Gaining physician buy-in for the patient experience requires changing, in large part, physicians’ concept of excellence in health care delivery, according to members of a physician panel at Press Ganey’s 2016 Patient Experience Leadership Summit.

Until relatively recently, health care excellence was primarily a clinical consideration—a function of caregivers’ efforts to treat, cure and heal patients’ illnesses and injuries. Today the definition also comprises every aspect of a patient’s encounter with the health system, including not only their physical needs, but also their educational, interpersonal, social and emotional ones, according to Press Ganey Chief Medical Officer, Dr. Thomas H. Lee, who moderated the panel.

With this more inclusive, holistic definition in mind, Dr. Lee posed the following question to the panelists: “How do we get our colleagues to really feel excellence—to deliver high-quality care that is reliably safe, compassionate and coordinated all the time?”

One way the leadership at New York–based Memorial Sloan Kettering Cancer Center has achieved this is by bringing patients and families into the physician fold, according to Dr. Larissa K.F. Temple, attending surgeon in the colorectal service.

“A few years ago, Memorial Sloan Kettering developed the Division of Quality and Safety, moving quality from administration to physician [leadership],” Dr. Temple explained. “Our charge was to transform the care culture by increasing its patient-centeredness. To do this, we needed to engage patients in everything we do, so we formed a patient and family advisory council [PAC].”

Although other cancer centers had similar advisory councils in place for a few years, “Memorial Sloan Kettering never had one, so we looked to some of the other models,” Dr. Temple said. “We wanted to get up to full speed quickly, so we opted to have the PAC be completely patient-run. We identified patient and family advisors, including a chair and vice chair, from the entire cancer continuum, including those who had been treated and cured, young adults who had cancer as children and family caregivers of patients, and we embedded these individuals into everything we do within quality.” For example, every quality committee has one or two patient advisors, as does every quality improvement project.

The presence and voice of the PAC advisors have helped bring the consideration of the patient perspective to the forefront of physicians’ consciousness in all matters of quality and safety, as has the more recent decision to train a group of PAC advisors to conduct root cause analyses, said Dr. Temple. To date, trained advisors have participated in more than 12 root cause analyses.

“The first time we brought one of the advisors into a root cause analysis, the physician leading it was surprised, but now they’ve really just become part of how we do business,” Dr. Temple said. “They’ve also helped us start thinking of the patient voice in ways we haven’t before, and we’ve been responsive to them.”

In particular, the PAC advisors have provided the quality and safety team with important insight into the needs of patients around critical care transitions, including becoming a patient, transitioning from active to surveillance care and end-of-life care. “We work with them to identify projects to embrace within and around these transitions,” Dr. Temple said.

At the Johns Hopkins Hospital in Baltimore, an important catalyst for physician engagement in patient experience improvement has been a fundamental change to organizational culture, according to Dr. Elizabeth C. Wick, who played a key role in the implementation of a multicomponent, standardized care plan and trust-based accountability program called the Integrated Recovery Pathway (IRP), which was designed to improve all aspects of the surgical patient experience at the hospital. (Previously an associate professor of surgery and oncology at Johns Hopkins University School of Medicine and a colorectal surgeon at the hospital, Dr. Wick recently joined the faculty of the University of California at San Francisco.)
“Hopkins is unique in that it is a much decentralized organization. Although there are some central figures in quality and safety, the majority of the safety and quality work gets done in the departments,” Dr. Wick said.

Through her work with the safety and quality leaders, Dr. Wick and her colleagues realized that the best way to achieve safety and quality improvement goals was to adopt a team-based approach at the department level that included partnering with the patients. “We realized we needed to bring the patients into the conversation more and more in order to get the outcomes we were looking for,” she said. This realization led to the development of the IRP program, which standardizes the consistent application of evidence-based best practices, engages patients and requires accountability among clinicians at all levels.

Expanding on the hospital’s existing safety program, the IRP program was launched in the colorectal surgery department in February 2014 with the aim of improving patient outcomes, value and experience, Dr. Wick reported. “We had executive support coupled with participation from the front-line health care staff, so this QI effort was a priority for everyone. We consistently kept the patient at the center of care.”

The core components of the program are education, communication and teamwork. Prior to its implementation, project leaders educated the staff about the pathway and the need to engage patients and their families as partners in their care. Ongoing staff education included an electronic dashboard, which shows progress on the main outcomes being evaluated: length of stay, SSI rate and patient experience.

In addition to shorter hospital stays, reduced infection rates and lower costs, the program has led to significantly improved patient experience scores, especially for staff communication about medications, staff responsiveness to patients’ requests and pain management.

The improvements have been highly motivating to the care teams, Dr. Wick explained. “The message is much more powerful than having some external force telling us we need to partner with patients.”

Team-based, patient-centered care is also central to physician engagement at MD Anderson Cancer Center, explained panelist Dr. Joseph R. Steele, professor of interventional radiology at the Houston-based organization. And radiologists—often invisible team members, given the fact that they are not generally “hands-on” care providers—are an integral, and visible, part of the MD Anderson care team.

“What most people don’t realize is that other than the hospital’s blood lab, radiology sees more patients than any other department in the hospital,” according to Dr. Steele. “While the sarcoma clinic may see 40 to 50 patients on a busy day, radiology will see as many as 1,500 to 1,700 patients a day across 45 CT scanners and magnets. That’s a lot of touchpoints that really were not being focused on in terms of the patient experience.”

To optimize this “hidden” patient experience improvement opportunity, “we decided to train people [in radiology] up,” Dr. Steele said. “The first step was to get them on board. We had to win their hearts and minds.”

This included giving them feedback on their bedside manner and access to improvement resources. “We worked with our resources and partnered with academic hospitality to build out some service excellence academy modules,” Dr. Steele said. “We built a full-day course and have pulled thousands of people in diagnostic radiology offline to complete it.”

Radiologists in the hospital are also getting more face time with patients. In the head and neck cancer center, for example, there’s a radiologist working alongside the other clinicians, and the radiologist will sometimes go into a patient’s room so that they can make sense of what they’re seeing on the images. “This is something we would like to do more often,” said Dr. Steele. “Not only does it optimize another patient touchpoint, but the feedback we’ve received from our clinical colleagues is that they would rather have the radiologist present in the clinic so they can bounce cases off of them.”

The challenge is managing the volume, Dr. Steele acknowledged. “There’s no mystery that if someone sits in a dark room uninterrupted, they can move through more studies than if they are in a busy clinic running from room to room,” he said. “So we try to balance embedding a radiologist with higher volume and reimbursement pressures that we all face.”

Rising to this and the myriad other challenges care providers face daily in the rapidly evolving health care environment requires consistently defining excellence around the patient, the panelists agreed.

“The fundamental driver for all physicians is that we want to do good things and take care of patients,” said Dr. Temple. “What we, as organizations, need to do, in addition to making sure we have the quality and safety systems in place to optimize the care our patients receive, is to also start working on how we optimize the patient experience and how we use the physicians at the front lines to help push that forward.”