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Case Study

Deploying an improvement strategy across a rapidly expanding health system: A framework for repeatability and cost-effectiveness

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Abstract
With nearly 40,000 employees and physicians spread across 14 states, a robust system was needed to engage front line teams at the point of care to meaningfully enhance patient and family communication practices in Prime Healthcare, an award-winning, community hospital system with 45 hospitals. Among its key elements, Prime's system-wide road map for deploying relationship-centered communication tools involved identification of and investment in frontline champions, education that was synchronized with leader-deployed digital rounding, and online self-reflection modules that promoted true behavior change. This economical and easy-to-follow road map is shared for others seeking a high return on investment from their patient experience efforts.

Keywords
Patient experience, patient-centered care, empathy, HCAHPS, therapeutic relationships, communication training, leader rounding, health system improvement

Introduction

The measurement, public reporting and financial incentivization of patient experience metrics demonstrate the healthcare industry's commitment to creating more informed consumers and an openness to patient-generated data.[1] Research by Goldman et al. shows that physicians, too, take experience into account when deciding where to refer patients.[2] McKinsey research found that physicians placed considerable weight on the patient experience, in addition to considering the hospital's environs and staff; researchers noted that "almost one third of general practitioners even said they would honor a patient's request to be treated at a hospital that provided a superior nonclinical experience, but care that was clinically inferior to that of other nearby hospitals."[3] Patients, surprisingly, reported that the "nonclinical experience is twice as important as the clinical reputation in making hospital choices."[3] All of these converging factors are creating a pressing need for hospitals to improve their care delivery. In addition, the sense of urgency to identify cost-effective methods for creating and sustaining those improvements adds another layer of pressure that hospitals and health systems are eager to relieve.

SYSTEM feels both the common challenges of most hospitals and health systems as well as the unique challenges that come with its rapid growth rate. Among *SYSTEM*'s 45 hospitals are small facilities and large facilities; urban, suburban, and rural facilities; facilities on the west coast, the east coast, and several points in between. Since 2014, *SYSTEM* has nearly doubled its size, acquiring 22 hospitals in the last five years and continuing to pursue others.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) was developed as a valid and reliable survey instrument and has been demonstrated to correlate highly with key outcomes such as mortality, infections and readmissions.[4] With *SYSTEM*'s HCAHPS performance in key domains between the 5th and the 11th percentiles in 2015, the challenge to keep up with the industry's increasing attention to patient experience was obvious and immense. System leaders identified a need to leverage, learn and embrace regional and local variance in elevating patient experience, while also lifting collective scores across a rapidly growing health system. Through best practice research, c-suite level collaboration, and local-leader input regarding the elements that could be universally applied and those that would require some local flavor, *SYSTEM* developed a framework for improvement that was implemented successfully for enhancing provider-patient communication and will be utilized again as future needs are prioritized. Anyone who has or may undergo a merger or acquisition would benefit from understanding *SYSTEM*'s process to help guide their work.

Methods

Outcomes Measures

HCAHPS is a long-established measure of patient experience perceptions and served well to assess the effectiveness of the Relationship-Centered Communication (RCC) training program that *SYSTEM* adopted. Because the focus of the training was to enhance the interactions between physicians, caregivers, and patients, the reporting composites "Communication with Nurses," "Communication with Doctors," and "Staff Responsiveness" were chosen as the most appropriate measures to evaluate as adoption of the principles made its way through *SYSTEM* hospitals. In addition, knowing that the communication aspects of care are most closely related to how patients feel about their overall experience,[5-6] the "Overall Hospital Rating" measure was also included.

Development of the Eight-Phase Plan

SYSTEM's Corporate Chief Medical Officers, Vice President of Communications, and Executive Vice President of Clinical Operations all recognized that the organization needed to separate the wheat from the chaff and identify behaviors that would distinguish *SYSTEM*'s service from its local and national peers. These corporate leaders came together as the development team. With a focal point on communication, they solicited input from their local counterparts as well as peer-reviewed journals to create a tapestry of communication approaches that would rejuvenate each hospital team's approach, distinguish them from others in the market, and be received affirmatively by customers.

The development team's inquiries and literature review landed on creating therapeutic relationships and providing care based on authentic, genuine relationships formed between the customer and everyone on their care team, in line with the findings of Cleveland Clinic[7] and the American Academy of Healthcare.[8] In this model, caregivers start by recognizing that many variables are outside of their control. It is well within their control, however, to approach patients with respect to the knowledge they have of their bodies, prioritize their wellness, and try to form, foster and consciously appreciate human, personal connections.[9] One important focus is on enhancing caregivers' ability to communicate empathy.[10] Another essential element for *SYSTEM*'s model was to provide parallel paths for physician and non-physician champions so that all could lead the work. To improve the experience of patients and the resiliency of the care delivery team, the development team structured an eight-phase plan to make therapeutic relationships more reliable. (See Appendix 1 for the full plan.)

Initiatives

Part I: Training the Trainers

Phase 1: Alignment with Leadership

At the local level, the effort began with a face-to-face conversation with the hospital's leadership team. At a minimum, the CEO, CMO, CNO, and CFO were required to be present, but teams were invited to bring in others who may have an important role in planning. During the meeting, leaders were introduced to a sample of the core relationship-centered communication model and highlights from each of the phases to come. After discussion of the phases, the focus returned to the beginning of the implementation, and the group was asked to brainstorm key leaders and dates to assign to each phase. When the group was finished mapping out the plan, the CEO was given a pen and encouraged to "make his/her mark": edit the names of key players, the names and ordering of the phases, and the due dates.

Phase 1.5: SYSTEM Rounds Integration

For the local patient experience leader to prepare the digital rounding application for use at the designated time in the deployment plan, the hospital EHR had to be integrated with the tool being used for the digital rounding. This would allow for importing pertinent patient data from *SYSTEM*'s nine EHR systems to the cloud-based digital rounding app.

Phase 2: Physician and Caregiver Leadership Relationship-Centered Communication (RCC) Training

The physician and non-physician champions separately assembled for RCC training. For effectiveness, the 90-minute sessions were intentionally capped at no more than 12 participants (though this was often exceeded, and no one was turned away).

The training was divided into three components: 1) building the relationship, 2) collaborating with the patient, and 3) concluding the encounter. After each section was discussed, the learners participated in a role-playing exercise and received feedback from their small 3-4 person groups. A summary of each component follows.

Building the relationship: This section focuses on finding a human connection through exchanges as simple as "Before we get to your examination, I would like to learn one thing about you as a person." Phrases such as, "Tell me where you grew up, how would your friends describe you, what's your favorite movie" go a long way toward transforming transactional and procedural interactions into the caring encounters that make up the core of care delivery. For relationship building, it is also important to demonstrate preparation before the patient encounter by reviewing his/her record and beginning the interaction with a confidence-building statement based on that review.

- Introducing technology is an important principle. Care providers should narrate, pivot, and display how the technology is used in the patients' best interests rather than having them guess or assume what is happening behind a computer screen.
- Encouraging the patient narrative, rather than launching into yes or no questions, is a way to distinguish care. "I'd like to learn as much as possible about your shoulder pain - from when it first began until now." Another example would be "My colleague, Sue, told me about your shoulder pain. What else can you share with me?" Finally, providers should check for completeness with a statement like, "What else would you like to discuss or what else concerns you?" to summarize or reflect patient narrative to ensure accuracy.

Collaborating with the patient: This section seeks to set the agenda for the time spent together, elicit the patient's perspective on the illness/procedure or encounter, and demonstrate empathy when emotions are present.

- Conflict is unavoidable in many healthcare encounters. *SYSTEM*'s commitment is to elicit expectations and have meaningful discussion and negotiation at the onset of the encounter rather than end the encounter with the patient discussing their biggest concern while the caregiver is exiting the room, leaving both parties frustrated. Examples would look like the following: "I'd like to get a list of all the things you'd like to cover today." "Of all the things you brought up, what's most important to you?" "What are you hoping we can do for you today?" "I understand chest pain brought you to the ED. You also said you have sharp back pain. We can discuss both. I would also like to go over your preliminary test results, too. How does this sound?" The plan is solidified by seeking verbal agreement.
- In designing this framework, relationships need to offer opportunities to solicit and receive perspective from both parties. The goal is not to presume what it's like to be in the patient's shoes but rather to be curious and open to learning. Examples: "What made you decide to come in now?" "How does it disrupt your daily activities?" "Often people have a sense of what is happening; what ideas do you have about it?" "Do you know others who have had similar symptoms; what worries you most?"
- As emotions arise, providers practice by naming the emotion, validating the emotion, acknowledging the emotion, and reassuring the patient; in these moments of vulnerability, a timely response instills trust and strengthens the relationship.

Concluding the encounter**:** In this section, the provider seeks to develop a plan, educate the patient, and demonstrate appreciation as the encounter comes to an end.

- The provider describes treatment options, elicits patient preferences and integrates them into a mutually agreeable plan while probing for potential treatment barriers and the need for additional resources, again affirming the patient's verbal commitment to the plan.
- As a sign off, the healthcare provider should give advance notice that the encounter is going to end and part with appreciation for something such as: "We've gone through a lot today, and I feel ready to let you get back to your reading, rest… I'm glad you asked to have me paged, what other questions can I try to answer before I leave?"

Phase 3: RCC Practice

As champions conclude phase two, phase three is assigned to them. Phase three requires the learners to apply the techniques in their own personal practice over a period of 3-6 weeks. They were given a self-reflection worksheet to be used for documenting their struggles using the techniques, their found successes, and their need for additional help. This was deployed both on paper and via an online education portal. Lastly, in this phase, the trained leaders worked with local hospital leadership to plan the schedules and prioritization of RCC training to the frontline caregivers.

Phase 4: Physician/Caregiver Leadership RCC Facilitation Training

This phase brought the trained leaders' stories of successes and challenges (as documented in their self-assessment worksheets) into an environment that simulates them, teaching in pairs to departments within their hospitals. In this facilitation training, the original training was dissected, and learners customized the RCC slide deck and scenarios to be most relevant for their people. Time was also dedicated to adult learning principles and how to structure self and group reflection.

Part II: Implementation

Phases 5, 5.5, and 6 were launched nearly contemporaneously to maximize impact through exposure, recognition, and accountability. Success was fostered in timeliness of this apex of the plan.

Phase 5: Initiate Training Implementation

In phase five, trained leaders began delivering frontline 90-minute RCC training in the manner they had practiced. They were encouraged to meet with other champions, reflect on their training performance, and update their trainings based on feedback (post session review cards were distributed). Limited spot checking of the training sessions by local executives and corporate leadership

ensured quality, customization pertinent to the audience, and consistency between trainers and between facilities.

Phase 5.5: Onsite Training Implementation of SYSTEM Rounding
SYSTEM and *ROUNDING SOLUTION* teams spent 1-2 days at each facility to conduct this training. This phase introduced three processes intended to bring transparency and accountability to how RCC is perceived by the customer:

1. Rounding for Recognition and Rewards
2. Daily Rounding Data Utilization
3. Development of Leadership Monthly Rounds

On a daily basis leaders ask questions, record the responses, trigger and resolve service recovery issues through an app, and translate positive, specific recognition weekly to the digital screens of the clocking-in-clocking-out units in every area of the hospital. Monthly, leaders round as teams and debrief to take action on ongoing interdisciplinary issues that are identified or trending with importance during rounding.

Phase 6: RCC Assessment through VENDOR Strengths & Weaknesses Survey
The learner, after receiving an in-person training (Phase 5) and seeing leaders round on their patients (Phase 5.5), is now assessed via an online scenario about how they are putting their training into action. (Example: You've just met a patient who says, "I'm so scared; I don't know what's going to happen next.") The learner is prompted to respond, utilizing as many elements of RCC as possible, in a free text format. They are also prompted to share which components of RCC come most naturally, which they have incorporated into their standard behavior as a result of receiving their training, and finally which elements they find most difficult to implement, noting if they would like help from their supervisor.

Part III: Accountability
Phase 7: Physician/Caregiver Leadership Accountability Training
In this final face-to-face training modeled by Vanderbilt researchers,[11-12] physician and caregiver leaders are taught how to address behavior that jeopardizes the reliability of RCC. For late adopters and reluctant learners, this 60-minute course provides a tiered approach to give learners every opportunity to self-correct or escalate through a disciplinary ladder. The training also prepares champions to have 10-minute check-ins to review phase 6 results. Vanderbilt, as a result of their impact on reducing malpractice claims by utilizing this approach, teaches and shares their model through a non-profit organization called the Center for Patient and Professional Advocacy, making the model accessible to their health system partners.

Phase 8: RCC Implementation and Professionalism Check-ins
In this phase, frontline learners, champions and their direct supervisors reflected on how they deployed RCC, as directed through the online self-reflection module in phase 6 and patient feedback.

Outcomes

SYSTEM experienced strong year-over-year improvement between 2015, when the work began, until now, as the work was sustained (Table 1). In the key outcome measures identified from the HCAHPS survey, the greatest increases from 2015 to 2019 to date in percent top-box scores were achieved in Overall Rating of the Hospital (4.63 points) and Staff Responsiveness (9.63 points).

SYSTEM hospitals also lowered the number of complaints and grievances logged, averaging a 30% reduction across all hospitals.
Employee perception of prioritization and focus on patient experience also improved 69%, from 26.8% in 2016 to 40.7% in 2017 as measured by an employee engagement survey administered anonymously by paper and electronically. Unfortunately, discontinuation of the survey makes more recent improvements impossible to report.

Table 1 - System HCAHPS Improvement Year Over Year

	2015	2016	2017	2018	2019 YTD	Change from 2018
Overall Rating of the Hospital (%ile rank)	61.37 (11th)	64.53 (14th)	64.86 (17th)	65.20 (22nd)	66.0 (22nd)	+0.80
Comm w/RNs (%ile rank)	71.83 (5th)	73.60 (9th)	73.67 (12th)	75.15 (19th)	75.2 (20th)	+0.05
Comm w/Doctors (%ile rank)	73.67% (5th)	75.42 (7th)	74.33 (5th)	74.88 (10th)	76.60 (22nd)	+1.72
Staff Responsiveness (%ile rank)	58.27 (11th)	60.38 (18th)	62.17 (30th)	66.42 (60th)	67.90 (65th)	+1.48

Discussion

The reproducibility of this initiative extends its value beyond the improved communication skills developed by participants. In an estimated $2 billion per year patient experience industry in the US, *SYSTEM* spent between $8,500 and $11,000 (depending on the size of the hospital) per hospital per year on an outside digital rounding solution. Everything else was designed and trained in-house and with a multitude of HCAHPS providers in contracts, and total costs were kept below $16,000 per hospital per year.

Hospitals and health systems can benefit from simply following the specific eight-phase plan described above. Going a step further, they can also advance their own improvement strategies by embedding some key framework elements:

Key Framework Elements

Structured Deployment

What made this approach successful is not so much the "what" but the "how": the structured, timed, and deployed approaches that yielded positive results. Leaders and frontline caregivers reported that a clear and concise roadmap providing specific steps was reassuring and "liberating" in that it provided focus. Hospital leaders, champions, and patient experience coordinators that were at the same phase (or had just completed that phase) in the deployment plan also benefited from monthly structured calls to assist each other.

Local CEO Engagement

CEO leadership of the program was a critical success factor as well. Offering the CEO the opportunity to establish the timeline and key players was essential, as was negotiation and dialogue about the speed at which the hospital would progress from phase to phase. By working linearly from phase 1 to 8, the development team provided a shared language for those who would execute the work while allowing flexibility for senior leaders to set timing, prioritization, branding, and personnel allocations in balance with other organization priorities. Seldom do corporate and local approaches align as well as this effort did in gaining both buy-in and follow-through across the nationwide system.

Clear Accountability

The documented commitments of time and personnel from each hospital's CEO in phase one made it easy to track hospital progress and identify delays that needed attention. Without that documentation, it would have been very easy for a hospital to "hide" its slow implementation pace. At the buy-in stage, the planning was treated almost as a contracted service because corporate resources were invested in exchange for advancing the plan along as expected. Hospital CEO, CFO, CNO, and CMO signatures were included and marked on the plan along with key dates and participants. This provided a point of reference when delays or leadership changes occurred. The importance of this concrete, documented alignment cannot be emphasized enough, along with competition between sites to advance the work and collaboration among sites to help each other. Juxtapose that structure with the fluidity with which an engaged leader will want to try something they did at their last company or learned at the latest conference. "Floating on the wind" often leads to a frontline team that is burned out on the latest patient experience fad, and that feeling of aimlessly floating in an unknown direction can act as an impediment to advancing the rigor of this critical field. Willingness to change is depleted when the frequency of the requests to change is high and the outcome metrics are viewed as disconnected. *SYSTEM* committed to and adhered to a structure, and it paid off.

Leadership Monthly Rounding Meeting

The format of the monthly rounding meeting is based on the framework Tony Padilla designed and deployed at UCLA Health System.[13] The larger problem-solving capacity of the hospital is activated here, in these monthly forums, to use rounding data as a real-time indicator of performance to keep ahead of HCAHPS scores. Frequently reoccurring high-value operational improvements are identified by rounding trends and HCAHPS data and comments; when identified, task forces activate around these strategies. Rounding is valuable in promoting awareness and accountability, but by itself, rounding does not improve operational or system issues.

Supervisor/Staff Synchronization

Sustainability is an ever-present challenge with any improvement initiative. Historically at *SYSTEM* hospitals, after a face-to-face training, managers would move on to the next project as frontline learners were just starting to process the material. Feedback from many frontline colleagues indicated that the material became "real" for them when their immediate supervisors were discussing metrics around their communication performance. Long-term success depends on these two groups keeping their behaviors and attention in sync. To that end, a support binder was created and shared with the patient experience leader at each hospital; it included peer-reviewed journal articles supporting the concepts behind each stage, as well as common barriers and actions required. The binder is intended as a "living" resource, and leaders are encouraged to add materials as they find their own effective support assets. Leaders reference and add to the binder during a weekly nationwide huddle that highlights journal articles relevant to the work being done.

Online Assessment Tool

It is believed that the online RCC assessment tool is an industry-first. The development team worked with

VENDOR to create the scenarios, the assessment form, and the feedback process in order to provide learners with a no-risk opportunity to practice what they learned and reflect on their own comfort with internalizing the training and modifying their own behaviors. Phase 6 was an integral component of the plan that served to reinforce the concepts presented in training, and the work would not have been as successful without it. The assessment can easily be reproduced at little or no cost using many online survey providers.

Careful selection and thorough training of champions
Consistency in how champions are elected is imperative. The development team began with the best intentions of having peers and leaders vote on who among their unit/department would receive additional training and would provide day-to-day advice and feedback on relationship-centered communication; unfortunately, fiscal and time pressures altered that path. If two to four champions had been elected from each unit/department (depending on the size) and worked to ensure night, weekend and per diem visibility based on their communication aptitude and ability to positively influence their peers, outcomes would have been better. Time pressures led the team to ask the local CNO to quickly designate champions across the hospital. This reduced frontline ownership and presented only one perspective regarding who would take on the responsibilities of becoming champions.

Experience working on the floors or leading teams is an inadequate proxy for how successful caregivers will be at teaching and coaching their peers in relationship-centered communication. At the onset, the development team planned for four hours of total training for each champion in group settings to practice training. In practice, hospitals were reduced to two to three hours, and this was adequate preparation for only 40-60% of champions to gain competency in teaching RCC. More time is needed for champions to practice teaching and provide feedback in a controlled environment to ensure they are providing a high-quality training.

Future Implementation
Improving the patient experience is moving up the priority list for all health systems. *SYSTEM*'s patient experience roadmap improved HCAHPS outcomes across a large and expanding health system. The design elements were inspired from the best in the industry and structured to accommodate regional differences, and the tools were inexpensive and/or improvised.

Most importantly for the industry, the content can be interchangeable, and this broad framework can be used to execute any improvement program within an organization of any size: it will work for one hospital, or four hospitals, or 100 hospitals. *SYSTEM* expects to deliver new content and advanced topics of interest through this same deployment strategy, replicating the framework elements that were successful and improving on the framework elements that were not executed as needed.

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Appendix 1. Eight Phase Plan for Therapeutic Relationships