2014

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Abstract

Improving the quality of the patient experience has become an imperative for healthcare organizations. Value-based payment models include patient perception data, and a negative experience can impact an organization's finances. Sustainable improvement requires more than quick-fix cosmetic enhancements, 'flavor-of-the-month' service trainings, or bonuses for front-line staff. Organizations must actually improve the patient experience. Doing so requires a culture of accountability and a systematic framework for collecting and acting on patient perception data.

This article revisits Mayo Clinic Arizona's (MCA) "7-prong" model for improving service quality: (1) multiple data sources to drive improvement; (2) accountability; (3) service consultation and improvement tools; (4) service values and behaviors; (5) education and training; (6) ongoing monitoring and control; and (7) recognition and reward. The focus of this article is Prong 2, creating and sustaining a culture of accountability for acting on service quality data to improve the patient experience.

The model has demonstrated efficacy in specialty and primary care areas. Based on our experience since the model's publication six years ago, we still contend that a comprehensive approach to improvement produces the best results. We have fine-tuned our approaches to leadership engagement, data transparency, reporting and accountability processes to ensure action on the data, and leveraging the committee structure and front-line staff. To help other organizations on their patient experience journey, we share the methodologies, tools and resources used to create and advance the culture of accountability for patient experience at MCA

Keywords

Healthcare accountability, patient experience, service performance, service quality improvement, continuous improvement

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Accountability, simply defined, involves the manners and methods by which one party justifies and accepts responsibility for its activities.[1] Accountability in healthcare, where the stakes of caring for patients are so high, is necessarily more complex. Numerous legislative and regulatory bodies help assure professional competency, quality care and safety through mandates and standards that are adopted by healthcare organizations. Incentive programs, such as pay-for-performance and, more recently, value-based purchasing, were designed to help assure accountability and create value.

Healthcare value is enhanced by improving quality (clinical outcomes, patient safety, and service/patient experience) relative to costs.[2] Although the current healthcare landscape emphasizes the patient experience, there is neither a common definition[3] nor consensus on how best to measure and improve this complex, multidimensional concept.[4] A patient's experience is the sum total of countless points of contact with an organization before, during, and after the service encounter. The potential for service delivery failure exists at any of these touch points, so improving the patient experience requires a comprehensive approach.

In this article, we briefly review the evolution of accountability for healthcare quality, including its recent extension to patient experience. We describe Mayo Clinic Arizona's (MCA) comprehensive, "7-prong" approach to improving service quality (Figure 1). Developed and implemented in 2008, the model is driven by data and accountability and has demonstrated efficacy in improving the patient experience in specialty and primary care settings.[5,6] The model incorporates seven widely accepted service quality principles: (1) multiple data sources to drive improvement; (2) accountability for service quality; (3) service consultation and improvement tools; (4) service values and behaviors; (5) education and training; (6)

Figure 1. 7-prong Model for Improving Service Quality

ongoing monitoring and control; and (7) recognition and reward. The focus of this article is Prong 2, accountability for acting on service quality data to improve the patient experience. We share the methodologies, tools and resources used to create and advance the culture of accountability for patient experience at MCA.

Advancing Accountability for Quality of Care

In the past two decades, healthcare organizations have made much progress in quality measurement and reporting to enhance accountability to patients and other stakeholders.[7] The Joint Commission's ORYX program, initiated in 1998, was the first national program to measure hospital quality. At that time, there was no consensus on which measures to report, no systematic collection of quality data and only non-standardized performance data were reported. Hospitals were not receptive to collecting and reporting quality measures, so very little information was available to the public. In contrast, today the National Quality Forum endorses more than 600 quality measures.[8] Publicly reported data are standardized, which improves efficiency in the reporting process and enables consumers to compare hospitals. Currently, the most robust measurement and reporting programs are in place in the inpatient setting; however, initiatives to improve quality and create value have migrated to the physician practice and other outpatient settings.

The focus on value is another example of progress made in enhancing accountability in healthcare. From the organization's perspective, value is created when patients are cared for by the right member of the healthcare team in the most appropriate setting, allowing all members of the team to practice to the full extent of their training and licensure. Aligning the right provider with the right patient results in the most efficient use of resources, drives waste out of the system, creates capacity for other patients and reduces costs. From *the patient's* perspective, value is created when the benefits received from the healthcare experience (e.g. the surgical outcome) outweigh the monetary and non-monetary burdens endured to receive the care.[9] Satisfaction surveys (e.g. Hospital Consumer Assessment of Healthcare Providers and Systems or HCAHPS) help us to better understand patient perception of benefits and burdens so that we may improve the processes, behaviors and physical environments that impact the patient experience.

Advancing Accountability for Service Quality and Patient Experience

When the Center for Medicare and Medicaid Services (CMS) began collecting HCAHPS survey data in 2006, healthcare accountability evolved to include service quality and the patient experience. Most patients lack the technical expertise to judge medical quality and use service quality – e.g. the courtesy of staff, the cleanliness of facilities, the compassion of nurses, and the communication skills of the doctor – as a proxy.[10] Good provider communication skills have been shown to favorably affect clinical outcomes[11] and patient adherence to prescribed treatment.[12] Conversely, poor provider communication is a well-documented source of errors in healthcare[13], making it, perhaps, the most important service dimension on which to focus improvement efforts.

Currently, HCAHPS data account for 30 percent of CMS' formula for calculating value-based payment to hospitals, a weighting that has stimulated much national debate.[14] Financial rewards based on patient perception of the experience of care means hospitals must measure and improve not only the quality of the processes of care but *how* those processes are carried out by the healthcare team. Recognizing that an individual's service performance can impact perception of quality of care and an organization's finances, focus on individual accountability has increased. O'Hagan and Persaud contend that holding employees accountable on a daily basis – that is, creating a culture of accountability for the work as opposed to fleeting programs of the month – "ensures the permanence of performance management and continuous improvement."[15, p.124] One patient experience consultant notes that a culture of accountability correlates highly with staff satisfaction and that a "true culture of accountability starts at the top and takes root with every single employee."[16] Front-line workers see service delivery failures every day, often performing on-the-spot service recovery to 'shore up' the patient experience. These employees are a treasure-trove of improvement

suggestions. Good leaders create an open, psychologically safe climate that encourages front-line staff to report frequently occurring errors and problems.[17] Appreciating and empowering employees brings meaning and joy to their work and improves their job satisfaction which, in turn, improves patient satisfaction.[18]

Advancing the Culture of Accountability for the MCA Patient Experience

MCA is an integrated, multispecialty, physician-led, academic medical practice that employs more than 400 physicians and 5,000 allied health staff and renders services to approximately 100,000 patients each year. An organization cannot improve what it does not measure, so MCA's 7-prong model begins with measurement. Multiple service-related metrics – e.g. time to answer telephone calls, call abandonment rates, complaint rates, patient perception of service at key touch points in the experience (e.g. an appointment was available when needed, the doctor listened to my concerns), and physician and allied health staff perception of internal service to each other – are compiled in a department-level scorecard[19] and e-mailed quarterly to executive leaders, department chairs, and administrators to stimulate action. Continuous improvement of the patient experience is achieved by putting valid, reliable, timely, meaningful and actionable data, including qualitative data obtained through patient comments, focus groups and direct observation, in the hands of accountable process owners and front-line staff that create the experience. At MCA, patient experience data are used by the Chief Executive Officer (CEO) and governing board, practice oversight committees, department chairs and administrators, nurse managers, non-clinical department managers and supervisors, front-line staff and especially physicians and mid-level providers to improve their communication and interpersonal skills.[20]

Just as service quality and patient experience are measured with multiple data sources, accountability is created by involving leaders from multiple layers in the organization. In the six years following implementation of the 7-prong model, MCA's infrastructure and reporting processes that create accountability for service quality and patient experience have continued to evolve and improve, as demonstrated with the following examples.

Enhanced Service Quality Reporting
The Patient Experience Committee, chaired by the Medical Director for Patient Experience, oversees service quality for the practice. The committee reviews the service scorecard and provides quarterly service quality updates, highlighting departments performing below target, to the CEO and governing board, the Clinical Practice Committee (CPC), and other leadership groups. The CPC oversees practi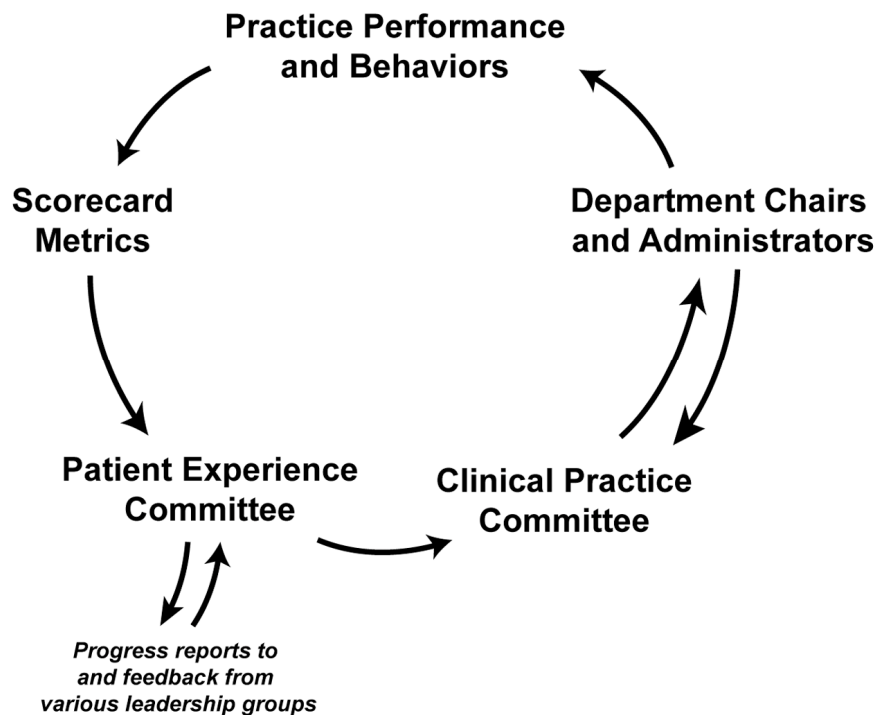ce quality and requests action plans and progress reports, as needed, from department chairs and administrators. Action plan requests are prioritized using the following criteria: (1) planned strategic expansion of the service line, (2) magnitude of the gap between actual performance and target, (3) duration of performance below target and (4) volume of patients impacted. Subsequent improvements in the service quality metrics are noted by the Patient Experience Committee, reported to the CPC, and the cycle repeats itself to ensure continuous service quality improvement (Figure 2). The cycle requires a strong, mutually respectful partnership between patient experience leaders and department leaders.

Formation of an Operations Coordination Group
Leadership commitment is essential for improving the patient experience. In 2008, the CEO began reviewing department-level service metrics in regular meetings with department chairs and administrators. Discussing service performance in the same context as operational and financial performance heightened awareness of service quality deficiencies and department accountability for patient experience.

In 2012, these departmental reviews were formalized and standardized with the creation of an Operations Coordination Group (OCG), a subset of senior physician and administrative leaders from the Clinical Practice Committee. The OCG's purpose is to provide a forum for reviewing each department's operational activities and metrics to ensure alignment with institutional priorities. Each year, using the OCG's standardized practice profile dashboard, department chairs and administrators provide an assessment of key performance indicators (e.g. patient demand, patient volumes, staffing, productivity, and financial) and a proposed plan for the coming year. Providing an 'unparalleled' patient experience is an institutional priority, so the dashboard also includes global patient perception metrics (e.g. likelihood to return, likelihood to recommend and perception of value). Using this standardized approach to review each department ensures alignment throughout the organization and highlights opportunities for expense reduction and improved efficiency through practice redesign. OCG reviews are conducted annually in the first quarter, improvement plans and initiatives are approved and targets are set. After these reviews, each department has two quarters to achieve identified initiatives and targets. The standardized dashboard of metrics is updated quarterly, so the OCG can monitor progress. In the fourth quarter of each year, department chairs and administrators review practice initiatives with the CEO. Significant progress towards identified initiatives and targets is expected.

Figure 2. Service Accountability Loop

Practice Performance and Behaviors

Scorecard Metrics

Department Chairs and Administrators

Patient Experience Committee

Clinical Practice Committee

Progress reports to and feedback from various leadership groups

Leveraging a Multidisciplinary Patient Experience Committee

Solving complex system issues requires active engagement and input from a variety of clinical and non-clinical departments.[21] At the start of the 2014 year, a new incoming physician chair expanded membership of the Patient Experience Committee to include broader representation of service areas and job grades in the organization. Members include physician leaders; administrative leaders of the hospital, the outpatient practice and patient experience; supervisors from billing and appointment scheduling; the team lead for the front-door ambassador staff; and a mammography technician. Conscious attention was given to forming a group that was psychologically safe, inclusive and engaging so all members, regardless of position in the organization, would feel comfortable speaking up about the service challenges they observe each day in their jobs.

Individuals in psychologically safe work environments speak up without fear of judgment, ridicule, loss of social standing within the group or loss of employment.[22] At the first meeting of the Patient Experience Committee, members were invited to share a service-delivery challenge from their work areas. Other committee members were invited to ask clarifying questions and share additional perspectives or related experiences. With committee support, members were encouraged to develop

improvement ideas and implement small tests of change in their work areas. This process has produced several "grass roots" projects – e.g. provider education to increase accuracy of mammography orders, better approaches to providing walk-in requests for information, and development of FAQs to help patients understand the new insurance exchanges. As a result of this group formation process, members are more engaged, feel valued for their contributions to improve the patient experience and show enthusiasm for serving on the committee. Improvement suggestions are now routinely offered by everyone in the group. Members willingly accept ownership of the quality of the patient experience, spearhead these projects in their work areas and make regular progress reports back to the committee.

Lessons Learned

Six years and many reporting cycles have taught us lessons that could help other organizations enhance their cultures of accountability for improving the patient experience. First, the prongs in the model are interconnected, so all prongs must be implemented for best results.[5] For example, with the service scorecard being emailed quarterly (Prong 1) and the accountability and standardized reporting processes in place (Prong 2), department leaders are more likely to request service consultation and education and training (Prongs 3, 4 and

5). While consulting with departments, monitoring and control processes (Prong 6) and recognition and reward programs (Prong 7) can be implemented to sustain the improvements made during consultation.

Second, executive leader involvement is necessary to set the tone for accountability for patient experience. Leaders must demonstrate a genuine commitment to service excellence, model desired behaviors, communicate performance targets, and monitor results. MCA's Operations Coordination Group, with its final annual progress report to the CEO, is an example of engaged leaders setting and monitoring standards and performance.

Third, data transparency creates a sense of urgency and accountability for improvement. Unmasking department names on the service scorecard in 2010 initially was met with some resistance. Over time, the scorecard has enhanced accountability, motivated improvement, and fostered opportunities for sharing best practices. It also has helped prepare the organization for imminent provider transparency under the CG-CAHPS program.

Fourth, when the accountability and reporting processes were implemented, discussions of below-target metrics between peer physician leaders were uncomfortable, delaying the process several weeks. To support this

accountability dialogue, distinct timeframes were added to the workflow (Figure 3). Now, the initial meeting with department chairs and administrators occurs within two weeks; an action plan in a standardized template, noting responsible persons and completion dates, is due to the practice oversight committee within one month; and an update on action plan implementation is due to the oversight committee at 90 days. Standardized action plans ensure that all departments approach improvement planning with appropriate strategies and tactics, accountable persons assigned, and completion dates noted. Oversight committee review of the action plans ensures effectiveness and closure.[23] Standardizing this process has contributed to more timely action on the data and seamless transitions of physician committee chairs.

Fifth, the medical director and administrator for patient experience serve as internal consultants to department chairs and administrators. Much like internal audit, they function independently and are deliberately structured *outside* the accountability processes. This structure leverages the global view of service quality held by patient experience leaders. It also promotes trust and a sense of partnership when department leaders seek consultation for service quality deficiencies.

Sixth, advancing a culture of accountability requires

Figure 3. Reporting, Oversight, and Accountability Process for the Outpatient Experience
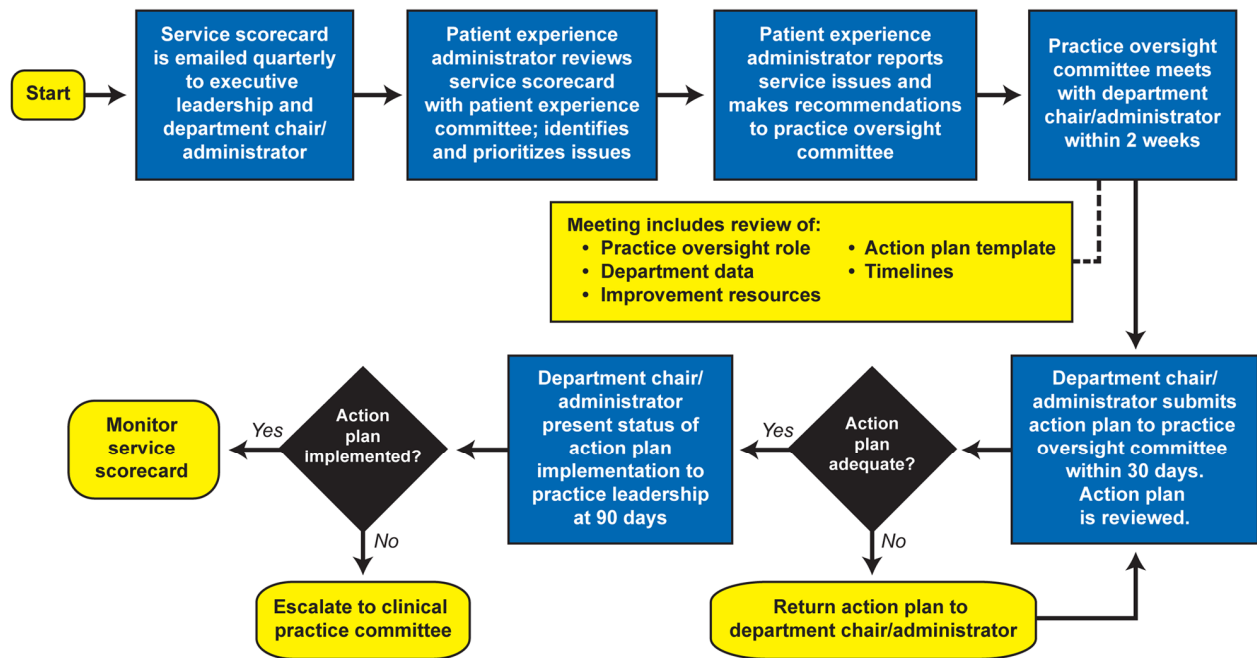
standardized processes, while allowing for some flexibility for different physician leadership styles. One committee chair might prefer putting a department on "watch" for several quarters to establish a statistical trend in the data before contacting department leadership. Another might be comfortable calling attention to slipping data right away. The culture has evolved. There is increased comfort with monitoring data, discussing performance and holding department leaders accountable for patient experience.

Seventh, the front-line staff, like physician leaders, also needs standardized processes that allow for some flexibility to provide 'above-and-beyond' service, when needed, to either delight a patient or recover from service delivery failures. The front-door ambassador staff developed its own standardized checklist of the service behaviors expected in their roles but have been known to wheel a patient to the cafeteria and help them get lunch and remove a license plate frame from a patient's car.

Conclusion

Even the most service-conscious organizations must monitor and adapt to environmental changes that increase transparency and accountability.[18] The Affordable Care Act has fueled a new wave of consumerism in the healthcare marketplace. Many people are purchasing their own healthcare insurance on the exchanges. Many of these plans have high deductibles and are structured to shift more personal financial responsibility to patients.

Patients are also consumers at service giants such as Starbuck's, Southwest Airlines and Ritz Carlton Hotels. They know what a great service experience feels like and recognize when they have received value for their dollar. As healthcare consumers are asked to personally pay more for health care services, they will have higher expectations, shop for services more discriminately, be less tolerant of poor service, and more quickly leave providers who don't satisfy their needs. It is not enough to simply make cosmetic enhancements to a facility; healthcare organizations must actually improve the patient experience. Doing so requires a culture of accountability, which is difficult to create and even harder to sustain.[24] It requires a systematic approach for collecting and acting on patient perception data.

MCA's comprehensive model for improving service quality is a long-term approach to creating value by improving patients' service experiences. Accountable care delivery models and value-based payment programs are designed to enhance not only the technical quality of healthcare but also patients' experiences. Improving service is the right thing to do for the patient and, in a value-based payment model, helps to sustain an organization for the future.

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24. Based on our own experience implementing the model, as well as the most frequent questions and comments received from numerous conference attendees and readers of our publications. Most organizations agree that creating and sustaining a culture of accountability for service quality and patient experience is the most difficult prong of the model to implement.