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Physician-led patient experience improvement efforts: The CONNECT program, an emerging innovation

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Abstract

In 2009, the leadership of the Children's University Medical Group (CUMG) embarked on an effort to answer the question, "What would it take to promote and foster a culture of service amongst the medical staff?" The challenge was to engage the physician group in leading patient and family experience improvements within Seattle Children's. In this article, an innovative, physician-designed and led approach to improving the patient experience is described. The effort focuses on encouraging local, grass roots strategies rooted in readily available and validated best practices. In support of that effort, novel tools that were developed and deployed to elicit input, engagement and self-assessment are also described.

Keywords

Physicians, patient experience, physician-led, CONNECT, self-assessment, Children's University Medical Group, CUMG, Seattle Children's, engagement

Introduction

The 1999 publication of the Institute of Medicine's report, *To Err Is Human: Building a Safer Health System*¹, triggered a flood of initiatives to improve health care quality and patient safety in America. The 2001 corollary, *Crossing the Quality Chasm*², amplified the momentum and the urgency. Health care facilities and institutions responded with the establishment or expansion of quality assurance programs. The growth of the quality assurance industry has been dramatic, and the number of governmental and accreditation mandates nearly overwhelming.^{3,4}

Relatively new to the landscape is the focus on the patient's experience and satisfaction. In its 2013 *State of Patient Experience Study*, The Beryl Institute found that "patient satisfaction is a top priority for the next three years for two-thirds of the respondents."⁵ Multiple factors have contributed to the growing national movement to improve patient satisfaction. These factors include federal reporting and reimbursement, the emergence of patient-centered care, and the evolution of the informed healthcare "consumer".

In many ways, efforts related to optimizing the patient experience parallel the early days of the quality and safety revolutions in healthcare. The content of the patient experience work is perhaps a softer science than the more concrete metrics and recommendations related to safety and quality. In terms of how to proceed, however, patient satisfaction, clinical quality and safety improvement efforts

all must address the common central question of, "Who owns this work?" And, further, "What is the role of the physician in leading the way?"

In this article, we report an innovative physician-led and physician-focused program directed at optimizing the patient and family experience, while also optimizing physician job satisfaction and engagement. Fundamental to the strategy and tactical rollout is the program vision, which is simple yet ambitious.

We endeavor to create an environment wherein:

1. Physicians won't want to practice anywhere else, and,
2. Patients and their families won't want to go anywhere else for their care.

We describe the steps taken to encourage physician participation and commitment, the instruments developed to assess the current cultural landscape, and the tools developed to assess provider readiness and baseline performance.

The Setting

With over 500 pediatric medical and surgical specialists, *Children's University Medical Group (CUMG)* employees nearly all of the hospital-based physicians at Seattle Children's Hospital. Seattle Children's is an academic medical center, anchored by the 323-bed hospital in Seattle, Washington. Care is also provided in nine regional multispecialty clinics throughout Washington with one cardiology clinic in Alaska. Seattle Children's cares for

patients from Washington, Alaska, Montana, and Idaho. There are approximately 351,147 combined inpatient and outpatient visits a year.

In 2009, the leadership of *CUMG* embarked on an effort to answer the question, “What would it take to promote and foster a culture of service amongst the *CUMG* medical staff?” The goal was to engage the physician group in leading improvements to the patient and family experience.

The challenges were those common to any institutional improvement effort. How does one appeal to the busy clinician with seemingly competing obligations related to productivity? Even more challenging is the recognition that participation of the frontline medical staff is vital to implementing and sustaining any improvement measures, and yet physicians are notoriously wary of and reticent to adopt initiatives that threaten their autonomy or conventional practices⁶. How then, do institutions convince physicians to embrace these efforts, and to what extent is it the physicians’ duty to “play along”? Our hypothesis and strategy were founded on the belief that success would require an independent, grass-roots effort developed and implemented from within the physician ranks. We have been steadfast and unwavering in that approach.

Answering the Call to Action: Finding the “Why?”

A physician champion was identified early on, and continues to lead this work. Critical to the physician champion’s credibility is the fact that he is an active clinician. In the champion role, he seeks input regarding best practices, advocates for resource allocation to support the *CUMG* work, and strives to secure participation and engagement of all *CUMG* physician members, regardless of seniority or role. Based on best practices, he also developed the initial vision for the infrastructure and support that physicians would need to improve at Seattle Children’s.

Before formally launching the improvement effort, *CUMG* wanted to better understand the current physician culture with respect to attitudes and beliefs about the patient and

family experience, as this would have implications for physician engagement strategies. An essential early step was deployment of a survey designed to elicit feedback on general familiarity with the concepts of patient satisfaction, the perceived value of focusing on the patient and family experience, and to assess enthusiasm for such work amongst the physicians. Equally foundational to the effort were a set of questions querying physicians about determinants of their job satisfaction. The survey was conducted in the summer of 2013. Sixty-three percent (>300) of *CUMG* physicians responded. Key findings are described below and in Table 1 and Graph 1.

Physicians...

1. Recognized their unique role in the patient/family experience;
 - y improvement work⁶, and has been fundamental to the
2. Valued feedback about their patients’ experiences
3. Confirmed opportunities to improve the patient and family experience;
4. Endorsed strong engagement with concepts related to patient/family experience;
5. Acknowledged the connection between the patient experience and clinical outcomes;
6. Identified the relationships with patients and families as the prime element of job satisfaction.

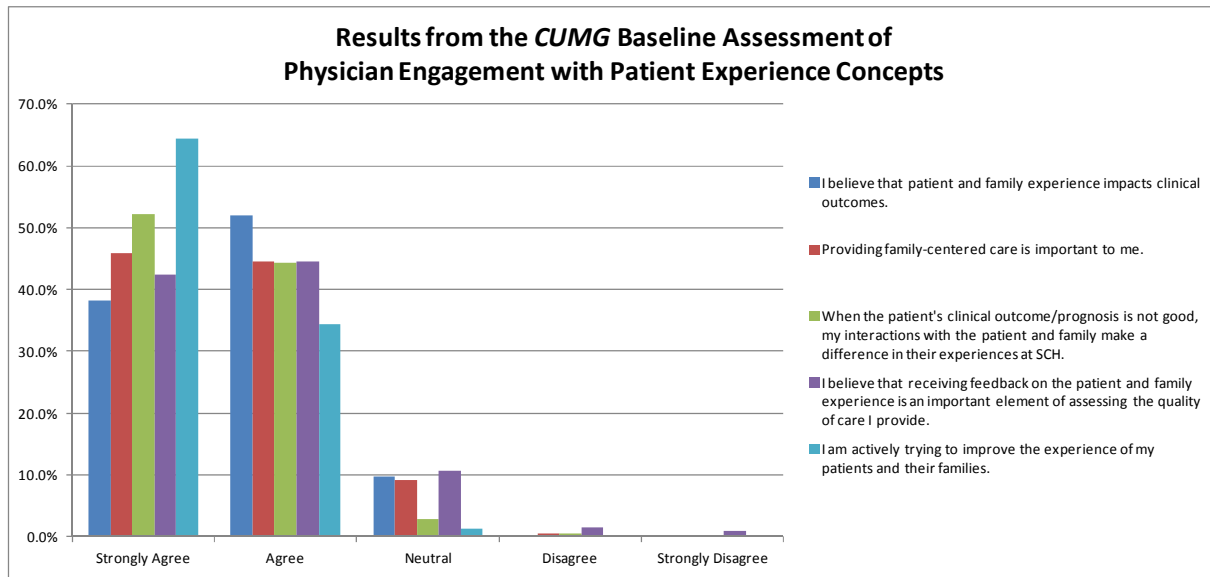
CUMG physicians were primed for efforts to improve the patient and family experience; in fact, there was a strong mandate for action. Assessing readiness set the stage for kicking off the physician improvement efforts. When working to engage physician hearts and minds, it is compelling to say, “We’re here to follow-up on what you told us matters most to you, and where you see needed improvement.” The shift from focusing on the institution’s agenda to the physicians’ agenda (their “Why”) is identified by IHI as critical to engaging physicians in quality efforts at Seattle Children’s.

What and How?

After clearly identifying the “Why” for this work, the physician champion and sponsors turned their focus to the “What” and the “How”. For a medical group newly

Table 1. Top contributors to physician job satisfaction

Please rank how important each of the following factors is in your overall job satisfaction	Average Rating					
	1 st Place	2 nd Place	3 rd Place	4 th Place	5 th Place	6 th Place
Relationship with patients and families	2.49					
Practicing my craft		2.85				
Being in service to others			3.18			
Collaboration with colleagues				3.23		
Scholarship					4.51	
Career Advancement/recognition/compensation						4.74

Graph 1. Physician engagement with patient experience concepts

charting the patient experience waters, there are now a plethora of resources to inform their improvement efforts. Well-respected quality improvement thought leaders like *The Institute for Healthcare Improvement* (IHI) offer resources for improving the patient experience on their websites and at national and local conferences. Innovative healthcare systems offer helpful “how to” stories. The Beryl Institute provides webinars, conferences, white papers and opportunities to share best practices with colleagues and institutions across the country.

Review of available resources reveals a relatively intuitive and narrow array of behaviors and tactics on which to focus improvement efforts. The Beryl Institute’s white paper, *Voices of Physician Practices and Medical Groups in Exploring the Patient Experience*,⁵ provides an excellent summary of improvement options that have been most commonly and successfully used by healthcare organizations to enhance physician actions and the patient experience. These include: sharing patient satisfaction survey results and increasing transparency about the data, communication training, coaching and peer shadowing.

As with our internal survey, a medical group beginning its patient experience journey can relatively easily describe its, “Why”, and can readily find the “What” It is the “How” that can remain elusive, largely because each medical center or hospital has its own structures and cultures. It can be challenging to impose remedies without tailoring them to the local environment, where physicians may express skepticism that “what worked there, will work here.” IHI’s, *Framework for Engaging Physicians in Quality and Safety*⁶, recommends:

1. Understanding the local physician culture
2. Involving physicians from the beginning

3. Making physicians partners not customers
4. Identifying and activating champions
5. Generating light, not heat with data
6. Making the right thing easy to try

Indeed, at Seattle Children’s, a genuine effort to understand the existing culture, and early engagement of local champions, both in leadership positions and on the frontlines, were critical steps in generating momentum and broad-based physician involvement.

Structure for Improvement

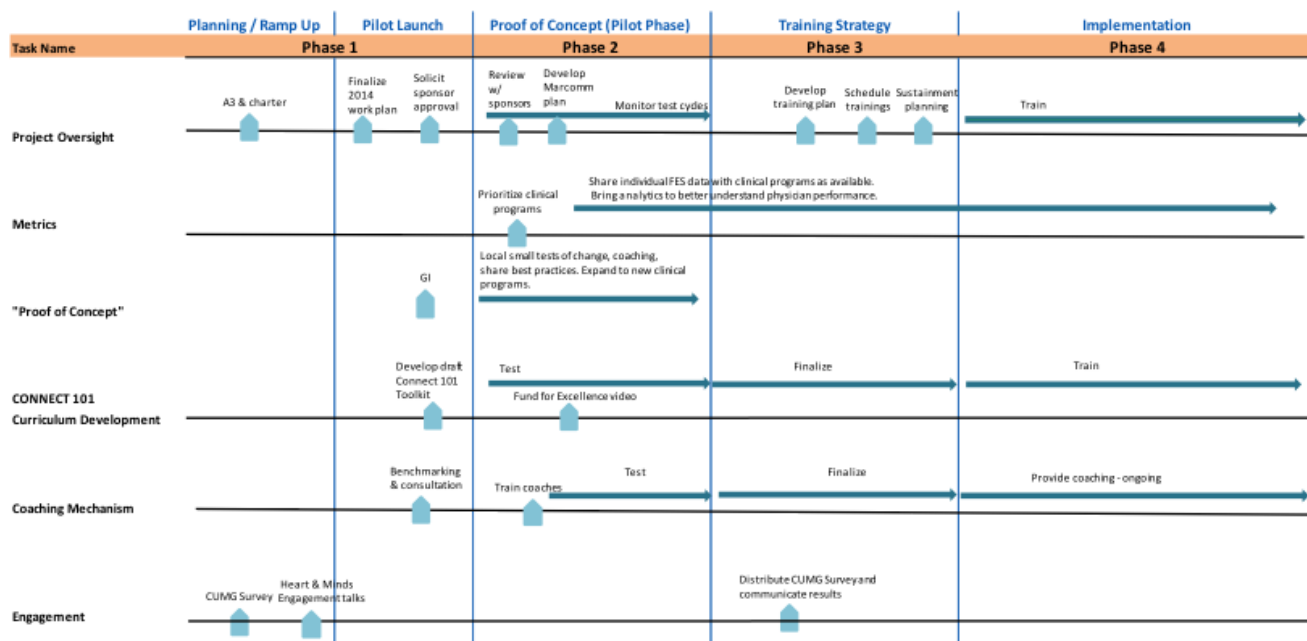
The work is sponsored by the CUMG president and executive director. The physician champion is a practicing clinician with a portion of his FTE appropriated for this role. A project manager was hired to help develop the physician training and coaching program. An executive leadership group comprised of the physician champion, the project manager and five physician champions from across the hospital meets twice monthly to plan and spread the work. An ever-expanding Advisory Group of physicians meets quarterly.

Work Plan & Model for Improvement

The CONNECT initiative was originally conceived in distinct phases, as depicted in Figure 1. Phase 1 focused on advocacy and “winning hearts & minds”. The physician champion presented the vision and solicited input and buy-in from institutional leadership, the board of directors of CUMG, and across the spectrum of rank and file physician members. Our “Four Questions” were developed to facilitate discussion and understanding of the proposed work. They consist of:

Figure 1. CONNECT program key milestones

CUMG CONNECT Program Milestones: Fiscal Years 2013 - 2015



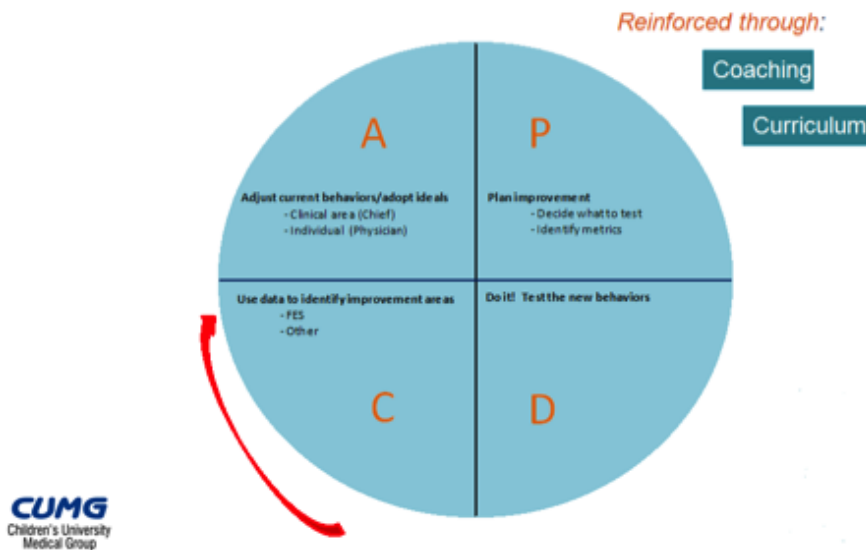
1. *Why are patients and families here?*
2. *How do they feel?*
3. *What do they want?*
4. *What do you want to give them?*

The group discussions were consistently rich and inspiring, and invariably highlighted by descriptions of personal experiences, both as providers and as consumers of health care services.

In Phase 2, the focus is on small tests of change in a variety of clinical divisions and programs. Fundamental to the strategy has been the encouragement of efforts based on local patient experience data. Our “Proof of Concept” cycle (Figure 2) based on the Deming PDCA model⁷, illustrates the steps taken in each clinical area. The cycle begins in the **“Check”**, quadrant. The section chief and the physician champion review existing patient satisfaction data at both the clinical unit level and, if available, at the individual provider level. In the **“Adjust”** quadrant, the physician champion and the chief identify local opportunities for focus and plan for next steps. In the **“Plan”** quadrant, the physician champion kicks off improvement efforts with a presentation to engage the “hearts & minds” of the physicians in that area. Central to the introduction is a facilitated discussion of our *Four Questions*. Our homegrown “Toolkit for Improvement” is distributed to offer guidance for areas of focus and specific behaviors. Lastly, in the **“Do”** quadrant, the intervention is tested and data are collected for review in

the **“C”** quadrant, thus completing the cycle. During this phase, the project manager and physician champion regularly check in with the local chief to learn what is working well and what might be adjusted for future test cycles. In addition, successful strategies and activities are collated and categorized for the third phase of the project (development of formal curriculum).

Essential to our efforts has been the development and deployment of two new tools. The *Physician Self-Assessment* asks the physician to rate themselves on behaviors known to be associated with favorable patient encounters while somewhat insidiously serving the dual purpose of raising awareness of those desirable behaviors and actions. The second tool, the *Physician Service Competency Assessment*, was developed and distributed to nurses, medical assistants, respiratory therapists and others who routinely interact with physicians in the clinical setting. The survey consists of 10 multiple choice questions focused on physician behaviors, followed by two open-ended questions designed to highlight both favorable and unfavorable behaviors. In aggregate, this survey helps to identify best practices that are encouraged in all providers, as well as those actions that should be discouraged. Individual reports are generated for each provider, including de-identified data showing where the provider stands relative to peers within their area of practice, as shown in Graph 2. Together, these tools have been essential to fostering physician motivation and enthusiasm for the work and familiarizing physicians with the concepts and behaviors

Figure 2. Proof of Concept Test Cycle Model

known to be associated with optimal patient experience and satisfaction. Equally reinforcing is the positive feedback and gratification described by physicians partaking in these efforts. The programmatic growth has been consistent, with more than a third of clinical centers signing on in less than 6 months (Graph 3).

The final phases consist of developing a curriculum based on learnings from the numerous tests of change in the Proof of Concept phase, and establishing a reliable method for teaching, promoting, and sustaining best practices. Ultimately, we anticipate incorporating measures of performance into our medical staff appointment and reappointment processes, as well. Lastly, we have embarked on a peer-coaching program that is consistent with the focus on local efforts and solutions.

Lessons Learned

We have been gratified and to some extent surprised by the almost universally positive reception that this work has received from the physician group. We have not encountered the skepticism, which sometimes accompanies the rollout of a new improvement initiative. In reflecting upon why the CONNECT project has been engaging for physicians, we feel that starting with winning Hearts & Minds (before focusing on data or a skill deficit of any kind) was a critical step. This makes engagement in the program very personal for the individual physician and resonates with the reasons that the physician chose to become a healer.

One of the areas where we initially struggled was in providing individual patient satisfaction data to physicians.

Our organization is just beginning to provide data at this level of specificity and in most clinical areas sample sizes are variable. Physicians in some areas of the hospital (e.g. inpatient) will not have individual data due to the challenge of attributing the care experience to one physician when multiple physicians are involved in an episode of care. We now believe that this apparent problem has actually benefitted the program and allowed it to flourish without emphasis on performance targets in its early stages. The absence of individual data led to the development of our *Physician Self Assessment* and *Physician Service Competency Assessment*. These tools provide individual performance information that is very personal. The physician is asked to define his or her own goals and to view the evaluations in terms of those personal goals and

the Four Questions – e.g. “What do you want to give patients and their families?”.

Another lesson learned relates to our test cycle approach. We initially conceived of the test cycles as small tests of change centered on specific behaviors that would ultimately lead to the development of a curriculum. As the pilot has evolved, we have realized that the content of the curriculum will be similar to well established best practices. As such, our focus has shifted to developing a reliable method, which will support local physician leaders in engaging physicians in improvement opportunities.

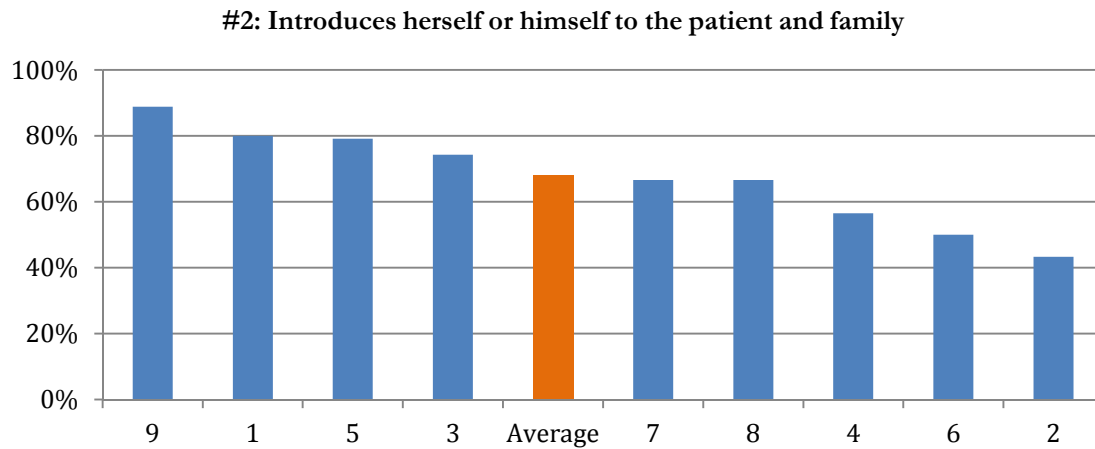
Conclusions

In this article, we describe an innovative, physician-designed and led approach to improving the patient experienced. The effort focuses on encouraging local, grass roots strategies rooted in readily available and validated best practices. In support of that effort, we describe novel tools that were developed and deployed to elicit input, engagement and self-assessment. In addition, the tools served to introduce general principles and tactics associated with enhanced patient experience. Equally important and mission critical is the symbiotic relationship between patient satisfaction and physician job satisfaction.

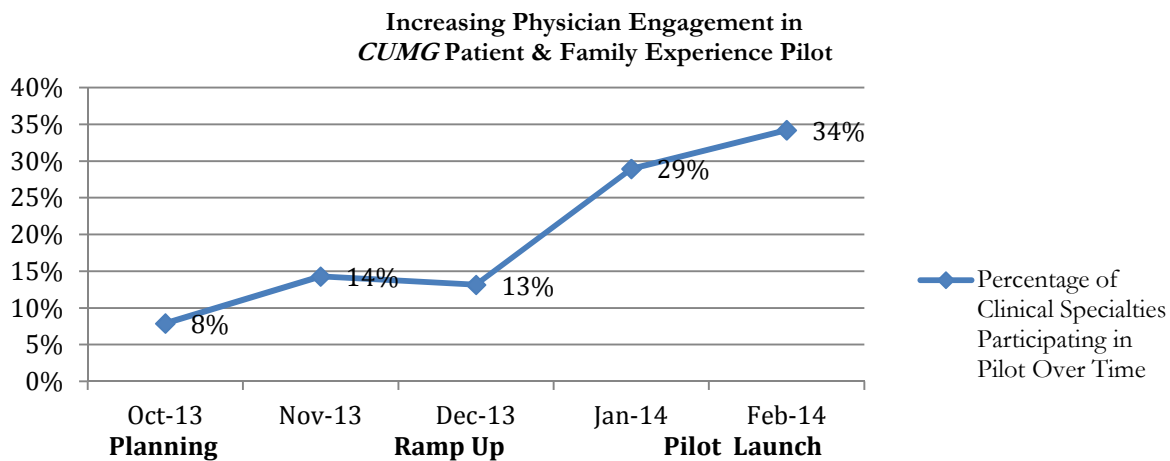
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Graph 2. Sample Report from the Physician Service Competency Assessment



Graph 3. Rate of Participation in CONNECT Program Pilot



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