Breaking New Ground in the Era of Health Care Consumerism

Geisinger Health System’s chief patient experience officer reveals how the organization is embracing innovation to meet the needs of today’s health care consumers and deliver on the guiding vision of its foundress.

By Diana Mahoney

Health care has consumer elements, but it is not a commodity. This is an important distinction, according to Dr. Greg Burke, chief patient experience officer for Geisinger Health System, particularly as the health care consumerism movement gains momentum and providers are increasingly being challenged to deliver value to meet patients’ needs and expectations.

“Health care is something very personal, very deep. It is not a product,” Dr. Burke said in a presentation at Press Ganey’s 2016 Transparency & Innovation Summit in Salt Lake City. Health care is grounded in the patient-caregiver relationship and fueled by trust and caring, he explained, noting that providing the tools and technologies to help patients make value-based health care decisions is not the same as helping customers get the best deal on a car or a television set. “The stakes in health care are much higher.”

And while transparency of cost, quality and experience outcomes is essential to success in today’s health care marketplace, so is maintaining a laser focus on the true mission. “[Geisinger’s] CEO, David Feinberg, has encouraged us to remember that our real competition is not other health systems. It is cancer, diabetes, depression, infant mortality,” Burke explained. When transparency efforts are viewed through this lens, physicians, nurses and staff appreciate the importance of empowering patients to make informed decisions, because doing so is consistent with the “higher calling” that drew them to health care in the first place: the reduction of suffering. It is also consistent with Abigail Geisinger’s ambitious vision “to build a hospital and make it the best” more than 100 years ago, when she opened the George R. Geisinger Memorial Hospital in her husband’s memory.

Geisinger and health care look much different today than they did 100 years ago. Geisinger has evolved from a 63-bed hospital in Danville, Penn., into one of the nation’s leading fully integrated health service organizations, comprising a 1,200-member multispecialty group practice, nine hospital campuses, two research centers, a 467,000-member health plan and more than 23,500 employees. During this time, technological advances, the price of care, regulatory policies and cultural shifts have moved health care toward a more patient-empowered approach.

In this month’s issue of Industry Edge, Dr. Burke describes how Geisinger embraces consumerism and transparency as the organization, which now serves more than 3 million residents throughout 48 counties in central, south-central and northeast Pennsylvania, continues to evolve and adapt to the changing health care landscape.

Q: Nearly 10 years ago, Geisinger took pay-for-performance medicine to a new level with its ProvenCare evidence-based approach for ensuring care quality, by charging a flat fee for care processes associated with certain high-volume diagnosis-related groups (DRGs)—essentially attaching a service warranty to these procedures. More recently, this model has been extended to the patient experience. Can you explain the reason behind the decision?

A: ProvenCare was one of the great initiatives from our previous CEO, Dr. Glenn Steele. It involved hardwiring best practices for certain high-volume procedures to ensure they happen every time for every patient, leading to better outcomes and lower cost. 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 electronic health record through templates, order sets and reminders. If something goes wrong with the patient—if there’s a complication or an infection, for example—Geisinger, not the patient’s health insurance, is responsible for the cost of that care, regardless of how much it exceeds the flat rate.
When Dr. Steele began talking about the position of chief patient experience officer, the term that immediately came to my mind was ProvenExperience. I thought, why don’t we learn the best practices for optimizing the patient care experience—evidence-based practices like hourly rounding and better communication among doctors, teamwork and care coordination—and hardwire them so that they happen every time, for every patient? Dr. Feinberg took it one step further by deciding that if patients don’t have a good experience, we will give them their money back. We went live with that back in November. It was radical, but it’s backed by a moral imperative. If you have a bad cup of coffee at Starbucks, they give you your money back or a new cup of coffee. Health care is a profession bound by an oath. We have to be even more accountable.

We piloted ProvenExperience with our lumbar back and bariatric surgery patients. We chose these because they have very large copays, typically $1,000 or more. We created an app with a sliding scale, from $1 to $1,000. Patients who feel their care experience was not good are asked to describe their bad experience and indicate how much of a refund they think they should get. Geisinger is riding the risk for this. There is the possibility that people might try to take advantage of us, but our experience to date is that most people don’t. A lot of the requests have been small copays. What this comes down to is trust. We include a comment in the app: “You put your trust in us, so we should put our trust in you.”

Q: Geisinger recently joined the ranks of health care systems that post online physician ratings and patient comments, and in fact was one of the first organizations nationwide to earn Press Ganey’s Seal of Integrity, validating the reliability of its data transparency program. You’ve noted, however, that transparency of information is not new to Geisinger. Can you provide some further insight into this?

A: We have a long tradition at Geisinger of sharing our performance, both internally and with patients. Our OpenNotes program, for example, provides patients with electronic access to their doctors’ notes.

On our Quality & Safety website, we’ve always published our scores for quality, mortality ratios, vaccination rates, even our Press Ganey scores. And long before we added physician transparency, we reviewed our performance data. We’ve looked at our reports from the Pennsylvania Health Care Cost Containment Council, we’ve looked at Hospital Compare and we’ve looked at our health quality indexes, and we’ve always put these numbers out there for public consumption.

Looking at the data is only part of the process, though. You have to embrace the message, especially when the message might be uncomfortable. You have to be honest about it, and you have to want to do better. Then you can use the data to map where you want to go.

Q: You have stressed that there’s more to transparency than numbers, and that in order to best meet consumers’ needs, providers should try to understand the story behind the numbers. How has Geisinger been able to achieve that?

A: One of the most powerful things we’ve done recently was to invite the family of one of our patients who died from metastatic cancer to come to the morbidity and mortality (M&M) conference for that case and present it from their perspective. There were no major areas on the medical side that we were concerned with. The resident presented the case in the classic manner. He read the EPIC notes and described the clinical situation and actions. Everything seemed logical and in order. Then it was the family’s turn, and they told a different story. They described missed opportunities for communication, unnecessary delays, losing consent for the procedure, miscommunication from an attending, phone calls that were not answered—all of the things you don’t see when you read the medical record.

It was fascinating to hear those two voices: the voice of medicine and the voice of the family. The resident went through all of the records, but the woman’s daughter got up and talked about her mother by name. It was a totally different narrative. At the end of the day, that may have been one of the most compelling M&Ms we’ve ever had. We did a root cause analysis and a fishbone diagram. The family participated and there was a lot of healing. I know our house staff appreciated the experience very much, and it changed them. The next question is: Where do we go with this? Do we open up and invite patients into these “sacred” spaces that previously have only been opened to doctors? And if we do that, how do we protect those spaces when they need to be protected?

We are exploring some of these questions and experimenting with some new approaches. For example, Dr. Feinberg surprised a lot of people with his first leadership meeting when he invited a dissatisfied patient to come and speak. It was uncomfortable, but necessary. He has also been very big on executive rounding. He tries to get every executive leader to round and routinely talk to patients, and he’s asked the board members to do the same. Again, this gives rise to a lot of questions. How far are we willing to let patients into executive activities, and vice versa? Do we invite patients into high-level committee meetings? How involved in transparency do we want patients to be? How far do we go in education? Should we have a patient experience rotation in internal medicine in the same way we have rotations in palliative care, geriatrics and oncology? To truly be innovative, we have to ask questions.
Q: With respect to the decision to be transparent with online physician reviews, has this led to a measurable impact on the patient experience?

A: Although it’s still very early in the process, the improvements we have seen to date are powerful indicators of how our transparency efforts meet our patients’ needs for information. For example, patient experience ratings for provider communications have improved substantially since we implemented the transparency pilot and training programs. Among community practice providers, scores on this measure have risen from a mean score of 93.3 (39th rank) in July 2015 to 94.2 (59th rank) in March 2016. Among outpatient specialty providers, these scores have increased from a mean of 93.6 (44th rank) in July to 94.6 (71st rank) in March. Also, since implementing provider transparency, we’re seeing substantial increases in the number of user sessions on Find a Provider, including page views. Most notably, provider transparency has helped increase the number of referrals by 44.5%.

Q: What are your thoughts about transparency around issues of patient safety and medical harm?

A: Our M&M with the patient family was our first foray into that. It requires a cultural shift. We are trained to run away from fires, but really we should be running toward them. If we get a complaint from a patient, we should be on that and ask to meet with the patient and family face-to-face. There has to be some ownership, and this extends to medical errors. We are working with our ethics committee on this, and in fact, we recently had a symposium about the importance of being forthright and honest in all communications.

Q: At the Transparency & Innovation Summit, you made the statement, “In the end, quality is love, where love is doing the right thing for people to earn their trust.” Can you describe the definition of love in this context?

A: One of the most powerful comments made during the M&M with our patient’s family was when our chair of Critical Care got up and said to the family, “I am so sorry. We didn’t love your loved one enough.” That has been going through my mind. Every time I get a patient phone call or patient concern, I feel I have to respond in a way that they feel love—not an emotional feeling, but rather as a fulfillment of that sacred oath that health care providers have taken for hundreds of years, promising to sacrifice their own time to care for people, be honest with people and put the needs of others before their own.