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The importance of physician to physician coaching, medical director and staff engagement and doing “one thing different”

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Abstract

With the Center for Medicare and Medicaid Services incorporating patient experience into the Value Based Purchasing metrics, there is increasing hospital focus on improving this important aspect of patient care. The Value Based Purchasing program bases 25% of its value on the patient experience domain and is based on patient perspective as gathered via the Healthcare Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS). Our system chose to implement simultaneous pilot activities to train our 6 Hospitalist groups, obtain Hospitalist medical director buy in and deliver timely physician group feedback in a transparent manner. In addition, a single hospital was used as a pilot site to establish behavioral expectations and empower our front line staff with an innovative “One Thing Different” campaign. Varying results were seen by our different Hospitalist groups and while the group training was the same, it was the level of engagement of the Hospitalist medical director that made a significant difference in the results. Hospitalist group A went from 31st percentile to a current score of 70th percentile; Hospitalist Group B improved from 21st percentile to 63th percentile; Hospitalist group D went from 15th to 31st percentile. Hospitalist Group C improved from 3rd percentile to 25th percentile in just 6 months of project initiation. For the hospital pilot, the average monthly overall rate the hospital score increased from a starting score of 69.2% to 73.96% with the final FY 17 month reaching 77.5%. Currently, the overall rate the hospital score has sustained and is at 73.9%.

Keywords

Patient experience, HCAHPS, patient satisfaction, patient centered care

Introduction

With the Center for Medicare and Medicaid Services incorporating patient experience into the Value Based Purchasing metrics, there is increasing hospital focus on improving this important aspect of patient care. The Value Based Purchasing program now includes 25% of its value on the patient experience domain and is based on patient perspective as gathered via the Healthcare Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).¹ Hospitals are now under increased pressure to improve their scores or face substantial financial losses and therefore a structured approach to providing patients with a positive hospital patient experience is critical to success.

Our urban healthcare system has 5 hospital facilities with a total of 1453 licensed beds; 9,332 Hospital based employees; and 68,309 hospital discharges on average per year. Our Hospitalists see up to 80% of our in-house patients and therefore we felt that it was imperative to focus on these physicians as a starting point for improving our HCAHPS scores. In addition, one of our five hospital sites was performing at less than 50th percentile for the overall rating of the hospital scores and was consistently missing their organizational targets on this metric. The site

Chief Executive recognized the need for immediate attention and garnered the assistance of the physician senior director of patient experience and medical management, to assist in improving the site scores.

The purpose of this article is to address ways to overcome some inherent barriers that organizations struggle with in terms of patient experience improvement efforts. We hypothesized that we could improve our physician communication scores and overall hospital rate the hospital score by piloting several simultaneous initiatives which included: focused training of our physicians, provision of monthly transparent HCAHPS data about physician communication, and implementing an innovative approach to empowering our front line staff. The strategies and results that we have obtained as a result of this initiative are being incorporated across our system and it is our hope that by sharing our roadmap, that others can achieve similar positive outcomes.

Description of the issue that our effort looked to address

The first and most important change that we had to address was changing the culture of our hospital physicians and staff, from one of disbelief that the hospital

Table 1. Processes, practices and programs that were implemented and the reason for selection

Process, practice and programs selected to improve hospitalist and staff engagement	Reason for selection
Steps needed to highlight the importance of key behaviors that influence patient experience scores	Physicians are data driven and therefore we presented evidence based articles highlighting the importance of sitting at the bedside in terms of patient
Structured monthly feedback mechanism for physicians	Aggregate monthly group data was sent to the medical directors with the site names so that data was openly communicated. Gaps for each site to 50 th and 75 th percentile on the overall physician communication scores were listed on the monthly reports.
Physician led coaching in group sessions and 1:1 bedside shadowing	Simple techniques and key phrases were felt to have a larger impact than a complicated system. Therefore, we implemented the “Knock, Sit, Ask” initiative to help to hardwire these simple changes. We felt that this model would reinforce behavioral changes. Key words were taught during these training sessions to assist our physicians in focusing their time spent with their patients. These words included “Explain, Inform, Respect for privacy, Listen and Asking the patients their greatest concern.”
Staff engagement sessions	Physicians need support from the front line staff if improvement efforts are going to be successful. Therefore interdisciplinary staff one hour patient experience sessions were held to review key behaviors, phrases and tips to “Manage up” the team. The rollout of our “One Thing Different” campaign was felt to assist with staff engagement to find one thing that they could do differently than they were already doing to change their interactions with patients, their families and other staff members

scores could actually improve. The hospital had tried various improvement measures over the previous 5 years with little to no change in their scores and it was our belief that if we did not change the fundamental culture of truly placing the patient in the center of all of our improvement efforts, we would be unsuccessful in any initiatives that we tried to deploy. Measurable outcomes that we focused on tracking were the physician overall communication roll-up scores from the HCAHPS survey results as well as the rate the hospital scores for our pilot site. The physician lead was empowered to identify the improvement priorities given the HCAHPS domain scores. These priorities and strategies are described in further detail in our paper but consisted of: bedside direct physician to physician coaching as well as group training, standardization of our physician data reporting with monthly updates, group training sessions, and the implementation of an innovative pilot to engage our front line staff called the “One Thing Different” campaign.

We felt strongly that physicians would respond more positively to another physician in terms of being open to coaching and therefore a single physician coach was utilized to conduct the physician training. Since the lead physician was active clinically and had credibility with the staff, we felt for consistency purposes that the same physician should conduct the staff training sessions as well so that a uniform message could be delivered.

The practices, processes and programs applied to address the issues and why these were selected

The first practice that we needed to focus on was the bedside behaviors of our hospitalists. Our system has 5 hospital facilities with 6 separate hospitalist groups. The medical directors of each of the groups were contacted and were asked to be actively involved in the change management process. The importance of physician to physician communication was recognized by our system Chief Executive Officer and senior leadership team, and therefore a physician lead spearheaded our efforts. This physician had proven results at another facility and had expertise in physician coaching. Table 1 outlines the processes, practices and programs that were selected and the reason for their selection.

Physician to physician interaction and provision of monthly data

This physician met with the medical directors and the directors had the option of inviting the physician coach to their monthly Hospitalist staff meetings for a one hour group training session. One hospital had such low scores that they asked specifically for 1:1 MD to MD coaching on rounds in addition to the group training sessions. Prior to the initiation of this program, the physicians had not received any data regarding their performance on the HCAHPS survey. Therefore, monthly Hospitalist department scores were evaluated and sent to all of the medical directors to share with their physicians outlining the scores on not only the roll up Physician

Communication score but also the scores on the following questions: How often did doctors explain in a way you could understand; how often did doctors treat you with courtesy and respect; how often did doctors listen carefully to you?. The scoring scale was: never, sometimes, usually and always. While our organization prides itself on transparency, we had not focused on patient experience as much as we had on our quality initiatives. We did not have physician data reports in place prior to this pilot; therefore in addition to providing the medical directors with this information, we began to share the scores of all of the Hospitalist groups with each other on a monthly basis. This not only helped to show the differences in the scores and physician engagement but also allowed for open communication between groups about best practice opportunities. Teaching sessions focused on 3 initial behavioral initiatives: Knock, Sit, Ask.² Knocking on the door or curtain showed that our team respected the patients' privacy; Sitting at the bedside was not only a sign that our physicians were listening carefully and not rushed but also studies have shown that patients actually over-estimate the time spent at the bedside if the clinician is sitting.³ Asking the patient what their "Greatest Concern" for the day was also focused the physician's attention on the patients' needs and not our medical agendas. Utilization of some key words and phrases was also reinforced and these included keeping the patients informed about their tests and plan for the day; explaining in non-medical jargon, and "managing up" the entire physician team including not on the hospitalists but the other physician consultants caring for the patient.

In speaking with our patients, we discovered that they did not know who was coordinating their care particularly when multiple physicians were involved. We asked our hospitalists to let our patients know about the purpose of the Hospitalist service, starting with the emergency department admitting Hospitalist and continuing when the patient is admitted to the floor. We encouraged improvement of the hand off process by 1) Having the off-going Hospitalist tell the patient who the on-coming physician was and reassuring the patients that they would be in great hands and 2) Having the on-coming physician acknowledge the signing off physician by name and reassuring the patients that a discussion had taken place and that the new Hospitalist would be taking good care of them.

Physician buy in was achieved by the physician coach who attended division meetings and reviewed MD specific patient experience reports on a monthly basis and provided tips on how to improve bedside care. In addition, this physician rounded with individual hospitalists to hardwire the teaching points and incorporate them into daily practice.⁴

Medical director buy in

While the training from the physician lead was standardized, the method of reinforcement and review of the monthly MD specific reports was left to the discretion of the site medical directors. The medical directors of Hospitalist Groups A and B, regularly reviewed their group's aggregate physician HCAPHS scores at department meetings and they reinforced the training tips with a focus on the key areas such as "explaining in a way the patient understands." Hospitalist Group C, asked for 1:1 MD to MD training in April 2017 as they started in the 3rd percentile and wanted to rapidly try to improve their scores. In addition, the physician coach attended department meetings on an every other month basis to review the data and reinforce the training tips and areas of improvement. Hospitalist Group E asked for individual MD monthly scores based on the discharging physician but did not ask for an in person meeting with the physician coach. However, training tips were shared via email as well as the monthly reports. Results were tracked over a one year period- Fiscal Year 2016 as compared to Fiscal Year 2017.

Hospital staff engagement

For the hospital pilot, 7 one hour teaching sessions were scheduled in January of 2017 by the Chief executive and the pilot floor nurse manager. The lowest performing hospital floor was selected as the initial pilot site and also because the floor had a new nursing manager who was passionate about patient experience and had the desire and enthusiasm to engage her staff. The staff training sessions were led by the same physician coach who led the hospitalist initiative in order to maintain message consistency. The sessions were comprised of 25-30 attendees, 15 were nurses or certified nurse assistants and the remaining slots were filled by members from the ancillary staff- food and nutrition, environmental services, patient transporters, case management, social workers, lab and radiology technicians, front desk staff, volunteers, rehabilitation specialists and respiratory therapists. Data was shared about the lack of progress over the prior 4 years and a sense of urgency was imparted on the group. Key phrases and words were suggested and included simple measures such as explaining in non-medical terminology, asking the patient what their greatest concern for the day was, and keeping them informed about their medical care. In addition, staff was encouraged to sit at the bedside with their patients particularly during the discharge process. Similar to the physician training, a three step minimum was advised- Knock, Sit, Ask about the patients greatest concerns. Additionally, the importance of "managing" up the rest of the team was emphasized as an integral aspect of making our patients feel confident in the care they were receiving. This included introducing the oncoming staff, highlighting our physicians who were on the patient's care team and acknowledging our ancillary departments as being part of the patient's healthcare team.

Feedback on communication was an important aspect of the group training sessions. The physician coach asked for a culture change in which staff at all levels was comfortable giving feedback to each other about interactions with staff and patients that could be improved upon. Interestingly, patient transporters and housekeepers did not feel comfortable at first giving this type of feedback to the nurses and physicians due to a sense of hierarchy. Both the physician and the chief executive reinforced that all team members were equal from this point forward and that feedback was not only welcome but necessary for change to occur. Strategies on how to give peer to peer direct feedback were discussed and one suggestion was to preface these difficult conversations with the phrase “I have some feedback for you if you are willing to listen?” Staff was also given coaching on the appropriate time and place to discuss improvement opportunities with each other such as moving the conversation to a private place and not in front of the patient or family.

One Thing Different campaign

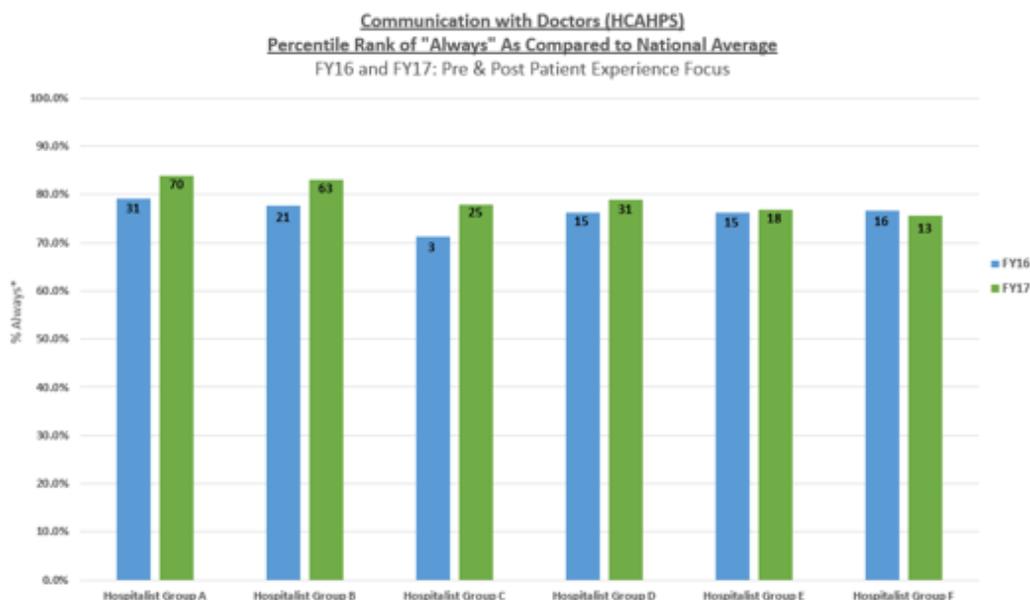
At the end of each session, participants were asked to verbalize “One Thing Different” that they were going to commit to doing on their next shift. This was an integral part of the culture shift as their comments were recorded and then reinforced on the daily unit huddles. Patient experience data was presented at the unit huddles on an ongoing basis and when the results started to show an improvement, the chief executive and physician coach

expanded the training to 2 of the other lower performing floors as improving one floor was not going to be enough to move the dial on the overall hospital scores. In addition, reminders about the focus on our patient experience scores was reinforced at employee forums with an emphasis of continuing our “One Thing Different” momentum for every patient, every encounter.

The measurable outcomes realized as a result of the effort

Varying results were seen by the different Hospitalist groups and while the group training was the same, it was the level of engagement of the Hospitalist medical director that made a significant difference in the results. Figure 1 shows the comparison scores from the start of the training in Fiscal Year 2016 to the results in Fiscal Year 2017. Of note, the Hospitalist groups with the most Director level engagement and passion for patient experience had the best results. Hospitalist group A went from 31st percentile to a current score of 70th percentile; Hospitalist Group B improved from 21st percentile to 63rd percentile; Hospitalist group D went from 15th to 31st percentile despite significant physician turnover in the past year. Hospitalist Group C just began their training program in April 2017 and improved from 3rd percentile to 25th percentile in just 6 months of initiation. However, since we have started reporting this data on a monthly basis, group E and F have asked for additional training support

Figure 1. Comparison hospitalist scores prior to patient experience focus



* % Always refers to the percent of patients responding “Always” on the Communication with Doctors HCAHPS Domain.

Figure 2. Monthly Overall Rate the Hospital Score Pre and Post Pilot Program Fiscal Year 2017 (Percent 9s and 10s)

Target	Sept 2016	Oct	Nov	Dec	Jan 2017	Feb	March	April	May	June	July	Aug
71.6	69.2	67.9	70	71.4	68.4	72	72.2	71.9	73.9	75	75.2	77.5

* Gray results indicate Post- Go Live scores

and data based on discharging physician so that they can try to improve on their scores.

For the hospital pilot, the hospital started out the fiscal year which started September 1st 2016 at 69.2 percent for the rate the hospital overall score, which was below the site's target metric that had been approved by the hospital Board for fiscal year 2017. The hospital was failing to meet patient experience targets starting at the beginning of the fiscal year in September 2017 until the start of our patient experience pilot in February of 2017. With a "Go-live" date of February 1st, the overall rate the hospital score showed an increase in their monthly score. The post go-live (February through August) average monthly score increased from a starting score of 69.2% to 73.96% with the final FY 17 month reaching 77.5%. Currently, the overall rate the hospital score has sustained and is at 73.9%. Figure 2 shows the month to month trends before and after the training was initiated and shows a sustainment over the subsequent 7 months with an increasing monthly trajectory. One of the most meaningful stories regarding the One Thing Different campaign came from a patient transporter who initially felt that he was not an important part of the team. At the end of the session he stated that he realized that he was the last non-clinical person that the patient saw before whisked off to surgery. His "One Thing Different" was to put his hand on the patient's shoulder, make eye contact and simply say "You are in really good hands." Several months later, the transporter was queried on his change in practice and his response was that he could "Physically feel the patient relax under his touch."

Implications for further practice and recommendations to help to improve patient experience scores based on our outcomes

Our case highlights the importance of physician led coaching, the continued focus of the hospitalist medical directors on monthly review of the HCAHPS results with review of the key behaviors and words that help to drive patient perception of their bedside care. Sites with active medical director buy-in had the most remarkable increases in their year to date scores in comparison with sites who did not have the same focus on patient experience.

The "One Thing Different" concept sparked staff enthusiasm and engagement as it was not a "scripted"

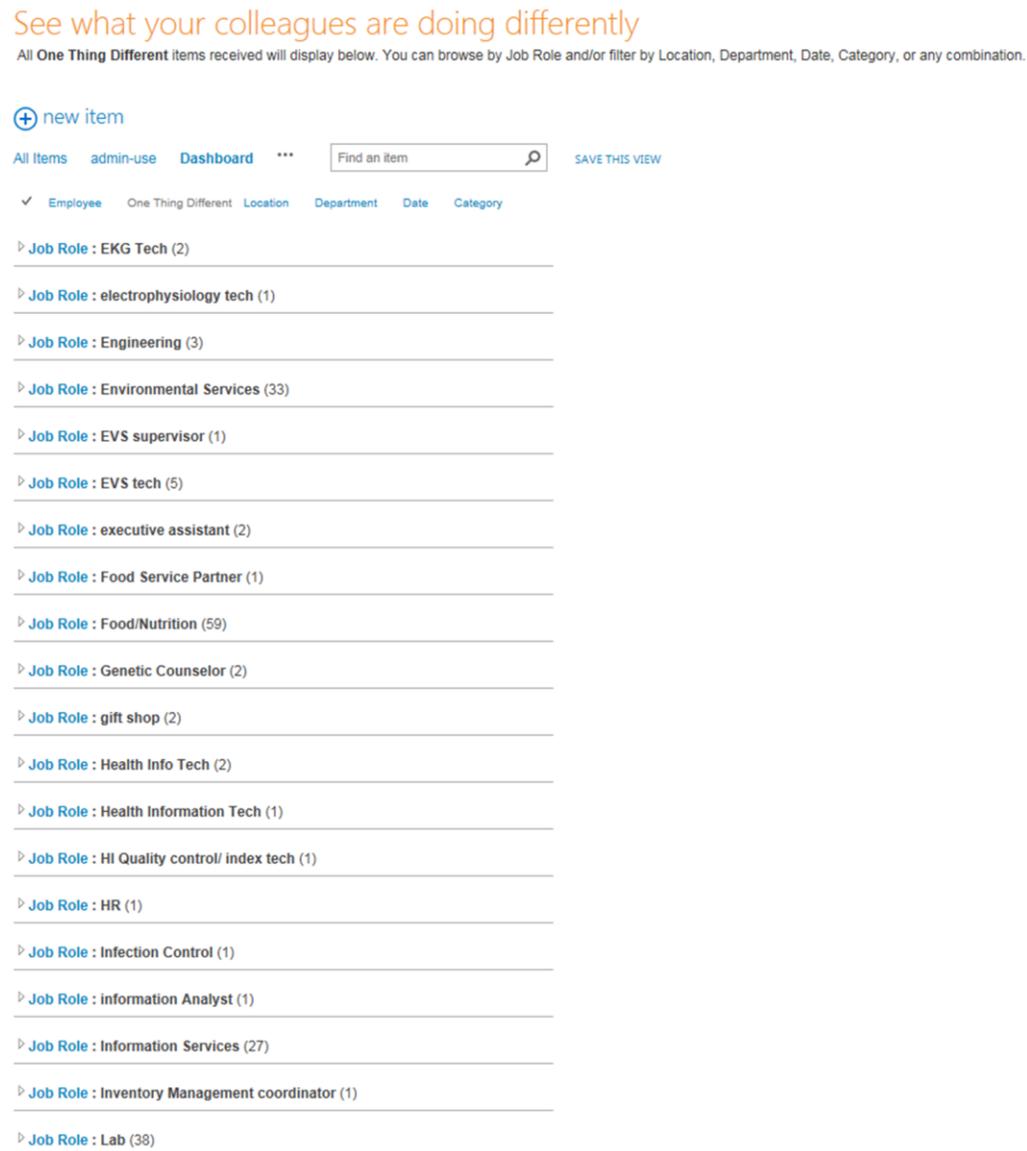
concept. All staff were empowered to choose their own "one thing" that they could do to help patients, families and staff. As part of our systemwide patient experience improvement efforts, we have now established a patient experience "One Thing Different" website, where all staff can submit their commitments to add one new thing to what they are already doing to improve the care that their patients receive. This website was developed in response to the heartwarming ideas that our staff verbalized during the training sessions and our desire was to share these with our entire team of 15,000 employees, 3000 physicians and 2000 volunteers across the system. The website categorizes staff by their roles so that other employees in the same field can obtain ideas about what they can do differently from their direct peers. (Figure 3)

Suggestions for further exploration and general recommendations

Our study highlights the importance of ongoing and focused attention to the data with not only direct physician lead support but the critical nature of buy in from the Hospitalist medical directors. The important questions that remains is how to sustain the results and how to get buy-in from the other medical directors?

1. Based on our results, the administrator who leads our hospitalists has added an additional financial incentive to the hospitalists in their compensation packages. This may assist in focusing the medical directors and site hospitalists on patient experience improvement efforts. We are exploring the impact of this incentive and initiated that change in April 2018. However, because we recognize that financial incentives are not necessarily key drivers for performance, we wanted to highlight the importance of a personal improvement journey. Therefore, we have just implemented monthly reporting of individual Hospitalist scores attributed to the discharging Hospitalist. The discharging Hospitalist was chosen as we feel that it is this physician who has the opportunity to do service recovery if needed and reinforce important aspects of the patients discharge instructions. Aggregate group data has been effective, but we would like to influence change more directly by individual physician score reporting.
2. Hard-wiring of staff and physician behaviors is crucial to sustain change. Suggestions for further exploration

Figure 3. One Thing Different Website Page



include incorporation of on-going attention staff training program with quarterly refreshers to assist them incorporate their patient experience training into their daily routines.

3. Enforcement and highlighting of the importance of the patient experience can perhaps be strengthened throughout the system through daily huddles not only on the hospital floors but by the ancillary department leaders as well. The provision of practical and easy to implement tips as well as a focus on the scores may reinforce that small behavioral changes can dramatically improve HCAHPS scores but more

importantly how our patients feel about the care they have received from all members of the healthcare team.

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