American College of Emergency Physicians Emergency Department Directors' Academy Leadership for Great Patient Experience

Thom Mayer, MD, FACEP, FAAP, FACHE
Executive Vice President, Leadership, LogixHealth
Medical Director, NFL Players Association
Founder-Best Practices, Inc.
Senior Lecturing Fellow, Duke University

The Most Important Slide?

thommayermd@gmail.com

DOC VADER

ON PATIENT SATISFACTION

Why are YOU Here?

VIEWPOINT

Criterion-Based Measurements of Patient Experience in Health Care

Eliminating Winners and Losers to Create a New Moral Ethos

Thom Mayer, MD
National Football League Players Association, Washington, DC; and Duke University School of Medicine, Durham, North Carolina.

Arjun Venkatesh, MD, MBA, MHA
Department of Emergency Medicine, Yale University School of Medicine, New Haven, Connecticut; and Yale-New Haven Health Services Corporation, Center for Outcomes Research & Evaluation (CORE), New Haven, Connecticut.

Donald M. Berwick, MD
Institute for Healthcare Improvement, Cambridge, Massachusetts.

Prevailing measurements of patient experience in health care are norm based and focused on percentile scores and rankings, a system of assessment that inherently produces winners and losers. There is a better way: a criterion-based system with transparent reporting of results, driven by intrinsic motivation toward benchmark practices that make health care team members' work easier and patients' lives better. Simply stated, norm-based measurements are based on an individual's or organization's standings relative to that of others, or "grading on the curve," producing rankings. Criterion-based measurements rely on standards that produce ratings instead of rankings, of which board certification examinations are perhaps the most common example in health care. Percentile scores and rankings rely on extrinsic motivation and are often linked to perverse payment and incentive systems in which teamwork, mentoring, mutual accountability, and sharing best practices are far too rare.[1,2] Health care is thus not unlike many educational systems, in which rankings have devolved into a zero-sum game, chilling learning and treating "grades" as more important than the individuals whose performance is being assessed.

Despite these well-known and fundamentally inexorable consequences of grading on a curve, surveys from the Centers for Medicare & Medicaid Services' current Care Compare and Consumer Assessment of Healthcare Providers and Systems (CAHPS) continue to score individual measures and calculate Hospital CAHPS

The Problem: 2 Truths

There are 2 truths regarding using measurements to improve patient experience: it is essential, and done poorly, it does far more harm than good. (Although these also apply to other measures of quality, the focus in this Viewpoint is on patient experience.) Measurement of patient experience and a commitment to patient-centered care are welcome additions to the way in which quality is judged in health care, as is a deep commitment to continuous improvement for all clinicians. In a cross-sectional study of 5445 physicians, 44% met criteria for burnout (defined as emotional exhaustion and depersonalization on the Maslach Burnout Inventory), and although overall higher resilience scores were associated with lower odds of burnout, among the 1359 physicians with the highest resilience scores, 29% met criteria for burnout.[5] Two of the most common causes of burnout among physicians are dealing with the electronic health record and an unreasonable focus on rankings, particularly in norm-based percentile systems,[6] which are examples of what Muller[7] has referred to as "metrics fixation" or "metrics madness."

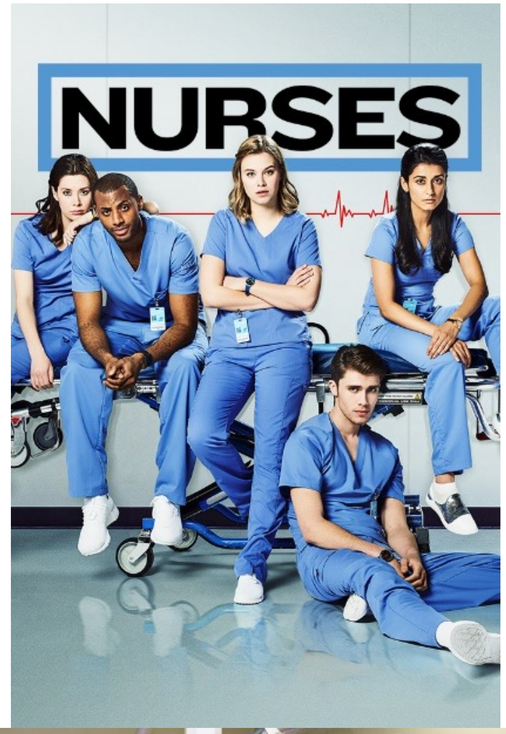
The dynamic tensions between job stressors and adaptive capacity or resiliency could be resolved by moving not *away* from measurement and improvement but *toward* a more humane and healthier system of transparent criterion-referenced reporting of what works best for everyone to improve patient experience.

Clinical leaders should take a lesson from medical education in realizing these benefits. Already, 90% of

10 Evidence-Based Disciplines for Patient Experience

1. Making the Patient a Part of the Team and Precision, Personalized Patient Care
2. Intrinsic Motivation-Accentuate the A Team, Eliminate the B Team
3. The Open Book Test Approach to Surveys
4. ED Team as Performance Artists-Chief StoryTellers
5. 3 A Team Behaviors
6. 3 Survival Skills Core Competencies
7. Taxi, Take-Off, Flight Plans, Landing+ Druckenbrod's Details
8. Dispel the Myths of Impossibility and Autonomy
9. Shadow Shifting, Focused Coaching
10. The A Team Toolkit

Tool # 1-Making the Patient a Part of the Team
Leading is a Team Sport-Say Team vs. Play Team



Making the Patient a Part of the Team

- Moving from…to…
- From…“What’s the *matter with you?”*
- To…”What *matters to you?”*
- This moves patient from being
- *Recipients* of their care to…
- *Participants* in their care
- Nothing About You Without You
- Our pledge to every patient, every time
- Our pledge to ourselves and our teams

The Tools of Making the Patient a Part of the Team

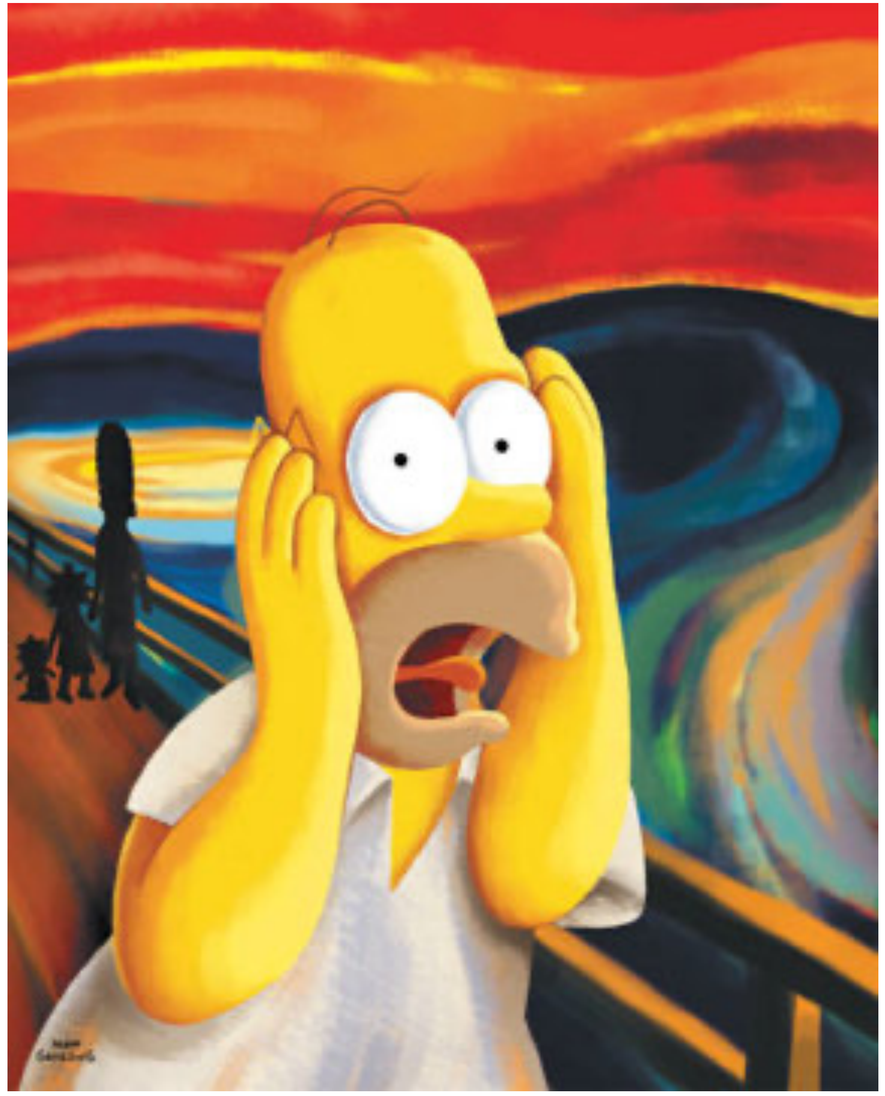
- "Mrs. Jones, we have a team of dedicated who are here to serve you. *But you are the most important member of our team.* We want to keep you fully informed of every aspect of your care, so please let us know if you have any questions at any time."
- "As the key team member, we want you to participate in the diagnostic and treatment decisions and understand them."

- "Please let us know how the medication affects your pain/nausea/symptoms…"
- "I'd like to perform a physical exam- would you be more comfortable if your family stepped out while we do that?"
- "Based on what we know so far, here's what we think our plan should be…Does that make sense? Do you agree?"
- EBL, SBL
- COWS at Bedside
- Personal Google Machines

Precision Patient Care

“What’s the most important thing we can do to make this an excellent emergency department experience?”

I **Hate** Being Rated!

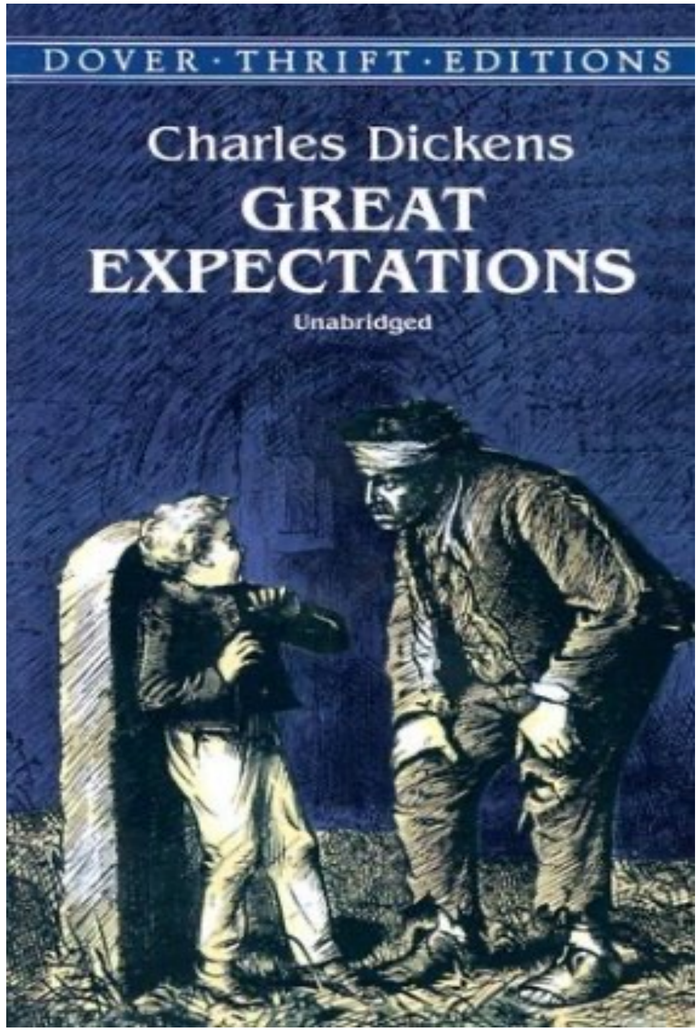


Key Questions

- Are patient satisfaction scores statistically significant?
- Isn't the "n" too small?
- Do they really measure satisfaction?
- Do they measure quality of care?
- Don't they always give them to homeless people, drug-seekers, and psych patients?

GET OVER IT!!!!!

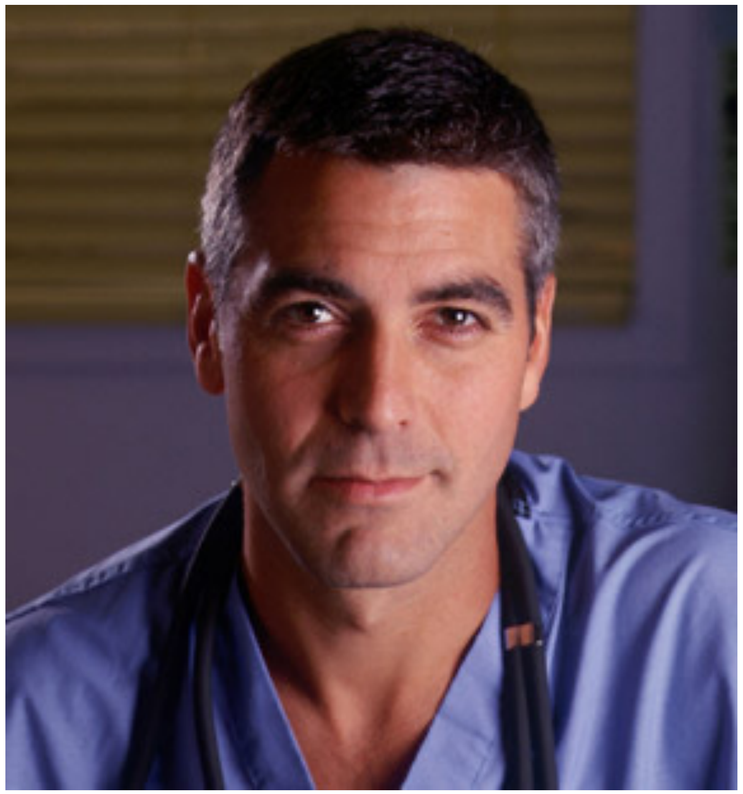
Understanding Expectations Is The Key



- Exceeded
  - Compliment (A-team)
  - Patient Loyalty
- Expectations “Merely” Satisfied
  - Complaint (B-team)
  - Service Recovery
- Disappointed

Let Them Know You **Expected** Them!

"We knew you were coming in today – we just didn't know your name!"



There Are Only **TWO** Issues…

1. WHY patient experience?
2. HOW patient experience?

The #1 reason to get patient experience right is…

It Makes Your Job Easier!

Do you offer good customer service?

It Depends!

A Team Members

- Positive
- Proactive
- Confident
- Competent
- Compassionate
- Communication
- Teamwork
- Trust
- Teacher
- Does whatever it takes
- Sense of humor
- Moves the meat

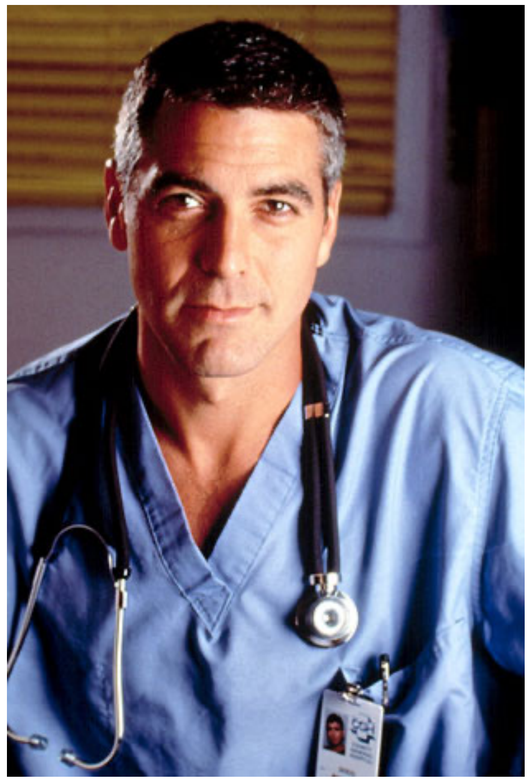
B Team Members

- Negative
- Reactive
- Confused
- Poor communication
- Lazy
- Late
- Constant complainer
- BMW club
- Can’t do
- Always surprised
- Nurse Ratched
- Dr. Torquemada

How many B-team members does it take to destroy an entire shift?

The Power of One

- One doctor…
- One patient…
- One family…
- One team…
- One choice…
- You will make a difference…
- What will the difference be?



What do B Team processes do to A Team Members?
Stop doing Stupid Stuff, Start Doing Smart Stuff

Are you an A-team member?

The B-team members are doing a job that isn’t theirs to do.


All meaningful and lasting change is driven by
INTRINSIC motivation…

The Open Book Test Approach
Using the Survey as a Tool, not a Club

- "Huddle Up – 1st Down" – within groups (MD-MD, RN-RN, registration, lab, radiology)
- Huddle Up – 2nd Down – exchange questions and scripts (MD-RN, RN-MD, etc.)
- Huddle Up – 3rd Down – Hardwiring Flow into the equation (Stop doing stupid stuff-start smart stuff)
- Huddle Up-4th Down-Shadow Shifting and "The Myths of Impossibility and Autonomy"

What's A "Good Doctor?" – PG

- Doctor's courtesy
- Doctor took time to listen
- Doctor informative
- Doctor's concern for comfort

ED CAHPS-People Who Took Care of You
The Only “Always” Questions

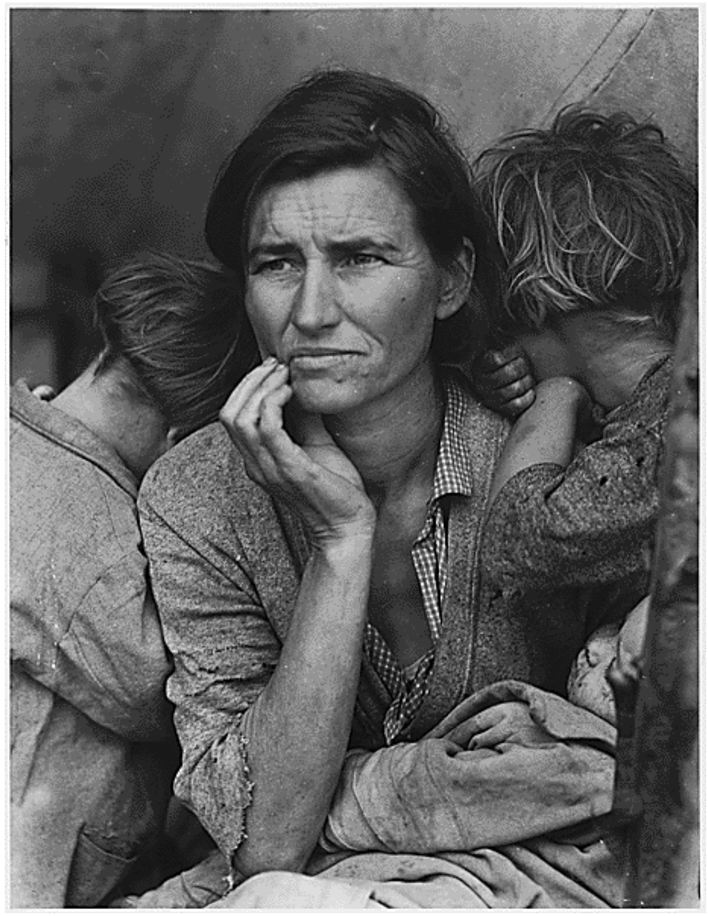
1. Courtesy and Respect
2. Listen Carefully to You
3. Explain Things in a Way You Could Understand

A New Beast…and a Nasty One!

• Press Ganey	Points
1 Very Poor	0
2 Poor	25
3 Fair	50
4 Good	75
5 Very Good	100

• HCAHPS	ED CAHPS
Never	Yes, definitely
Sometimes	Yes, somewhat
Usually	No
Always	

What's the Point?

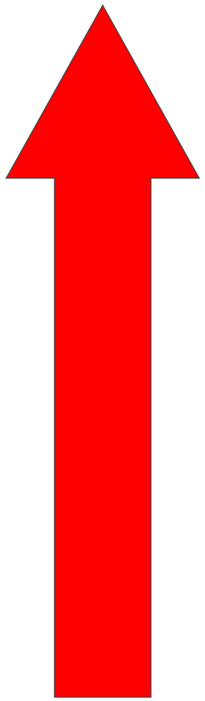


People won't remember what you did to them. They won't remember what you said to them. But they will always remember how you made them feel.

Maya Angelou

The Patient – CustoMeter

Patient **Customer**



The more horizontal you are,
the more you’re a patient.

The more vertical you are,
the more you’re a customer.

Good Patients?

Good Patients?

- Intubated
- Paralyzed
- On a ventilator
- Orphan (*no family*)
- Speaks “OUR” language
- Doesn’t come back
- In and out fast
- Wants only one thing
- Compliant (*wants it OUR way)*

3 Survival Skills Core Competencies

1. Making the Customer Service Diagnosis and Offering the Right Treatment
   - Anticipating experiences from the customer's viewpoint
   - Treating power and control options

2. Negotiating Agreement and Resolution of Expectations

3. Building Moments of Truth into the Clinical Encounter

Examples

Clinical Dx	CS Dx
Fever	Meningitis
Chest pain	MI attack
Abdominal pain	Appendicitis
>50 years	

1. Introduce yourself in a professional fashion
2. Address family members – bring them into the encounter
3. Establish a high level of professionalism and courtesy
4. Provide information as it becomes available – frequent updates
5. Check the patient's progress (multiple, brief encounters)
6. Never underestimate the value of pillows, blankets, water, OJ
7. Sit down

You are a Performance Artist!

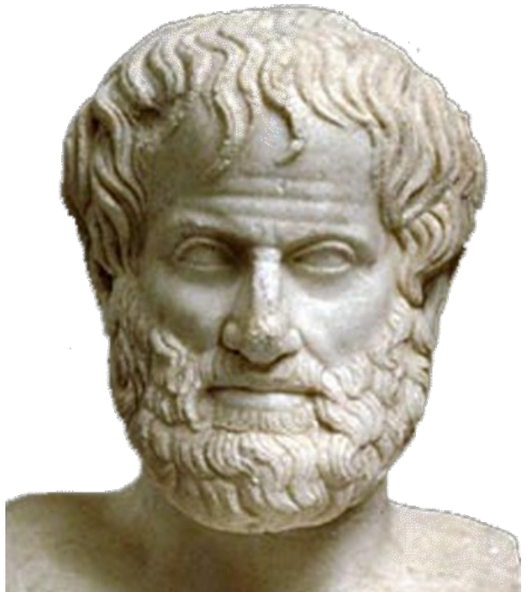
- You are the Chief Story Teller and Chief Sense Maker of the ED !
- Patients don’t wake up and say, “Great day! Off to the ED!”
- The faster and more effective you are at making yourself a “solution” instead a part of the bad experience, the easier the job
- It isn’t just LOS or TAT or intervals. It’s the perception of flow that matters!
- It’s not just how much time you spend, it’s how you spend the time!
- Onstage-offstage
- Expectation Creation

The Three A Team Behaviors

1. Sit down, smile, touch the patient, use Open Body Language
2. Active Listening
3. Making a Blameless and Effective Apology

"We are what we repeatedly do. Excellence is not a virtue, but a habit."

Nicomachean Ethics



Taxi, Take-Off, Flight, Landing

Taxi

- Emergency Physicians are “Performance Artists”
- You are the Chief Storyteller for the patient
- Review the nurses’ notes
- The Power of One
- Open Book Test

Take-Off

Enter with a flourish!

- Introduce yourself clearly and reproducibly
- Sit down and touch them
- “We want to make this the best possible ER visit.”
- “What’s the most important thing I can do to meet your expectations?”
- Make the patient part of the team
- Individualized Patient Care
- Get to the “Solutions Side”

Abdominal Pain Flight Plan

- CS Dx vs. Clinical Dx
- “It’s scary to have so much pain…”
- “We’re giving you this IV fluid/ pain meds/zofran because…”
- “These tests will tell us…”
- 10 days of work in 6 hours
- Expectation Creation

Chest Pain flight

- “Heart Attack” vs. our DDx
- “What’s you biggest fear/concern?’
- “Your initial EKG is normal-that’s good.”
- Here’s our (flight) plan..
- “I’ll let your Doctor know”

The Pain Flight-Concern for Comfort
"Did the staff do everything they could to help you with your pain?" "Well-controlled?"

- Scripts-Evidence-Based Language-AIDET
- "I'm sorry you are in pain. We'll do <u>everything we can</u> to <u>help you with your pain.</u>"
- "Your pain is an 8-is 4 a reasonable goal?"
- Avoid "Will/will not" use "can/cannot"
- "How's that medication working?"
- Explain ice, elevation, anti-emetics, etc.

Landing-Discharged

- Summarize the journey (Chief Story Teller)
- “These tests/ treatments showed…”
- Druckenbrod’s Queries
- “Have I met your expectations?”
- “What other questions do you have?”
- “How did we do?”
- Discharge instructions with Active Listening
- Sign-Out Rounds at Bedside

Landing-Discharged

Druckenbrod's Queries

- "Have I met your expectations?"
- "What questions do you have?"
- "How did we do?"
- Sealing the Deal
- "Are you comfortable with what we've discussed?"
- "Is there anything I can explain better?"
- "Thanks for coming to see us!"

Landing-Admitted

- Summarize the journey (Chief Story Teller)
- “These tests showed…”
- Druckenbrod’s Queries
- “Have I met your expectations?”
- “Any other questions?”
- “How did we do?”
- Leading Up
- Rounding on Next

Open Book Test

Doctors & Nurses

1. Courtesy & Respect

Tactics

- Knock before entering the room
- “Hi, it’s Dr. Mayer and the team caring for you. May we come in?”
- Make the patient a part of the team-IPC
- Eye contact
- Sit down! Alter the Angle
- “I’m sorry this happened to you, but I’m glad I’m here to take care of you.”
- What questions do you have?

Open Book Test

Doctors & Nurses

1. Courtesy

2. Listened Carefully to You?

   The 18 Second Rule

Tactics

- Chief Story Teller
- Expectation management
- Sit down
- Consistent communication
- Previews
- Manage/lead up
- Active Listening
- White Boards
- Physician notepads

Open Book Test

Doctors & Nurses

1. Treat you with courtesy and respect?

2. Listen carefully to you?

3. *Explain things in a way you could understand?*

Tactics

- "It's very important to me that you understand every element of your care."
- Active Listening-DDx
- T&T-Tests and Treatment
- Previews
- Time Frames-Expectation
- Patient as a Part of the Team-What they do?
- Show time! COWS

Open Book Test

Doctors & Nurses

1. Treat you with courtesy and respect?
2. Listen carefully to you?
3. Informative regarding treatment?
4. *Concern for Comfort?*

Tactics

- "It's very important to me that we make you as comfortable as possible."
- "I'm sorry you're uncomfortable-how's that pain medication working?"
- Explain ice, elevation, compression, fluids, anti-emetics
- "Can/cannot"

It Can't Be Done **Here!**
The Myths of "Impossibility" and "Autonomy"

- In fact, it can be done *here*…
- Because it's already being done *here*..
- It just isn't being done *by you!*
- Or at least not consistently enough to p
- *"That's not the way I practice!"*
- Then practice somewhere else!

The Most Powerful Tool?
Shadow Shifting

- 2 Ways-Doc to Doc or Coach to Doc-Both work-culture is the key
- Could you do this in your ED?
- If not, you will probably not get much better
- A Team with B Team works best
- 2-4 hours is plenty
- “I’m Dr. Mayer and this is Dr. Schmitz, who is one of my partners. You get 2 docs today!”
- “I’m Dr. Mayer and Olga is working with me today.”

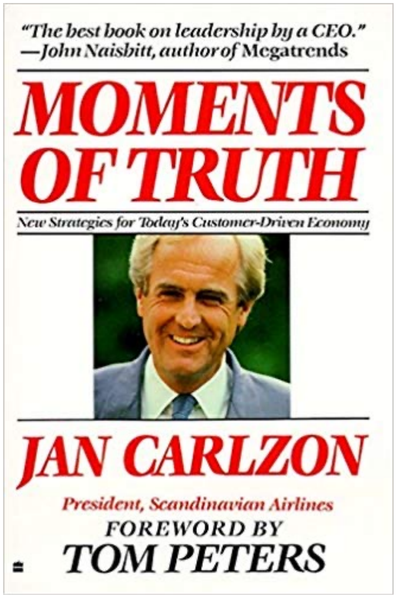
Negotiating Agreement & Resolution Of Expectations

3 Negotiation Steps

1. Discover YOUR expectations
2. Discover THEIR expectations
3. Invent options for mutual gain

The 3rd Survival Skill – Building Moments Of Truth Into The Clinical Encounter

- Jan Carlzon and SAS
- “50,000 moments of truth per day”
- Do you think your patients know how many …
- They know you!
- To them, you are the institution



The A Team Toolkit

1. Empowerment
   - Point of impact intervention
   - Patient loyalty and service recovery
   - Leading up
2. Dealing with B Team Patients and B Team Members
3. Shadow Shifting and Focused Coaching
4. Rounding – Yours, Next, Sign Out, Callbacks
5. EBL and SBL – Take 5 for a 5!
6. Hire right – Screen for the Gene
7. Taking 4s to 5s
8. Flow and the Psychology of Waiting
9. Reward your Champions
10. Leave a Legacy

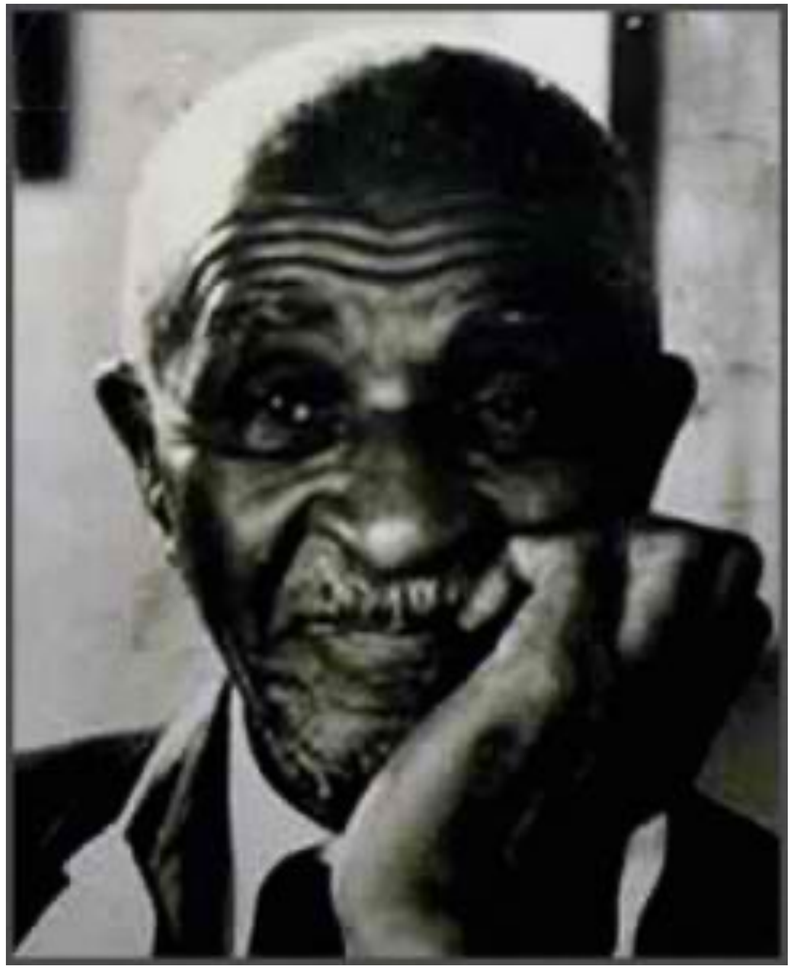
Tool # 10

Leave a Legacy

What’s Your Legacy?

The Star Thrower

George Washington Carver



“How far you go in life depends upon…”

Resources

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Thank you

Thom Mayer, MD, FACEP, FAAP, FACHE
Executive Vice President, Leadership, LogixHealth
Medical Director, NFL Players Association
Founder-Best Practices, Inc.
Senior Lecturing Fellow, Duke University
thommayermd@gmail.com