Re-envisioning the PATIENT EXPERIENCE
Since the start of 2015, we’ve observed a marked trend: our various sources have all been pointing to a surge of interest in improving the patient experience.

When you think about it, this finding isn’t entirely surprising. Patient experience is at the intersection of two major trends in the American health care marketplace: value-based payment and consumerism. Health care organizations need to focus on delivering an excellent patient experience because, increasingly, their reimbursements are tied to achieving high levels of patient satisfaction. By the same token, as consumers take more control over choosing providers and insurance plans, the quality of the patient experience will be ever more important.

This issue offers an array of perspectives from our researchers and consultants on improving the patient experience, ranging from the most strategic—Tom Cassels on the “human experience”—to the practical, on-the-ground lessons from Jessica Suchy, our lead dedicated advisor for the iRound patient experience technology product.

Given how much attention our own experts are paying to patient experience these days, it was unusually difficult to select the pieces here, but if this volume whets your appetite, you can find more (and the latest!) online at advisory.com/patient-experience.
RADIOLoGIST | 22
When Jennifer Kemp’s husband was diagnosed with cancer, she was given a new perspective on the patient experience that led her to ask a big question: Why can’t radiologists just talk to patients and give them their results directly and sooner?

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It’s no surprise that long wait times affect patient satisfaction, but it’s proven that actual amount time waited may matter less than perceived wait time. Find out how a Houston airport learned this lesson.

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Did you know more than 80% of hospitals with top HCAHPS scores are specialty hospitals? Get a list of the top scorers and see how this finding could impact your growth strategy.
FEATURED WRITERS

This issue’s contributing experts

Alicia Daugherty
Practice Manager
Research and Insights

While leading research on growth strategy, Alicia focuses on ambulatory investments, health system integration, employer partnerships, and new product development.

Michael Koppenheffer
Executive Director
Research and Insights

Michael is an expert advisor on health care product development, marketing, and technological innovation, with two decades of experience as a consultant and researcher.

Eric Passon
Executive Vice President
Consulting and Management

Eric leads operations and business intelligence for the firm’s Consulting and Management engagements.

Brad Pancratz
Executive Director
Consulting and Management

Brad is an expert on client services, survey consulting and teleservices communication—with proven success helping multispecialty groups enhance patient and provider experience.

Thomas Cassels
Executive Director
Research and Insights

Tom continues to lead the Performance Initiative, an exclusive learning group comprised of system-level executives from the nation’s most prominent health systems.

Rivka Friedman
Practice Manager
Research and Insights

Rivka leads strategic research in support of employed and integrated medical group executives through the Medical Group Strategy Council.
Anthony provides short- and long-term executive project management, as well as strategic and operational services to Advisory Board Consulting and Management clients.

Jessica Suchy
Senior Director
Performance Technologies

Jessica is a Senior Director in the Advisory Board’s Performance Technologies division, serving as the Dedicated Advisor Team Lead for iRound for Patient Experience.

Tiffany Chan
Senior Analyst
Research and Insights

Tiffany is a senior analyst who currently serves on a research program supporting medical groups.

Anthony D’Eredita
Executive Vice President
Consulting and Management

Sruti Nataraja
Practice Manager
Research and Insights

Sruti provides strategic guidance for imaging leaders on topics including quality, operational efficiency, and alignment. She has 12 years of experience as a researcher at the firm.

Brian Contos
Executive Director
Research and Insights

Brian Contos oversees the Advisory Board’s clinical research and insights programs.

Jenn Stewart
Managing Director
Research and Insights

Jenn facilitates interactive workforce and strategic planning sessions with executives and travels extensively sharing the firm’s workforce practices and insights.

Sarah Hostetter
Senior Analyst
Research and Insights

Sarah is a senior analyst with six years of experience in health care who currently serves on a research program supporting imaging directors.

Rebecca Rabinowitz
Senior Analyst
Research and Insights

Rebecca is a senior analyst with expertise in employee engagement; she splits her time serving on research programs supporting nursing and HR leaders.

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What patients actually want—and why hospital leaders fail to grasp it

A DAILY BRIEFING Q&A WITH ALICIA DAUGHERTY

The Daily Briefing’s Dan Diamond spoke with Alicia Daugherty, practice manager of the Advisory Board’s Marketing and Planning Leadership Council, to discuss hospitals’ approach to consumer data.

DAN DIAMOND

We’ve written a lot about retailers’ move into health care. And it seems like one advantage that retailers have over hospitals is that they know consumers so much better—I feel like you told me once that retailers have so much consumer data, they measure it in petabytes.

How are health systems supposed to compete?

ALICIA DAUGHERTY

First off, I’d reframe the question. It’s not “retailers versus traditional providers” anymore.

Retailers are now part of the health care ecosystem, and traditional provider organizations should see them as such—and see their access to data as a competitive advantage, much like a rival hospital’s robotic surgery suite.

Should traditional provider organizations have data systems akin to retailers? Ideally, yes. But few—if any—health systems are set up to collect that data, much less make use of it.

I take your point. Walmart, Walgreens, CVS, et al. aren’t “coming” to health care delivery; they’re already here. And in many cases, playing key roles.

Here’s one way to think about it: Retailers have the fMRI of consumer data. Health systems have a Polaroid. But executives can’t wait on the fMRI. There are decisions to be made now.

So if you’re a health system, at least get an X-ray set up. To drop the metaphor, you need to get a better picture of what patients want in order to deliver the experience they need.

That’s why we’re pushing further into consumer surveying. Our teams have completed five surveys in the past year—on topics ranging from how consumers choose on-demand care to what makes a patient “go rogue” after receiving a referral.

We’re hoping members can use our results to inform both their immediate investment decisions and their future consumer data analysis.
Take me through a few top-level findings from these surveys. What have they told you that we didn’t already know?

They’ve all had unexpected results, which makes this work really fun.

First, convenience matters, but it’s defined differently depending on the type of care a consumer needs. For specialty care, it’s about drive times. For primary care, it’s about time to first available appointment.

Brand affiliation seems to be important only for certain types of services and specialties.

And when it comes to PCP loyalty, women were more likely to switch providers after having a bad experience, while men were more interested in new services other providers had to offer.

Interesting. How much do demographic differences matter when it comes to patient preferences? Is gender, say, an important factor?

Overall, demographic differences play a minimal to moderate role in patient preference. Gender isn’t a big differentiator on most preferences, nor is race or ethnicity.

Across the three surveys my team conducted, what mattered most was age. For example, older adults place more value on brand affiliation than younger groups do. Type of insurance plan was also important, so we’ll likely do a high-deductible-focused survey within the next year.

There was surprisingly little variation across regions or population densities—urban, suburban, rural—though we’re available to do market-by-market surveys if members want to test that conclusion.

What mistakes do you see health systems making in how they’re approaching surveying?

Many organizations collect patient feedback and survey data because it seems like the right thing to do, but then they can’t use the data because it doesn’t relate to the decisions they need to make. Others define their questions too broadly, only to find their results aren’t as actionable as they’d hoped.

My number one piece of advice to health care executives is to define the one question you want to answer. What is the specific decision you need to make, and what information do you not have that a survey can actually provide?

Survey questions capture such fine slices of data that you need to be incredibly precise about the information you need.

Want more on consumer preferences? Search “consumer preferences” on advisory.com
Want to please patients? Maybe you should start a SPECIALTY HOSPITAL
“Patient experience” is like motherhood and apple pie. It’s impossible to argue about its importance, and virtually all health care providers will tell you that making sure that patients have a positive experience is one of their top priorities.

Not all hospitals are doing equally well at fulfilling that aspiration, though. And it turns out that there is a group of hospitals that seem to have a decided advantage when it comes to providing an excellent patient experience: specialty hospitals. An Advisory Board analysis of recent Hospital Compare data suggests that specialty hospitals dominate the rankings when it comes to patient satisfaction.

The data we analyzed comes from the HCAHPS survey, which is administered to hospital patients around the country. The survey asks about nine dimensions of care: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, communication of discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.

When we tallied the scores, more than four out of five of the top-scoring hospitals were specialty facilities—surgical hospitals, orthopedics hospitals, or heart hospitals. And of the remainder, nearly all were small hospitals that were nominally general-purpose but in practice provided the same kind of focused care that the specialty hospitals did.

Why patient experience really matters now

Beyond the obvious reasons why health systems want patients to have a positive experience when visiting their institutions, there are two big reasons why “patient experience” matters more than ever today—and why the 95% of hospitals not at the top of the patient satisfaction rankings should be paying attention to the facilities with the best scores.
First of all, since patients are increasingly making their own decisions as to which providers they choose, whether as part of health care exchange network plans or at the point of accessing care, brand and reputation will be ever more important. So the word-of-mouth endorsements from excellent patient experiences are valuable in themselves, and also as a platform for marketing efforts.

What’s more, patient satisfaction, as measured through the HCAHPS survey, has also become a major component of value-based payment incentives. In Medicare’s Value-Based Payment Program, patient satisfaction comprised 30% of the overall score for fiscal 2015; for 2016 and 2017, it will comprise 25%.

Speculating on the secrets of specialty success

But what’s behind this survey data?

It’s impossible to know for sure, but I’d bet that a big part of the advantage that specialty hospitals hold here is that they can provide a predictable and therefore tightly managed experience for patients. Our service line research has consistently found that for procedures like joint replacement, highly structured hospital-based “center of excellence” programs produce more satisfied patients and better clinical outcomes than more loosely managed offerings.

Of course, it’s much easier for a hospital to have a high overall patient satisfaction
score when its mix of patients includes just scheduled cardiac, orthopedics, or spine surgeries, and not the less predictable, more difficult-to-manage medical cases.

Still, many of the specialty hospitals atop the patient satisfaction rankings promote their scores to the public, reinforcing the value of their brand and presumably supporting their market presence. While a general acute-care hospital can’t replicate the specialty hospital’s advantages entirely, health systems should consider how this finding could impact their growth strategies.

At very least, it’s one more piece of evidence in favor of the “center of excellence” approach to providing surgical care, and should reinforce the importance of health systems’ efforts to develop and strengthen cardiovascular and orthopedic centers of excellence. To take it a step further, though, systems might consider the value of stand-alone, specialized facilities as they pursue expansion strategies, particularly those targeted at attracting the increasingly retail-savvy health care consumer.

Want to see your patient satisfaction in real time?
Search “iRound” on advisory.com
What **patient experience** says about your medical group

BY ERIC PASSON + BRAD PANCRATZ

“Front-desk staff very rude. Poor reflection on practice.”

Those simple words, on the right website, or from the right person, can destroy your practice’s chances of acquiring a new patient.

In today’s retail market, it’s no longer enough to deliver high-quality care—providers need to deliver a high-quality experience, too.

We hear our members mention the concept of “patient experience” a lot, often in the context of value-based payment performance and penalties. But we think that for your medical group, patient experience means a lot more than a survey score—it’s the foundation of your brand.

By securing highly satisfied patients, an organization can reap many benefits: strong customer loyalty, a grassroots force of brand ambassadors, and the potential for millions of dollars in additional revenue every year. To get a better handle on this ever-important, yet sometimes vague concept, where should medical groups focus their attention?

Three priorities for improving patient experience

**ONE**

Capture patient feedback through surveys

Patient experience is often hard to capture in a meaningful way. Nevertheless, quantitative and continuous surveys can provide valuable insight into your medical group, and the value proposition it conveys to the market. Further, taking a pulse on patient experience can actually point you directly to fractures in operations and care delivery, and how those weaknesses might be impacting your brand.
Engage your providers
Aggregate survey reporting has found that one key factor is most influential in determining a positive or negative patient experience: communication between patients and their providers.

The irony here is that physicians—who are uniquely positioned to influence consumer perception—often present the biggest barrier to improving patient experience scores. Why is that?

There are three key steps to engaging your physicians in patient experience: training your physicians, providing targeted coaching to support new and mid-tier providers, and aligning provider incentives with the group’s broader patient experience goals.

However, even though 84% of healthcare executives are adding patient experience to their “top three” priority lists, only a fraction of leaders actually train their physicians to improve in this area or provide specific explanations on how central it is to improving patient experience. Naturally then, many physicians tend to believe that patient experience is not their responsibility.

In addition, physicians still predominantly work under a traditional RVU-based production model, which doesn’t incorporate non-productivity incentives like patient experience scores. Crafting a holistic compensation model is an important step to aligning clinicians with group strategy.

Operationalize “patient-centered care”
Measuring the patient’s experience is, in many cases, a measurement of the effectiveness of an organization’s care delivery system and processes.

Despite investments, many medical groups are struggling to hardwire improvements to patient experience. Sometimes, the fix is a simple adjustment that can improve patient perceptions. Other times, the solution requires addressing underlying issues with practices’ existing operations.

In fact, everything from scheduling protocols to EMR coordination across practices influences the patient’s experience. Fortunately, we’ve seen that a combination of regular patient experience surveys, together with tools that enable in-the-moment feedback, can facilitate faster and more targeted adjustments that can make our operations truly “patient-centered.”

Do you want to know what your patients really think about your practice?
Search “patient experience consulting” on advisory.com
Why the human experience trumps

THE PATIENT EXPERIENCE

and what to do about it
“With all due respect, I don’t want ‘patient-centered care’ unless I’m on my back in the hospital. When I’m not critical, I’m not your patient; you are my doctor.”

Focus group participant

I heard this statement in a recent consumer focus group I led for a health system in the Northeast, and it stopped me in my tracks, because it was so contrary to how most health systems are approaching the “patient experience” issue.

This focus group participant was completely right. Most people lead 99% of their lives never thinking of themselves as patients. But health care providers are so focused on how they serve people at the most vulnerable times—during acute episodes or when managing chronic illnesses—that they are failing to deliver a superior experience the rest of the time.

To win consumer loyalty in the ever more competitive market for health care, providers need to do more than transform the patient experience for people when they’re sick. Providers also need to design what I call a “human-centered consumer experience” for people when they are relatively healthy.

What’s the difference between patient experience and human-centered consumer experience? Patient experience improvement strategies need to focus on how providers organize operations to maximize safety, reliability, and affordability of sick care. Human-centered consumer experience focuses on the needs and preferences of the consumer rather than an organization’s own operations, and it starts by treating the consumer like a human and not a patient.

Here are five ways to start providing a human-centered consumer experience.
ONE

Recognize your patients immediately

When front-desk staff recognize a patient immediately, it sets the tone for a more human experience. The initial human experience is then amplified when the physician is knowledgeable of the patient’s medical history and reason for the visit, allowing interaction with the person and not the chart.

TWO

Consider the patient’s mind-set when communicating care plans

Our research shows that less than half of patients report the ability to understand what they’ve heard from their doctor and how to take the next steps they must take in their care plan. This disconnect is largely a function of when and how we share critical information to a person who is likely at their most anxious and vulnerable.

Often providers communicate with a sense of urgency. However, for the patient, that sense of urgency only enhances the anxiety they are feeling. For a more human experience, the communication should reflect the physician’s empathy for the patient and his or her family, while being very clear on next steps. And to really secure that human connection, ask what the patient needs and what more you can do to make their next steps easier to take.

THREE

Involve the patient’s family and support system

The patient’s family and social support system can be a valuable tool for providers, because they are the main influencers when the patient steps outside of the practice. They also happen to be very important to the patient from a personal standpoint. So not only do physicians and staff need to make the family and support team feel welcome, providers need to treat them like an extension of the patient and encourage them to stay involved. It helps ensure the patient follows the care plan, while also creating a personal connection that further enhances the overall experience.

FOUR

Be more than available, be accessible

Having space and availability at the choice locations of your consumers is a very important component of patient access—one of the most recent imperatives for a positive patient experience. But providers can’t stop there.

Providers must be accessible by patients’ standards, and patients are saying to providers: “I need to be able to reach you on my timetable; I need you to manage my needs, even more when they are complex; and I need you to serve my interests, whether I am in front of you, at home, or at another care site.”
Don’t let administrative processes hinder a human experience

The human connection is undermined every time someone has to start from scratch at the same site of care or manage overly complicated administrative processes. Make sure your processes are streamlined from the patient’s perspective—avoid multiple bills, duplicative forms, and technology hiccups like the patient portal being down.

Setting a system-wide strategy for the human experience

It seems like everyone in health care agrees that the patient experience needs a facelift. But my challenge to health system and practice leaders is to chase a distinctive patient experience and a human-centered consumer experience.

You can start by asking yourself and your fellow leaders these three questions:

Q1 What consumer segments are most important to our organization’s future, and how well do we understand them?

Q2 What elements of our operating model make us distinctively attractive or particularly vulnerable from an accessibility, navigability, and service perspective?

Q3 What capabilities do we have today, and what will we need to acquire, to become a distinctively fine choice for the consumer segments we choose to serve?

Want more insights?

To learn how our experts help clients design a corporate strategy and chart the course for long-term success search “strategy consulting” on advisory.com
It’s not news that long wait times decrease patient satisfaction. We’ve been telling our members all year: medical groups have to compete for increasingly consumer-driven business. As patients take a more active role in choosing their providers and data about patient experience becomes increasingly available, groups can no longer tolerate patient dissatisfiers like long wait times.

Groups around the country are tackling this challenge in myriad ways, from incenting providers on wait time metrics to redesigning their scheduling processes.

On one hand, some of our members report successfully reducing actual wait times, but without a resulting boost in patient satisfaction scores. On the other hand, other members improved patient satisfaction without reducing wait times. **What’s going on?**

You might be surprised to hear that when it comes to patient satisfaction, the actual amount of time patients wait may be less important than patients’ perception of wait times. To illustrate the distinction between targeting actual wait times and perception of wait times, we turn to an out-of-industry example.

**How one airport eliminated complaints about wait times**

A couple of years ago, the New York Times profiled a Houston airport that struggled to improve customer satisfaction with how long they were waiting for their baggage after arriving at the airport.

The airport’s first approach was to add baggage claim handlers. While this successfully lowered the time it took travelers to collect their baggage, the change had no impact on traveler satisfaction.

It turns out that even though travelers were getting their bags faster, they were spending 85% of their time waiting at the baggage claim. They decided to take a counterintuitive approach and took steps to maximize the distance between the arrival gates and the baggage carousel.

Even though the total amount of time it took travelers to collect their bags actually increased, they spent most of that time walking to the baggage claim and only two minutes waiting at the carousel. Customers felt like the airport had promptly delivered their baggage—and complaints fell to zero.
So, what can physician practices learn from an airport in Houston?
The airport had done nothing to reduce the actual wait time, but targeted customer perception of the wait time. We can take two key lessons from the airport’s experience:

ONE
Understand what customers want.
The airport knew that customers were unhappy with their wait times only because it tracked and responded to customer complaints. Similarly, medical groups should diligently collect feedback from patients, such as by administering patient satisfaction surveys and running patient and family advisor groups.

TWO
Changing perceptions is often simpler than it seems. For the airport, the root cause of customer dissatisfaction was a perception issue whose solution was relatively easy—a matter of reassigning arrivals to farther gates and rerouted bags to farther baggage carousels. While hiring additional staff improved actual wait times, it was unnecessary and expensive.

Have medical groups successfully changed patient perceptions of wait times?
Two simple ways to address patient perception of wait times are sharing information with patients and delivering a personal apology from the provider.

One practice manager at Atlanta-based DeKalb Medical Group took these principles to heart and successfully boosted patient satisfaction with exam room wait times from the 1st percentile to the 70th.

The solution was elegant: she hung a clock outside each exam room. After rooming each patient, the MA would set the clock. As a result, both MAs and the physicians would know how long the patient had been waiting in the exam room; MAs would give regular updates on the physician’s schedule and the physician would apologize for his tardiness when he entered the room.

Want more on consumer preferences?
Search “consumer preferences” on advisory.com
Patient experience is top of mind for health care providers across the country. And every member of the hospital care team—from administrators to service line leaders and everyone in between—is vital in ensuring a patient is comfortable and kept informed from entry to discharge.

The Daily Briefing’s Clare Rizer sat down with Jessica Suchy, a senior director for Advisory Board Performance Technologies and dedicated advisor for iRound’s patient experience tool, to understand how health care’s approach to patient experience is being transformed. Hospitals’ strategy must be about more than raising HCAHPS scores, Suchy says:

“It’s about improving patient satisfaction and building customer loyalty.”
CLARE RIZER

As a dedicated adviser, you work directly with hospitals to implement patient experience tools, analyze data, and connect institutions with peers undergoing similar process improvements. You have “boots on the ground,” so to speak.

So what do you see as the biggest challenges for hospitals trying to improve their patient experience?

JESSICA SUCHY

We work mainly with nurses, so a lot of what we see in terms of patient experience is from the nursing viewpoint. The biggest thing we hear most is that nursing leaders are being pulled in 20 million directions, and it is hard to dedicate adequate amounts of time to round on each patient. If they can make the time, many nurses tell me rounding and spending actual face time with patients is hands down the best part of their day.

Hospitals and administrators recognize that face time is exceedingly important to patients and to care teams. As such, some organizations have developed fixes like “meeting-free rounding time,” which are pockets of uninterrupted time that nurses and other clinicians can spend responding to patients’ needs.

Other challenges I’ve seen nurses encounter include finding people or teams with whom they can collaborate across divisions to make the most efficient use of time and resources. If you are a nurse leader with a 55-bed unit, finding time to round properly can be difficult, so it is vital that the entire care team is engaged in the process and that available entities step in to help when needed.

Creating and maintaining a positive patient experience is not a nursing problem. It’s everyone’s concern.

CR

Are there specific areas of the patient experience that hospitals seem blind to? Or areas where hospitals should be focusing more effort?

JS

More and more, I see that every entity at every hospital seems to be focusing on patient experience, and organizations are building their brands based on their responsiveness to patient needs. So in terms of where we’re headed with quality improvement efforts, that is a great thing.

But just because hospitals are zeroing in their focus, doesn’t mean there aren’t areas where they slip up.

Hospitals tend to get stuck on the patient-to-clinician interaction and forget about the “in-between” entities that can impact—positively or negatively—a patient’s time in the hospital.

Everyone from registration to transport to care team to discharge is part of the patient’s overall experience, but when considering process improvements, hospitals often overlook these areas. So it is really important that providers remain alert and recognize that a patient’s entire opinion of his or her stay can be colored by just one poor interaction.

CR

So what would you say are the key areas where hospitals can improve their processes to improve patients’ stays?
It definitely depends on the hospital, but patients often experience unhappiness from a lack of responsiveness and lack of communication, too.

I see a lot of opportunity for nurse leaders to individually coach nurses who may be less comfortable interacting with patients. It is an opportunity to manage up, especially because staff engagement can dramatically affect a patient’s experience and your HCAHPS scores. Nurses are on the front lines and are having the most day-to-day patient interactions, so it is important that they are communicative and attentive to patients who are already likely feeling vulnerable and potentially scared.

For instance, if a technician just enters a patient’s room, checks machines, and takes some notes, the patient might not understand what is going on and might become irritable or scared. But if that same technician follows rounding best practices like introducing themselves, sitting near the patient, and explaining exactly what they are about to do and why, the patient will feel more at ease.

You mentioned HCAHPS scores. How important are those—or any other measure assessing patient experience—to hospitals?

Hospitals and hospital executives focus on them a lot, particularly because they have an impact on value-based purchasing and reimbursement.

Of course, hospital patient experience officers and directors also see the broader picture of the importance of patient experience, not just what is reflected in their HCAHPS scores. Oftentimes HCAHPS surveys aren’t sent to all patients, and hospitals only receive a fraction of the surveys back.

But I don’t think patients really understand the surveys—they just care about the care they’re receiving.

The entire landscape of the health care industry is transitioning, so as patients have more choices, it’s important that hospitals commit to transforming care to stay competitive.
How do you see the retail revolution changing the patient experience? How are hospitals adapting to that?

Patients have more choices now, and they are more willing than ever to share the details of their experience on sites like Yelp and their social media profiles. And if patients are posting unfavorable reviews about their time in the hospital, I think it is getting harder for hospitals to overcome that.

As a result, hospitals utilize their grievance committees to field more formal complaints and focus on service recovery. It’s all about communication with the patient, so if they have a complaint, administrators and clinicians let the patient know how they plan to remedy it. The most important thing hospitals can do in these situations is to communicate (maybe even overly so) with the patient. Tell them: “We hear you. We hear what you’re saying. We are sorry this is happening and these are the steps we’re taking to follow up.”

I also see how hospitals are increasingly working to personalize medicine. With our iRound tool, patients’ comments and personal preferences are captured: what kind of food they liked or didn’t like the last time they were here, and so on. The tool also will soon offer the option for recorded discharge instructions so patients can continue their own care from home.

Convenience, communication, quality care, and clarity are what patients are looking for and what hospitals should be focused on delivering.

Want to see patient satisfaction in real time?
Search “iRound” on advisory.com
What one radiologist learned when she went from doctor to patient

BY SRUTI NATARAJA + SARAH HOSTETTER

When radiologist Jennifer Kemp’s husband was diagnosed with rectal cancer, she was given a perspective she had not had before—that of the radiology patient. What surprised her most during the experience was the amount of anxiety she felt while waiting for the results of the scans her husband received every three months.

Since she was a radiologist herself, she was able to sit down with her husband’s radiologist after each scan, usually about an hour afterwards. Even that hour turnaround time, which is much quicker than it takes most patients to receive their results, was extremely anxiety-provoking. On the days that she did not feel comfortable interpreting the scans herself, this anxiety was further multiplied over a 24-hour period.

This got Dr. Kemp thinking about how much anxiety most patients must feel when they are waiting for the results of their scans. She also wondered why there was an extra step put in place—the radiologist talking to the referring physician—that adds even more time and anxiety before patients get their results. Why can’t radiologists just talk to patients and give them their results directly and sooner?

RSNA and ACR looking into this issue

As a result of this experience, Dr. Kemp, now heads a committee of the Radiological Society of North America (RSNA) seeking to make radiologists more accessible to patients. This committee suggests that radiologists
give results directly to patients when asked, either through an in-person meeting or over the phone.

The American College of Radiology (ACR) is making a similar case. Both organizations agree that with electronic portals increasing patients’ access to their medical reports, the desire to obtain results quickly and directly from the radiologist is likely to increase.

Neither group is advocating laws mandating these efforts, but they are hoping to rely on stories of radiologists effectively communicating results to patients and on letting radiologists know that this is something patients want. Thus far, the two groups have discussed these topics with their members and published them online and in their journals.

The root of the issue is threefold
Fixing this problem requires a culture shift for all three stakeholders: patients, radiologists, and referring physicians. All three contribute to the lack of direct communication between radiologists and patients in their own ways.

Most patients are under the impression that they cannot speak with their radiologist, so they rarely ask. However, when they do ask, it is rare that they receive easy access to this provider.

Radiologists do not have the time built in their schedules to talk to patients, and there is some concern around what information a radiologist could provide to the patient when the results of the scan are bad news. Since radiologists are not involved in the next stages of a patient’s treatment plan, they are not positioned to give advice after a diagnosis is made.

Finally, referring physicians often do not want radiologists communicating these next steps to patients, putting them in a situation in which they get a panicked call from a patient without having received the results of the scan themselves yet. According to Dr. Geraldine McGinty, a radiologist at Cornell and the chairwoman of the ACR’s commission on economics, the first step toward fixing this problem is for radiologists to get to know their referring physicians. Referring physicians are often not comfortable with radiologists speaking to their patients because they do not know who the radiologist is.

A lesson from mammography
As patients take more control of their health care decisions and receive greater access to their reports and test results, radiologists will need to adjust the role they play in patient care. This transformation has already impacted mammography, where most radiologists meet with their patients immediately after their scan to discuss the results, and those who do not still send the report directly to their patients.

According to these new initiatives by RSNA and ACR, other subspecialties in radiology could take a lesson from mammography in how to deliver patient-centered care.

Want more on imaging’s role in patient experience?
Search “reading room” on advisory.com to browse our blog
Many HR executives have asked us for data supporting a connection between employee engagement and patient satisfaction. It makes sense that highly engaged health care staff—who are willing to go above and beyond for their organization—would be willing to go above and beyond for patients.

In fact, data from The Advisory Board Company’s Employee Engagement Survey demonstrates that for every 1% increase in employee engagement, an organization’s overall hospital HCAHPS rating increases by 0.33%, and patients’ willingness to recommend increases by 0.25%.

To build a targeted strategy that impacts employee engagement and patient satisfaction, HR leaders should focus on specific engagement drivers that are “two-fers”—in other words, specific drivers that impact both employee engagement and patient satisfaction.

There are 42 engagement drivers in the Advisory Board’s Employee Engagement Survey, but the 10 drivers listed here have the greatest impact on HCAHPS scores.

It’s not surprising that drivers related to care and service delivery rise to the top, as these are the most directly linked to HCAHPS metrics.

**Focus on these 5 ENGAGEMENT DRIVERS to boost your HCAHPS scores**

BY JENN STEWART + REBECCA RABINOWITZ

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1% Increase in Engagement

0.33% Increase in Hospital Rating

0.25% Increase in Recommendations

Where else should you focus?
When you consider your organization’s performance on these 10 drivers, you’ll likely find your organization is already doing well in some areas.

Nationally, we see that on average over 75% of employees agree or strongly agree with the following five drivers:

» My organization provides excellent care to patients

» My organization provides excellent customer service to patients

» My organization supports employee safety

» My organization gives back to the community

» My organization understands and respects differences among employees

This leaves the drivers with the most opportunity for improvement. Nationally, it’s the following five drivers:

» I have the supplies needed to succeed

» I have the technology needed to succeed

» My unit has enough staff

» I receive adequate support from my peers in other departments

» I have a manageable workload

Review performance on these drivers in your most recent engagement survey to see where your organization has the greatest room for improvement.

Want to know how engaged your workforce is?

Search “survey solutions” on advisory.com
Health systems across the country have been making huge investments to create coordinated care delivery systems that allow patients to get the right kind of care at the right time—whether at retail clinics, primary care clinics, urgent care centers, or traditional bricks-and-mortar hospitals.

But my recent experience suggests that at least some health systems have a very, very long way to go to make that vision of coordinated care come to life.

This past winter, I had the bad luck to slip on an icy patch of sidewalk and injure my ankle. Because I knew that one of our local health systems had urgent care centers in my area, I decided to forgo a trip to the emergency room and try urgent care instead. That’s where my troubles began.

Urgent care, as long as you don’t need X-rays

I called the central call center and got referred to a nearby urgent care center. My total hold time was nearly 40 minutes (with a phone disconnect in the middle). Despite this annoyance, I was certain urgent care would be a far more efficient option than the emergency room. Plus, the urgent care receptionist assured me that they could see me almost immediately and X-ray my ankle on-site. But I arrived to find out that they in fact had no X-ray capabilities at that facility, only mammography.

I was shocked—even more so when the receptionist referred me to another location ten blocks away and then asked me apathetically, “So, how are you going to get there?”

I furiously ordered an Uber and hobbled outside. The Uber came quickly and took me to the imaging center, where I got more bad news: after X-raying my ankle, the tech there told me that there was no radiologist reading that day, and although the hospital radiologist could read the images, there was no way to order a “stat” read, so it would be three days before the X-rays would come back.

At this point, I refused to leave the urgent care center until they managed to get someone to read my X-ray, so I parked myself in the waiting room and waited. After a while, the tech came out and whispered, “You have to go to the emergency room, you have a broken ankle.”
That was bad enough. But then, just like the other urgent care center, she asked, “How are you going to get there?”

I grabbed my borrowed crutches and left.

Why would you ever trust the urgent care clinic?

I ended up walking to the emergency room, where I waited for two hours to get triaged and another hour to get a bed, and then several more for another round of X-rays. Apparently the emergency department couldn’t access the images from its own outpatient clinic. Eight hours into the ordeal, and I wasn’t offered anything for pain or even so much as a glass of water.

To add insult to injury, more than one person on the emergency room staff asked me in disbelief, “Why would you ever trust the urgent care clinic?”

And, to close out the absurdity of the episode, when I went to a follow-up appointment with an on-staff orthopedic surgeon a few days later, she only had the X-ray images from the imaging center, not the emergency room.

Lessons for health systems

In retrospect, I can understand some aspects of how these serial missteps occurred. At the core of the issue, the health system has missed the mark on providing the right care, in the right setting, at the right time. They equate quick access with urgent care.

Unfortunately, getting in fast is necessary but not sufficient for delivering urgent care. The central call center did not have the information it needed about the equipment available at each location and how that relates to the type of care patients are seeking. The health system had not established all the necessary protocols among different sites that would allow them to care for urgent conditions at their urgent care centers. And this health system’s leaders had not successfully ingrained customer service as a high priority for its employees.

But it’s sobering to think that I got such fragmented and poor-quality care despite being someone who works in health care delivery for a living and was able to anticipate and communicate my needs. I can only imagine what someone might have suffered if they had not known what questions to ask or what care they needed.

Based on my experience, I would encourage health system executives to examine their continuum of care closely—as much as possible, through the experiences of real patients. My guess is that even the best-run health systems have gaps in their care continuum that need to be addressed.

Want to see patient satisfaction in real time?

Search “iRound” on advisory.com
Why one former medical group exec wants you to stop ‘MANAGING’ PHYSICIANS

BY ANTHONY D’EREDITA

What if, instead of medical group administrators spending all their time trying to “manage” inconsistent and complex day-to-day practice operations, administrators and physicians worked collaboratively to manage a consistent care delivery model?

It might look something like this:

- Centralized scheduling, pursuant to a well-developed access policy
- A predictable flow of patients each day, with same-day access
- A group-wide, consistently enforced point-of-care collections policy
- Consistent workflows supported by standardized medical record templates
- Care teams with a structure based on panel size and patient needs
- A consistent patient experience, regardless of the physician
Without the burden of dealing with physician-preference-specific concerns, the administrators could focus on working together with physician leaders to ensure the delivery model itself is functioning properly: monitoring growth in panel sizes, addressing readmissions, reviewing e-health queues, onboarding physicians and staff, and ensuring care is coordinated across various sites of service.

A long way from the current experience

Why doesn’t this happen today?

If I’m being honest, I think it’s because most medical groups are too busy trying to accommodate physicians’ varied preferences for how to run their practice day-to-day—across dozens of practices—to move toward partnering with physicians to manage a defined model.

In my experience as a practice executive, a typical administrator’s day is filled with conflict resolution and consensus-building with physicians related to operational issues: getting the care team to be more productive; negotiating access for patients; addressing collection issues; resolving staffing problems; solving room utilization challenges; or addressing EHR workflow-related complaints.

Not only do these activities take away from time better spent advancing strategic initiatives, but the resolutions to these operational issues are often different for every physician in the practice.
How we got here
The operational inconsistencies and complexities seen in many of today’s medical groups came about for the best of reasons and with the best of intentions.

As health system and medical group leaders recognized the substantial financial investment that came with employing physicians, everyone’s first priority for practice management became the financial sustainability of the practice. So health systems put physicians at risk for their individual practice operations, including what supplies are purchased, what positions are hired, and how patient care is coordinated. Then, medical group leaders set individual physician productivity targets, and moved away from net income models to productivity-based compensation plans, which made practice volume the physician’s primary objective. The result? Care delivery models based on each physician’s tolerance for financial or productivity risk, requiring medical group leaders to manage physicians according to varying operational practices and personal objectives and preferences. But ironically, this inconsistent, individualized approach to management has not turned out to be the best way to ensure that medical groups will be financially successful.

If access is the key to attracting and retaining patients, and a consistent practice-wide care delivery model can provide consistent access into the medical group, then revenue and productivity become less variable.

The first steps toward a new model
As we’ve learned over and over again working with our clients, creating a consistent, enterprise-wide medical group care delivery model is always a challenging, though rewarding, undertaking.

It’s important to start with a clear and directive vision for the medical group’s delivery model. But when determining how to meet that vision, it’s critical to bring physicians into the conversation and empower them to guide specific strategies of how care should be provided in a consistent manner across the entire medical group. In fact, as you implement the strategies, you should assign physicians to leadership positions and make them accountable for medical group performance.

While recently walking a regional Midwest health system’s leadership team through this process, one of the physicians in the room looked up and asked,

“So you’re telling me that I have to change my practice?”

I responded by asking if what he’s doing now is going to work for the next 20 years.

No response.

So I followed the silence by asking another question, “Would you be up to helping us figure out how to do this better?”

“Yes” came without hesitation.
The moral of this story, to me, is that physicians want a say in how care is delivered, so it’s best for everyone to give them an even bigger platform than just their individual practice.

Once you have your vision set and your physicians engaged, the heavy work begins: setting structure, clinical processes, infrastructure, and other requirements for the newly designed care delivery model. But with the guidance of a strong and directing vision, and physicians as equal partners in carrying out that vision, you can be on your way to a world where medical group administrators can truly manage the model, not physicians.

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Want to learn more about the components of an efficient medical group model?

Search "alignment consulting" on advisory.com
Additional Resources

» Consulting and Management

Need extra help creating a better experience for your patients? Not sure where to start, or how to make the change needed? Our Consulting and Management team of nearly 400 is experienced at change management, and we are available to help you design and execute a plan for a consistent, distinctive patient experience. For more information on how we can help you, visit advisory.com/consulting.

» iRound

iRound is a comprehensive platform aimed at improving the patient experience by providing real-time visibility into a patient’s perception of care, tracking service recovery issues from report to resolution, instilling accountability among physicians and staff, identifying opportunities for improvement, and providing ongoing, data-driven trend analysis for critical measures. For more information on how we can help you, visit advisory.com/iround.

To submit questions or comments to our team please email research@advisory.com.

For additional hard copies of this publication please email research@advisory.com.
Note to Readers

Since the start of 2015, we’ve observed a marked trend: our various sources have all been pointing to a surge of interest in improving the patient experience.

When you think about it, this finding isn’t entirely surprising. Patient experience is at the intersection of two major trends in the American health care marketplace: value-based payment and consumerism. Health care organizations need to focus on delivering an excellent patient experience because, increasingly, their reimbursements are tied to achieving high levels of patient satisfaction. By the same token, as consumers take more control over choosing providers and insurance plans, the quality of the patient experience will be ever more important.

This issue offers an array of perspectives from our researchers and consultants on improving the patient experience, ranging from the most strategic—Tom Cassels on the “human experience”—to the practical, on-the-ground lessons from Jessica Suchy, our lead dedicated advisor for the iRound patient experience technology product.

Given how much attention our own experts are paying to patient experience these days, it was unusually difficult to select the pieces here, but if this volume whets your appetite, you can find more (and the latest!) online at advisory.com/patient-experience.

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Michael Koppenheffer
Executive Director
Research and Insights
Re-envisioning the PATIENT EXPERIENCE