



2015

Creating and integrating a new patient experience leadership role: A consultative approach for partnering with executive and clinical leaders

Denise M. Kennedy

Assistant Professor of Healthcare Systems Engineering, Mayo Clinic College of Medicine and Patient Experience Administrator, Mayo Clinic Arizona

Follow this and additional works at: <https://pxjournal.org/journal>



Part of the [Health and Medical Administration Commons](#), [Health Policy Commons](#), [Health Services Administration Commons](#), and the [Health Services Research Commons](#)

Recommended Citation

Kennedy DM. Creating and integrating a new patient experience leadership role: A consultative approach for partnering with executive and clinical leaders. *Patient Experience Journal*. 2015; 2(1):155-159. doi: 10.35680/2372-0247.1074.

This Article is brought to you for free and open access by Patient Experience Journal. It has been accepted for inclusion in Patient Experience Journal by an authorized editor of Patient Experience Journal.

Creating and integrating a new patient experience leadership role: A consultative approach for partnering with executive and clinical leaders

Cover Page Footnote

Acknowledgments The author thanks Professor Leonard Berry, Mays Business School, Texas A&M University, for his early advice and counsel on developing and structuring the patient experience administrator role at Mayo Clinic Arizona (MCA). Mr. Kevin Paige, as Chair of Clinical Operations, provided leadership and support that contributed to the successful integration of the role at MCA. Their contributions to this work are much appreciated.

Creating and integrating a new patient experience leadership role: A consultative approach for partnering with executive and clinical leaders

Denise M. Kennedy, MBA, *Assistant Professor of Healthcare Systems Engineering, Mayo Clinic College of Medicine, and Patient Experience Administrator, Mayo Clinic Arizona, Kennedy.Denise1@mayo.edu*

Abstract

Many healthcare organizations are creating new leadership roles to add subject matter expertise and structure to their patient experience improvement efforts. The patient experience field is emerging, however, so there are many questions about this role's function and how best to structure it in the organization for maximal effectiveness.

This article explores the benefits of a consultative approach for improving the patient experience. Previous research on management consulting and the integration of new roles in established organizations is briefly reviewed. Mayo Clinic Arizona's (MCA) comprehensive, "7-prong" service model is revisited. Developed and implemented in 2008, the model is predicated on consultative relationships with executive and clinical leaders, is driven by data and accountability, and has demonstrated efficacy in improving the patient experience in specialty and primary care settings. Seven widely accepted service quality principles comprise the model: (1) multiple data sources to drive improvement; (2) accountability for service quality; (3) service consultation and improvement tools; (4) service values and behaviors; (5) education and training; (6) ongoing monitoring and control; and (7) recognition and reward.

The focus of this article is Prong 3, service consultation. MCA's consultative approach to structuring the patient experience leader is discussed, responsibilities are defined, qualifications are suggested, and key affiliations for integrating this new leadership role are proposed.

Key Words: Patient experience leadership, patient experience improvement, healthcare service quality, healthcare consulting

Introduction

For many years, management consultants have advised leadership on issues related to strategy and operations, with the goal of improving organization performance.¹ With their specialized knowledge, independence, and objectivity, management consultants have helped organizations successfully navigate challenging shifts in the business landscape. Arguably, today's healthcare landscape could be considered more challenging than ever. As examples, regulatory requirements are increasing, creating more financial and administrative pressures. The industry is consolidating, as organizations try to build critical mass to remain viable. Patients are incurring more personal expense for their healthcare, increasing their expectations for the best possible experience. As this wave of healthcare consumerism takes hold, patient perceptions of the experience, captured in standardized satisfaction surveys, are increasingly being used to determine value-based payment. Just as 'big business' leaders need the subject matter expertise of management consultants, healthcare leaders need the subject matter expertise of patient experience consultants.

Today's patient experience (PX) leaders have an opportunity to shape a new role in an emerging field by demonstrating subject matter expertise in the science of service.² Knowledge of and experience with service quality principles, marketing research methods, consumer behavior, and satisfaction surveying, as well as other general business principles such as management, audit, and data-driven process improvement, help to position the PX lead as the respected 'voice of authority' in an organization. Like the management consultant, the PX consultant leverages knowledge, experience, and reputation to be a trusted advisor to leadership.

This article explores the benefits of a consultative approach for improving the patient experience. Previous research on management consulting and the integration of new roles in organizations is briefly reviewed. Mayo Clinic Arizona's (MCA) comprehensive, "7-prong" service model is revisited (Figure 1). Developed and implemented in 2008, the model is predicated on consultative relationships with executive and clinical leaders, is driven by data and accountability, and has demonstrated efficacy in improving the patient experience in specialty³ and

primary care⁴ settings. Seven widely accepted service quality principles comprise the model: (1) multiple data sources to drive improvement; (2) accountability for service quality; (3) service consultation and improvement tools; (4) service values and behaviors; (5) education and training; (6) ongoing monitoring and control; and (7) recognition and reward. The focus of this article is Prong 3, service consultation. MCA's approach to structuring the patient experience leader is discussed, responsibilities are defined, qualifications are suggested, and key affiliations for integrating this new leadership role are proposed.

Background

Management consultants are specially trained, qualified, objective persons who work in an independent manner to help identify and analyze problems and offer recommendations for improvement.⁵ Though a valued industry today with revenues in excess of \$150 billion⁶, prior to World War I there were no management consulting firms. At that time, the science of management was not well understood, making it difficult for early consultants to demonstrate the value of their services.⁷

Turner proposed a hierarchy of eight goals that helped define the value of management consultants. From the most basic goal, "providing information," at the bottom of the pyramid, to the most sophisticated goal, "permanently improving organization effectiveness," at the top, the hierarchy defines the respective roles and responsibilities of consultant and manager and emphasizes the value of a trusting, collaborative relationship.⁸

Reay proposed three micro-processes for integrating a new nurse practitioner role into Canada's established healthcare system and asserted that embedded persons with established relationships and affiliations were better able to cultivate opportunities for change, fit a new role into established work processes, and demonstrate the value of a new role because they understand the organization's culture.⁹ Cultural competence enables them to push the boundaries of established norms and facilitate change without negative consequences.

Management consultants have been characterized as institutional entrepreneurs – socially skilled change agents who grasp opportunities in emerging fields to create new types of organizations and/or promote new roles within existing organizations. Previous research suggests that institutional entrepreneurs theorize the change they wish to effect, aligning their desired organizational changes with society¹⁰; affiliate with those in positions of status in an organization to

gain credibility and make their proposed changes possible¹¹; and build consensus to counter resistance from those in the organization who have a vested interest in maintaining the status quo.¹²

Patient experience leaders could be considered institutional entrepreneurs. As they develop and establish a new role in an emerging field, PX leaders theorize the best possible patient experience (and what is needed to create it), affiliate with their leaders to gain credibility and facilitate organizational improvement, and capitalize on their reputations and respect within and outside the organization to build consensus and change the status quo. The key functions of the PX leader are found within Turner's hierarchy of management consulting goals – (1) provide service-related data and other information to help diagnose problems that negatively impact the patient experience, (2) make recommendations to help solve those problems, and (3) facilitate learning so the manager can solve similar problems in the future.^{8,121}

Consultative Methods and Tools to Improve the MCA Patient Experience

MCA is an integrated, multispecialty, physician-led, academic medical practice that employs more than 400 physicians and 5,000 allied health staff and renders services to approximately 100,000 patients each year. Since its inception 150 years ago, Mayo Clinic has had a long history of partnering physician leaders with administrative leaders, who provide advice and counsel on business matters.¹³

During the 2001-02 academic year, a visiting scientist (and internationally renowned service quality expert) spent several months on sabbatical at MCA, immersed in the organization while studying the patient experience. Many lessons were learned as a result of that consultative engagement, including how best to position the PX leader in the organization.¹⁴ The following quote is the bedrock upon which the consultative approach to improving service quality and the MCA patient experience was built:

"The service lead is not responsible for improving service quality in the organization. The service lead is a resource to management – an analyst, an educator, a trainer, a cheerleader, a consultant, an innovator, a facilitator of improving service quality but not the individual responsible for improving service quality. Every employee provides service to a 'customer,' either internal or external to the organization, so every employee is responsible, in some way, for improvement."¹⁵

MCA's service model was theorized as a consultative partnership between the PX leader and work unit managers. Managers have specialized knowledge of

the operational issues that impact the patient's care experience. Patient experience leaders have specialized knowledge of the science of service quality and factors affecting the patient's service experience. When improvement was approached as a mutually respecting collaboration between the MCA Family Medicine department manager and the PX leader, systematically applying all seven prongs of the service model to the consultative engagement, double-digit increases in patient satisfaction were achieved.⁴

Consultation begins with analysis of the service quality dashboard, a screening tool that combines multiple data sources and identifies department-level improvement opportunities.¹⁶ Then, more detailed operational and perception data trends are compiled and analyzed at 15 key touch points in the patient experience – e.g. appointment office, reception desk, exam room, check-out process – where the quality of interactions depends on and is controlled by physicians, managers, supervisors, and the front-line staff. Perception and complaint data trends, patient comment themes, PX leader impressions, and recommendations for improvement, are compiled in a final report to management. The PX leader is one improvement resource, providing, as examples, undetected direct observation of patient-staff interactions and service quality education and training. Referrals are made to other subject matter experts, as the data indicate. For example, when satisfaction with provider communication skills is below target, a physician-led workshop or personal coach may be recommended improvement resources.¹⁷ The final report is reviewed with the manager, and a standardized action plan template is provided. While some believe the consultant should develop the action plan^{8,123}, MCA's department managers, who are more familiar with their operations and resources, develop the action plans. The PX leader reviews the plans with the manager to ensure all service gaps are addressed and plan the timing of improvement work.

Very often, managers need the objectivity of a consultant to help define the problem and its root causes.^{8,122} The "gaps model," a conceptual framework of service quality^{18,19}, is another tool used at MCA to help managers diagnose the most likely causes of patients' perceived poor service quality. Four gaps in the organization's service – (1) not understanding customer expectations; (2) not designing customer-focused processes and performance standards; (3) not hiring, educating, and training the right people; and (4) not communicating accurately about services – have been shown to contribute to the customer's experience falling short of the customer's expectations (the "customer gap") and, consequently, perception data falling below

target. The goal is to help department managers identify their gaps in service delivery (e.g. due to inefficient processes, resource constraints, and inappropriate physician and staff behaviors) and develop corrective strategies. Involving the department manager in the diagnosis of service deficiencies helps them acknowledge their accountability for improvement.

Lessons Learned

Since creating the PX leadership role at MCA several years ago, many consultations and dialogues with other organizations have provided lessons about positioning this new role for effectiveness.

First, the PX leader should be structured for independence. Like internal auditors, PX leaders are internal consultants. Both are employed by the organization so cannot have absolute independence. Internal Audit's reporting relationship to and close alignment with the governing board and executive leaders provide independence.²⁰ Similar dotted-line relationships give MCA's PX leader a highly visible affiliation with the governing board and the Chief Executive Officer. The CEO is visibly supportive, repeatedly clarifying the PX leader and department manager roles and granting the PX leader permission to go anywhere in the organization necessary to improve the patient experience. Quarterly status updates to the governing board and various clinical practice oversight groups keep leadership apprised of patient experience matters and give the PX leader status and credibility in the organization.

Second, adopt a framework to deliver the best possible service experience and build consensus around it. Executive and clinical practice leadership endorse the 7-prong service model and, from its inception, have given legitimacy to the PX leader's actions. Examples include distributing unblinded service performance data to increase awareness of service deficiencies and using the existing practice management structure to hold department managers accountable for improvement.

Third, affiliate with clinical leaders for credibility and status. Close affiliation with MCA's Chair of Clinical Operations, a C-suite position, helped integrate the PX leader by introducing and promoting the role, suggesting appropriate committee memberships, inviting presentations to department managers, and encouraging the PX lead to seek academic appointment to visibly reinforce subject matter expertise. Help with navigating the organization and its culture was invaluable in establishing the role.

Fourth, hire the right person with the right qualifications to lead PX initiatives. Many of the attributes required for successful executive leadership also are required for successful PX leadership. The PX leader has no authority over people, process, or resources so must, through a combination of technical and interpersonal skills, be able to compel others to want to be part of the organization's PX improvement initiatives. PX leadership attributes that contribute to success include but are not limited to: subject matter expertise, highly developed analytic and communication skills, boundless energy to change the status quo, flexibility to adapt for those who are not ready for change, confidence, a positive demeanor, a systems thinker with knowledge of healthcare operations, superior presentation skills, and the ability to teach abstract service quality concepts as relevant opportunities to improve a department.

Conclusion

MCA's data-driven, consultative model for improving service quality is a long-term approach to creating value by improving patients' service experiences. Predicated on a mutually respecting partnership, the consultative approach fosters teamwork and continuous learning, which improves service quality and organizational performance. Improving service is the right thing to do for the patient and, in a value-based payment model, helps to sustain an organization for the future.

Acknowledgments

The author thanks Professor Leonard Berry, Mays Business School, Texas A&M University, for his early advice and counsel on developing and structuring the patient experience administrator role at Mayo Clinic Arizona (MCA). Mr. Kevin Paige, as Chair of Clinical Operations, provided leadership and support that contributed to the successful integration of the role at MCA. Their contributions to this work are much appreciated.

References

- David RJ, Sine WD, Haveman HA. Seizing opportunity in emerging fields: How institutional entrepreneurs legitimated the professional form of management consulting. *Organ Sci.* 2013; 24: 356-377.
- For more information on the science of service, the reader is directed to the works of L. Berry, M. J. Bitner, S. Brown, A. Donabedian, J. Heskett, A. Parasuraman, F. Reichheld, W. Sasser, and V. Zeithaml, to name a few.
- Kennedy DM, Caselli RJ, Berry LL. A roadmap for improving healthcare service quality. *J Healthc Manag.* 2011; 56: 385-402.
- Kennedy DM, Nordrum JT, Edwards FD, Caselli RJ, Berry, LL. Improving service quality in primary care. *Am J Med Qual.* 2015; 30: 45-51.
- Greiner L, Metzger R. Consulting to Management. Englewood Cliffs, NJ: Prentice Hall; 1983.
- Kipping M, Clark T. Oxford handbook researching management consulting: an introduction to the handbook. In: Kipping M, Clark T. ed. The Oxford Handbook of Management Consulting. Oxford, UK: Oxford University Press; 2012: 1-26.
- McKenna CD. The World's Newest Profession. Cambridge, UK: Cambridge University Press; 2006.
- Turner AN. Consulting is more than giving advice. *Harv Bus Rev.* 1982; Sep-Oct 60(5): 120-9.
- Reay T, Golden-Biddle K, Germann K. Legitimizing a new role: small wins and microprocesses of change. *Acad Manage J.* 2006; 49: 977-998.
- Strang D, Meyer JW. Institutional conditions for diffusion. *Theory Soc.* 1993; 22: 487-511.
- Podolny JM. A status-based model of market competition. *Amer J Sociol.* 1993; 98: 829-872.
- Hiatt SR, Sine WD, Tolbert PS. From Pabst to Pepsi: the deinstitutionalization of social practices and the creation of entrepreneurial opportunities. *Admin. Sci. Quart.* 2009; 54: 635-667.
- Herrell JH. The physician-administrator partnership at Mayo Clinic. *Mayo Clin Proc.* 2001; 76: 107-9.
- Berry L, Seltman K. *Management Lessons From Mayo Clinic.* New York, NY: McGraw-Hill; 2008.
- Berry LL, Personal communication, October 15, 2008, Mayo Clinic, Scottsdale, AZ.
- Kennedy DM, Caselli RJ, Berry LL. Healthy returns: an inside look at Mayo Clinic Arizona's 7-step approach to improve service and delight customers. *Qual Prog.* 2012 October; 32-9.
- Kennedy DM, Fasolino JP, Gullen DJ. Improving the patient experience through provider communication skills building. *Patient Experience Journal.* <http://pxjournal.org/journal/vol1/iss1/10> Accessed September 21, 2014.
- Parasuraman A, Zeithaml VA, Berry LL. A conceptual model of service quality and its implications for future research. *J Mark.* 1985; 49: 41-50.
- Parasuraman A, Zeithaml VA, Berry LL. SERVQUAL: A Multiple-Item Scale for

- Measuring Consumer Perceptions of Service Quality. *Journal of Retailing* 1988; 64: 12-40.
20. Whittington OR, Pany K. *Principles of Auditing and Other Assurance Services*. 15th ed. New York, NY: McGraw-Hill/Irwin; 2006.
-

Figure 1. 7-Prong Model

