care,” Hartman explained in a recent interview with Partners. “You don’t have to be super brilliant to deliver good health care. You do have to be methodical, and thoughtful; fastidious and courteous and you have to be present—in the moment—with every patient.”

Yes, health care is in a period of transition, with changing funding structures and requirements, new technologies, merger dynamics, and cultural shifts, Hartman acknowledged, “but using that as an excuse for not fulfilling our professional and personal responsibility to provide humanistic care is nonsense,” he said. “Every patient deserves the best health care they can get.”

To accomplish this in his own practice, Hartman has established specific guidelines designed to minimize patient stress and anxiety and create a positive experience. “For example, today I am seeing seven new patients. We allot an hour for each of them, spacing the appointments in a way that the waiting room will not have more than one or two people in it at any given time,” he explained. “Does it have to be that way? No. Could I do it in 45 minutes or even a half hour? Probably. Would that be best for the patient? Probably not,” he said. “Imagine how you would feel if you were to walk into an office and there were a lot of patients in there because two or three patients are scheduled for the same time slot, and you had to wait an hour or even two before seeing someone.

“What would that accomplish, other than frustration?” Hartman asked. “Does it make the physician more efficient? Does it make the patient feel like they are getting care on a personal level? No.” Instead, he said, it starts the patient–physician relationship off on a negative note, which can be difficult to overcome.

There are other considerations, Hartman said, that fall under the category of basic courtesy. “If I am in surgery, my staff knows to check how I
am doing on time. If they realize I am not going to be out in time for an office appointment, they will call the patient to delay the appointment or schedule it for the next day,” he said. “This is not rocket science. It is just decency and common sense. Sometimes you have to step back and ask yourself, ‘What is the ideal way of doing this?’ I don’t want to waste patients’ time, and I also don’t want to feel pressured to finish up in the OR or feel hurried when I’m talking to families and making sure patients are stable in the ICU.”

Importantly, physicians have to identify the principles of practice that matter most to them, and consistently communicate those principles to their organization at the administrative level, Hartman said. “The expectation should be that the physician establishes the principles and the system has to accommodate them, not the other way around.”

For example, Hartman explained, “I find the common practice of asking a patient to disrobe and put on an exam gown objectionable for a first meeting. It doesn’t put people at ease, and it exacerbates the power differential.” Instead, his first conversations with patients occur after the nurse records the vital information, but before they are asked to change. “It seems like a small thing, but the small things—like giving the patient your full, uninterrupted attention, making eye contact, sitting down rather than standing up towering over them—makes the interaction more productive,” he said.

Hartman does not believe that his approach is either the best or only approach. “It is what works for me. We all recognize care when it is exceptional and when it is not. When we are providing care, we have to just step back and ask ourselves, ‘what is the ideal way of doing this?’ and follow our instincts. It should be intuitive.” If it is not intuitive, he said, “maybe that means we are selecting the wrong people to go to medical school. Either it is in your personality or it is not. If it is not, we should really re-evaluate the qualities we look for in people who will be providing care.”

Medical schools also have an obligation to incorporate some of these ideas into their curricula. Traditionally, medical schools have focused on ensuring students learned the science and the cut-and-dried aspects of the clinical rotations, Hartman said. “Clearly the science is important, but we have to make sure that students can communicate and interact with people in a meaningful way. Some of the newer medical schools are building that into their programs.”

Hofstra North Shore–LIJ School of Medicine, which this year enrolled its third class, achieves this through its Center for Learning and Innovation (CLI) by using simulation education with actors as well as computerized mannequins that talk and respond to students as they take histories and vital signs and perform procedures. “These real-life scenarios are recorded with digital video and critically analyzed by the medical school faculty and [CLI] staff during debriefings with the students,” Hartman said.

Through active learning exercises such as these, students are trained to focus their concentration and make an emotional investment in their interactions with patients. “The goal is to help form physicians who are more sensitive in terms of fulfilling the needs of our patient population,” said Hartman.

“Really, though, excellence in health care will always come down to providing the type of care you would expect if you were on the receiving end, because some day we all will be.”
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