



Deliver a Quality-Driven Patient Experience for Elective Surgical Patients

Four tactics to proactively align expectations and improve outcomes

PUBLISHED BY

Physician Executive Council
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Executive summary

Stakeholders are at odds over the patient experience ambition

CMOs often find themselves caught between two perspectives on patient experience: a C-suite with sights set on patient loyalty, and a medical staff struggling to establish strong patient relationships in a world of increasing documentation and burnout.

Both perspectives are valid. Securing patient loyalty is a critical revenue opportunity for hospitals and health systems in increasingly competitive markets. At the same time, physicians' limited capacity to take on additive patient experience initiatives can make it difficult for CMOs to engage them in system-wide experience efforts.

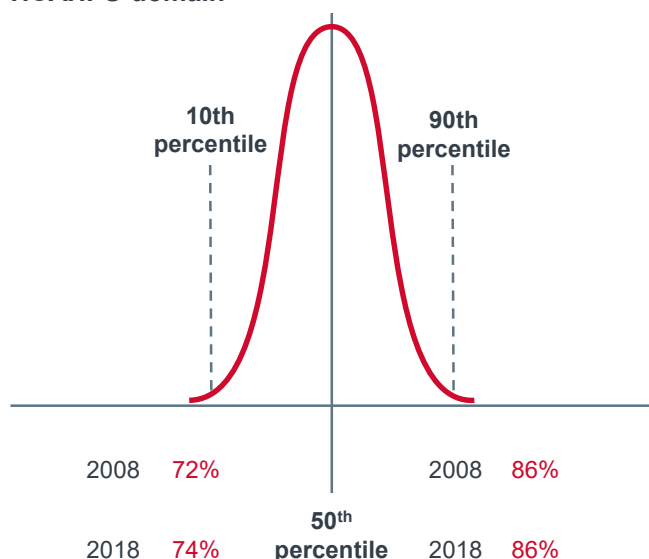
Reaching a point of diminishing HCAHPS return

There is one key point of agreement between executive teams and frontline physicians: HCAHPS is an insufficient measure of patient experience. First, the physician-specific HCAHPS domain¹ is too narrowly focused on communication—a necessary but incomplete measure of overall experience. Second, from a national perspective, physicians consistently perform well on HCAHPS.

Narrow opportunity to improve national physician HCAHPS performance

The narrowing bell curve for national HCAHPS performance indicates that focusing on physician communication alone is not enough to engage physicians in patient experience efforts and inspire transformational change. Rather, the greatest opportunity for hospitals and health systems to mobilize physicians and improve the patient experience is to look beyond HCAHPS.

Top box² performance on physician communication HCAHPS domain



HCAHPS physician communication questions

1. “During this hospital stay, how often did doctors treat you with courtesy and respect?”
2. “During this hospital stay, how often did doctors listen carefully to you?”
3. “During this hospital stay, how often did doctors explain things in a way you could understand?”

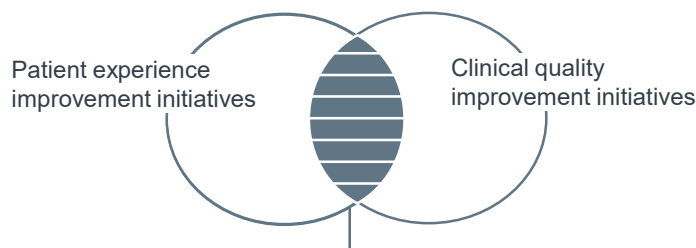
1) The three HCAHPS questions that address physician communication specifically.
2) “Top box” defined as patients who responded with “always” to all three HCAHPS physician communication questions.

An ambition everyone can agree on: delivering a quality-driven patient experience

To mobilize physicians in patient experience efforts, leaders must fundamentally shift their strategy to lead with clinical quality. Prioritizing initiatives that correlate to both quality and experience improvements aligns patient experience efforts to physicians' top priority: providing best-in-class clinical care.

In theory, nearly all CMOs agree that re-linking quality improvement and patient experience efforts is the right thing to do. In practice, it is difficult to identify strategies that drive both quality and experience. Delivering on a quality-driven patient experience requires two layers of prioritization:

1. Identify initiatives that correlate with both quality and patient experience improvement.



Tactics that improve quality and experience



Correlated with a quality measure

- Readmissions
- Length of stay
- Reduced opioid use



Correlated with a patient experience measure

- HCAHPS or internal experience survey
- Qualitative patient comments



Impacts physicians

- Physician-led
- Impacts physician workflow

2. Strategically map tactics to patient populations with the greatest opportunity to improve both quality and patient experience.



Elective surgical patients

In this brief, we outline four tactics to simultaneously improve quality and experience for elective surgical patients across their surgical journey.


Definition: Patients coming in for a scheduled surgery

Top opportunity to improve both quality and patient experience: Proactively align patient and physician expectations to improve outcomes

A massive elective surgical patient opportunity

Elective surgeries represent a large volume of patients and a significant revenue driver for hospitals and health systems. Even with surgical volumes shifting to the outpatient setting, inpatient volumes will continue to grow.


Growing surgical volumes and substantial financial stake



≈30% Of US admissions include a surgical procedure

175K Estimated inpatient general surgery procedure growth by 2022

10:1 Median ratio of elective to emergency surgeries in US



\$498B Annual inpatient surgical services revenue

2.5x Inpatient stays with a surgical procedure are 2.5 times more expensive than those without

\$5K Estimated cost of same-day surgery cancellation

Revenue, however, is not the only reason elective surgical patients merit CMO attention; they also represent a significant quality improvement opportunity. Physicians have an outsized opportunity to inflect clinical outcomes and patient experience for elective surgical patients because they have time to deeply understand patients' concerns and proactively set expectations.

“

Elective surgical patients is a group that all hospitals want to grow because they are high profit margin cases. And they are a group where you have a **huge opportunity to educate in advance and prepare for optimal post-surgical outcomes.**

Director of care transformation

5-hospital system in the Southeast

”

Source: McDermott KW, et al., "Overview of Operating Room Procedures During Inpatient Stays in U.S. Hospitals," AHRQ, <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb233-Operating-Room-Procedures-United-States-2014.pdf>; Prin M, et al., "Emergency-to-Elective Surgery Ratio: A Global Indicator of Access to Surgical Care," *World Journal of Surgery*, 42, (2018): 1971-1980; Turnunen E, et al., "Elective Surgery Cancellations During the Time Between Scheduling and Operation," *Journal of PeriAnesthesia Nursing*, 34, no. 1, (2019): <https://www.sciencedirect.com/science/article/pii/S1089947218300091#bib5>; Service Line Strategy Advisor, *Market Scenario Planner*, Advisory Board; Physician Executive Council research and analysis.

Surgical outcomes are falling short of patient expectations

Although physicians have the benefit of time to prepare patients for elective surgeries, patients often arrive with inaccurate expectations on the day of their procedure. For example, knee replacement patients often have higher expectations for their post-surgical mobility than their surgeons do.

Misaligned expectations don't just tarnish the patient experience—they impact clinical outcomes. A survey of over 25,000 surgical patients found that patients who did not know what to expect after surgery were more likely to report post-op problems than patients who knew what to expect.

Patient expectations often unmet

50% THA/TKA¹ patients had **higher expectations** for outcomes than their surgeon

Frequently unmet expectations



Independence
(e.g., getting out of bed)



Range of motion
(e.g., navigating stairs)

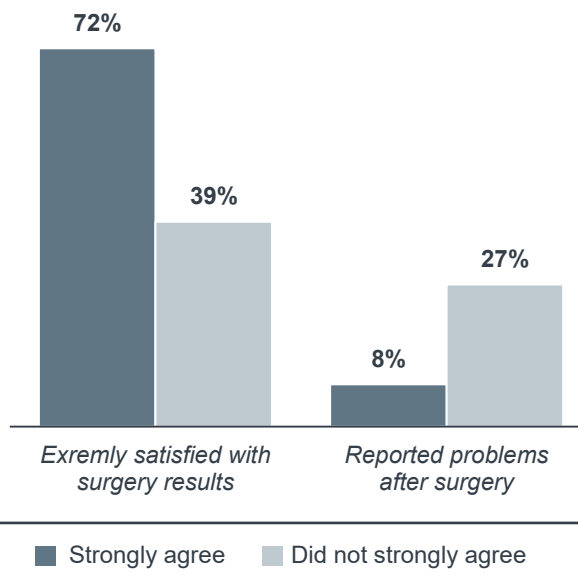


Physical activity
(e.g., participating in sports)

Clear expectations linked to better outcomes

Patients who agree with the statement "I knew what to expect after surgery"

n=26,128



1) Total hip arthroplasty, total knee arthroplasty.

Proactively align expectations and improve outcomes

Because patients' expectations are so closely linked to surgical experience and outcomes, proactively setting realistic expectations is critical for delivering a quality-driven patient experience. This research report includes four tactics to increase transparency and help surgical teams set patient expectations across the surgical pathway.

Critical opportunities to create transparency across the surgical pathway



Tactic 1: Patient-centered pre-op audit

Tactic 2: ERAS community of interest

Tactic 3: Physician-driven ERAS implementation

Tactic 4: Patient-reported outcomes collection

Tactic 1: Patient-centered pre-op audit

Tactic in brief

Audit your current pre-op process to identify opportunities to be more patient-centered. The goal is to ensure patients are adequately prepared for procedures and to avoid same-day cancellations.

Rationale

A disjointed pre-op process can undermine patient experience and clinical outcomes from the start. Asking patients to navigate multiple clinicians and locations before their procedure can lead to dissatisfaction, anxiety, and incomplete pre-op requirements. Most health systems have an opportunity to significantly streamline the pre-op process. This doesn't just make for a better patient experience, it also ensures clinicians obtain more comprehensive information from patients ahead of surgery.

Implementation components:

Component 1: Identify opportunities to improve current pre-op process

Complete the Physician Executive Council's Patient-Centered Pre-Op Audit to identify improvement opportunities at your organization.

Component 2: Connect with appropriate stakeholders to make pre-op more patient-centered

Based on your audit results, partner with the appropriate stakeholders to craft solutions to the identified pre-op gaps.

Tactic assessment

We recommend all organizations assess their current pre-op processes because the pre-op visit sets the tone for surgical patients' entire care experience. One of the most important—but challenging—goals is providing a single appointment for all pre-op testing. If a single appointment isn't feasible, start by providing patients with a cheat sheet outlining key tips and reminders they will need to prepare for surgery.

Undermining quality and experience from the start

A disjointed pre-op process can undermine patient experience and clinical outcomes from the start. From the patient's perspective, the pre-op process is often a burden. Navigating multiple clinician visits and locations before their procedure can lead to dissatisfaction, anxiety, and same-day cancellations. That's why—before considering any other intervention—we recommend auditing your current pre-op process.

Representative pre-op patient experiences



Overloaded with information and clinical jargon



Unsettled by the **lack of attention paid to preferences** and questions



Overwhelmed with numerous **pre-op requirements** and logistics

45%

Of patients are dissatisfied with their pre-op assessment

28%

Of patients report anxiety before surgery

5-15%

Of elective surgeries are cancelled on the scheduled day

Source: Gebremedhn EG, et al., "Assessment of patient satisfaction with the preoperative anesthetic evaluation," *Patient Related Outcome Measures*, 5, (2014): <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4172080/>; Rosiek A, et al, "Evaluation of Stress Intensity and Anxiety Level in Preoperative Period of Cardiac Patients," *BioMed Research International*, (2016): <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4793098/>; Xue W, et al, "Dynamics of Elective Case Cancellation for Inpatient and Outpatient in an Academic Center," *Journal of Anesthesia and Clinical Research*, 4, no. 5, (2013): <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3839960/>; Physician Executive Council interviews and analysis.

No-regrets moves to improve patients' pre-op experience

Component 1: Identify opportunities to improve current pre-op process

Complete the Physician Executive Council's patient-centered pre-op audit below to identify opportunities to make improvements. Based on your results, partner with the appropriate stakeholders to address existing pre-op gaps.

PATIENT-CENTERED PRE-OP AUDIT		
Before surgery	Yes	No
1. Do you batch pre-op tests into a single appointment?	<input type="checkbox"/>	<input type="checkbox"/>
2. During the pre-op appointment(s), do clinicians review all pre-and post-operative guidelines with the patient?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are clinicians trained to use open-ended language with patients? (e.g., "What questions do you have?")	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you provide patients with a checklist or cheat sheet including key reminders and contact information?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do nurses or schedulers call patients ahead of surgery to confirm location, time, and transportation?	<input type="checkbox"/>	<input type="checkbox"/>
Day of surgery		
6. Do you provide clear wayfinding upon patient arrival?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you arrange for comfortable waiting areas for family and/or caregivers?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you give accurate surgical time and wait times (that include time in recovery room) to patients and families?	<input type="checkbox"/>	<input type="checkbox"/>

Component 2: Connect with appropriate stakeholders to make pre-op more patient-centered

Based on audit results, prioritize implementing at least one item for which you checked "no." Identify key partners to help you craft solutions to the prioritized pre-op gaps.

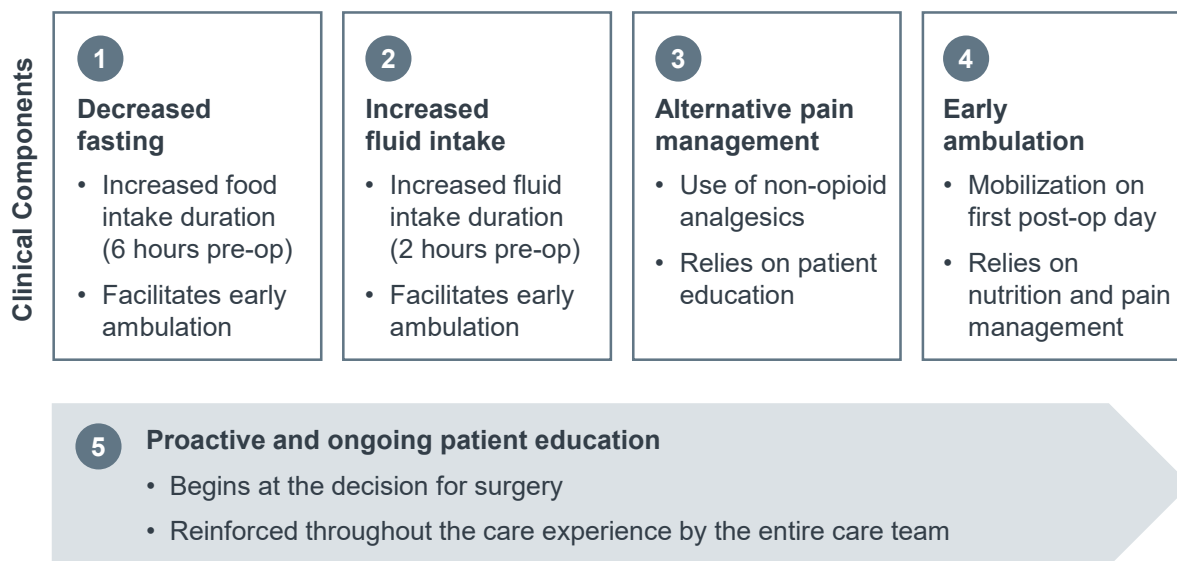
ERAS at a glance

Most organizations need to look beyond pre-op processes and across the entire surgical pathway to improve quality and patient experience. One strategy that is correlated to both types of improvement is Enhanced Recovery After Surgery (ERAS). ERAS is a surgical protocol that combines evidence-based clinical protocols with rigorous patient education to set expectations and expedite post-op recovery.

ERAS protocols typically include the five components below. The four clinical components work in tandem to promote recovery. For example, decreased fasting and increased fluid intake ensure that patients have the post-op strength necessary for early ambulation.

The fifth component, comprehensive patient education, supports the clinical components. Clinicians walk patients through the entire care pathway and specifically call out the patient's role in each step. Clinicians also give patients written and visual aids to reference at home before and after the procedure.

Enhanced Recovery After Surgery fundamentals



For an example of patient education materials, see **USC Keck's patient education infographic for lung surgery** on advisory.com/pec/electivesurgpx.

To access additional ERAS protocols, see the ERAS Society guidelines at <http://erassociety.org/>.



A winning strategy for elective surgical patients

ERAS can dramatically improve quality and patient experience across a variety of service lines and procedures. Existing research suggests that ERAS is a true win-win strategy that inflects quality and experience metrics.

Key outcomes of ERAS protocols

	Quality			Experience
	↓ Readmissions	↓ Length of stay	↓ Opioid Use	↑ Patient Experience
Colorectal surgery	48% reduction in readmission rate	2.3-day reduction in inpatient stay	78% reduction in perioperative opioid use	Overall satisfaction scores increased from 26th to 59th percentile
Cardiac surgery	1.5% reduction in ICU readmissions	1-day reduction in inpatient stay	50% only required 0.5mg of morphine equivalents	Patient satisfaction increased from 86.3% pre-ERAS to 91.8% post-ERAS
Gynecologic surgery	18% reduction in readmission rate	1-day reduction in inpatient stay	No intravenous opioids used	Pain management and teamwork HCHAPS scores increased to 63rd and 90th percentile respectively



For additional ERAS outcome data, visit advisory.com/pec/electivesurgpx.

Source: Modesitt SC, et al., "Enhanced Recovery Implementation in Major Gynecologic Surgeries," *Obstetrics & Gynecology*, 128, no. 3, (2016): https://journals.lww.com/greenjournal/fulltext/2016/09000/Enhanced_Recovery_Implementation_in_Major.7.aspx; Thiele RH, et al., "Standardization of Care: Impact of an Enhanced Recovery Protocol on Length of Stay, Complications, and Direct Costs after Colorectal Surgery," *Journal of American College of Surgeons*, 22, no. 4, (2015): [https://www.journalacs.org/article/S1072-7515\(15\)00012-5/fulltext](https://www.journalacs.org/article/S1072-7515(15)00012-5/fulltext); Williams JB, et al., "One-year results from the first US-based enhanced recovery after cardiac surgery (ERAS Cardiac) program," *Journal of Thoracic Cardiovascular Surgery*, (2018): <https://www.ncbi.nlm.nih.gov/pubmed/30665758>; Physician Executive Council interviews and analysis.

Tactic 2: ERAS community of interest

Tactic in brief

Provide forums for both supporters and skeptics of Enhanced Recovery After Surgery (ERAS) to engage with the evidence and discuss emerging research. The goal is to foster a community of physicians interested in ERAS and build buy-in over time.

Rationale

Despite the growing body of ERAS research, many organizations struggle to gain physician buy-in for the protocol because it requires physicians to deviate from traditional practice. Leaders frequently rely on top-down efforts to convince physicians, but that approach often fails to build and sustain buy-in for practice change. Dedicated ERAS forums connect internal champions, provide an outlet for healthy debate, and keep ERAS top-of-mind for physicians.

Implementation components:

Component 1: Facilitate an opt-in networking event for physicians interested in ERAS

ERAS physician leader invites surgeons and anesthesiologists interested in ERAS to an in-person networking event. Attendees discuss anticipated practice changes and meet internal ERAS team members or champions.

Component 2: Push regular updates to ERAS community of interest through a dedicated listserv

ERAS leaders use the networking event attendee list to populate a dedicated ERAS listserv—the ERAS community of interest. They regularly share emerging ERAS research and internal updates from service lines implementing ERAS. Leaders encourage members to reply directly to the thread with updates and questions.

Component 3: Intentionally pair ERAS community of interest members on surgical cases

Surgical schedulers use the community of interest list to pair ERAS champions on the same cases. Encourage ERAS physicians to share their outcomes and feedback with the community of interest to build and sustain buy-in.

Tactic assessment

Establishing a community of interest is an effective and low-resource way to organically build physician buy-in for ERAS and sustain it over time. To boost attendance, consider repurposing an existing surgical or anesthesiology department meeting for the in-person networking session.

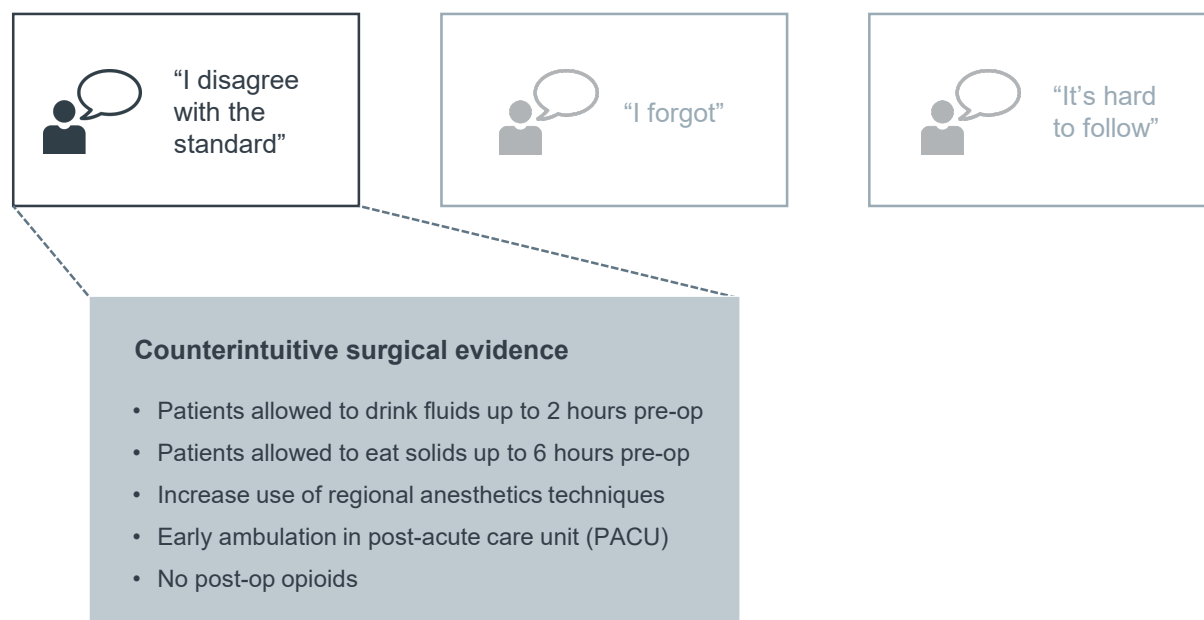
ERAS is a potentially contentious protocol

Despite the strong and growing body of clinical evidence on ERAS, leaders often encounter physician resistance because it includes counterintuitive surgical evidence. For example, traditional surgical pathways require that patients stop drinking fluids by midnight before their surgery. ERAS protocols, however, encourage patients to drink clear liquids, such as Gatorade, up to two hours pre-op to prevent dehydration.

Clinical skepticism is fairly unique to ERAS. Our previous research on reducing care variation found that physicians fail to adhere to standards for the three reasons detailed below. Most often, physicians agree with care standards but struggle to implement them due to the latter two reasons.

Disagreeing with the clinical evidence behind a standard is the least common reason for non-adherence, and requires a targeted initiative to overcome.

Three reasons providers don't adhere to care standards



Connect key stakeholders before protocol rollout

Component 1: Facilitate an opt-in networking event for physicians interested in ERAS

Leading organizations start cultivating buy-in by holding an opt-in networking event for physicians interested in ERAS. The rationale is that organizations can start building organic support for ERAS by bringing together interested physicians and giving them an opportunity to ask questions and debate aspects of ERAS.

Johns Hopkins Medicine, a six-hospital system in Baltimore, Maryland, holds an ERAS networking event for physicians before implementing a protocol in a new procedure or service line. Over dinner, attendees get to know Hopkins' centralized ERAS team,¹ discuss workflow challenges, and meet other physicians interested in ERAS.

Leaders can strategically tap into supportive physicians during the dinner to engage neutral physicians or address naysayers' concerns.

Hopkins' networking event to build physician buy-in for ERAS



In-person networking event

- Who:** Anesthesiologists
- What:** ERAS introduction, expected practice changes, preview education channel
- When:** ≈1 month before new protocol rollout²



How to choose where to start

- Target largest group of clinicians
- Start with the group that is the most skeptical
- Identify group most impacted by anticipated changes



To drive physician meeting attendance, watch our webconference [Why doctors don't attend your meetings—and how to change their minds](#), available on [advisory.com/pec](#).

When planning a networking event, organizations should prioritize the group of physicians they anticipate will be the most difficult to engage. At Hopkins, leaders focused on anesthesiologists because they anticipated their group would face significant logistical barriers (e.g., coordinating clinic education and ERAS surgical scheduling).

This in-person networking event generates excitement for ERAS, but one meeting is not enough to sustain physician engagement with the protocol over time.

1) Includes a physician, anesthesiologist, quality improvement nurse, and data analyst responsible for managing ERAS design and implementation across the organization.
2) If the protocol is complex (e.g., the literature is more ambiguous), earlier engagement is required.

Equip interested physicians with emerging evidence


Component 2: Push regular updates to ERAS community of interest through a dedicated listserv

Leaders can maintain physician support for ERAS by sending regular clinical updates to interested physicians. After the ERAS networking dinner, Hopkins maintains momentum through a listserv of interested clinicians referred to as the “ERAS community of interest.” The ERAS team pushes out emerging research, internal data from service lines with live ERAS protocols, and personal testimonials from clinicians participating in ERAS. A cadence of four emails a month reinforces buy-in without overwhelming physician inboxes.

Importantly, the listserv is not a passive communication channel. Physicians use the ERAS listserv to debate how to incorporate emerging evidence into practice or why certain deviations from traditional practice are necessary for enhanced recovery.

Hopkins’ ERAS community of interest listserv

	Digital reinforcement
Who:	All interested clinicians and skeptics
What:	Testimonials, updated evidence, and internal updates
When:	4x a month minimum

 **Implementation guidance**

- Provide balanced information from internal and external sources
- Encourage clinicians to reply to create a two-way dialogue



For more physician communication best practices, read pages 25-42 of our research report [Your Data-Driven Road Map for Physician Engagement](#), available on advisory.com/pec/physicianengagement.

Schedule bought-in physicians together

Component 3: Intentionally pair ERAS community of interest members on surgical cases

Hopkins realized that anesthesiologists who bought into ERAS were not consistently scheduled with surgeons who used the protocol. That meant many anesthesiologists were regularly switching between ERAS and non-ERAS cases. To address this issue, Hopkins leaders share the community of interest listserv with surgical schedulers to ensure they schedule participating anesthesiologists and surgeons together.

Not only does pairing anesthesiologists and surgeons streamline anesthesiologist workflow, it also produces a steady stream of internal evidence for the community of interest listserv.

Illustrative hospital surgical schedule

<u>Operating Room Schedule</u>			
<u>Patient Name</u>	<u>Operation</u>	<u>Surgeon</u>	<u>Anesthetist</u>
John Smith	Mastectomy	Dr. E. Buys	Dr. P. Smith
Jane Doe ERAS	TKR	Dr. H. Taylor	Dr. D. Johnson
Maria Miller ERAS	Colectomy	Dr. B. Jones	Dr. M. Wilson

Flag ERAS patients in the EMR

Schedulers cross-reference ERAS community of interest list when assigning anesthesiologists

Tactic 3: Physician-driven ERAS implementation

Tactic in brief

Use the fundamentals of care standard design to create ERAS protocols that meaningfully involve physicians and account for clinical workflow realities. The goal is to leverage your organization's existing care variation reduction infrastructure to efficiently scale ERAS across service lines.

Rationale

Despite strong clinical evidence, many organizations struggle to implement ERAS protocols across multiple service lines when the design process is inefficient and fails to incorporate clinician workflow realities. Instituting a standard approach to ERAS design and implementation reduces the burden on individual surgical leads, expedites protocol customization, and results in protocols that are easier for clinicians to follow.

Implementation components:



Note: The components below are consistent with the Physician Executive Council's care variation reduction (CVR) research. Review the descriptions below to see how you can use your CVR infrastructure to streamline ERAS protocol development and implementation. To learn more about individual components, see our study [Create Care Standards Your Front Line Will Embrace](https://www.advisory.com/pec) on [advisory.com/pec](https://www.advisory.com/pec).

Component 1: Front-load workflow considerations during ERAS design

Implement an organization-wide process for ERAS protocol development that includes ample time to understand how ERAS will impact existing frontline workflows, as well as sufficient time for clinician education on the new workflow.

Component 2: Professionalize the ERAS design team

Clinical leaders recruit the right people (and skills) to design and manage ERAS protocols across the organization. Importantly, ERAS design teams should include both clinical and non-clinical expertise.

Component 3: Anticipate procedure-specific roadblocks to ERAS implementation

ERAS team gives surgical leads appropriate flexibility to customize ERAS protocols, while maintaining standard condition-agnostic components of ERAS.

Component 4: Hardwire channels for protocol iteration

ERAS team regularly rounds on surgical units to gather in-the-moment feedback from clinicians using ERAS protocols. Team also facilitates dedicated ERAS meetings to solicit input and refine protocols post-implementation.

Tactic assessment

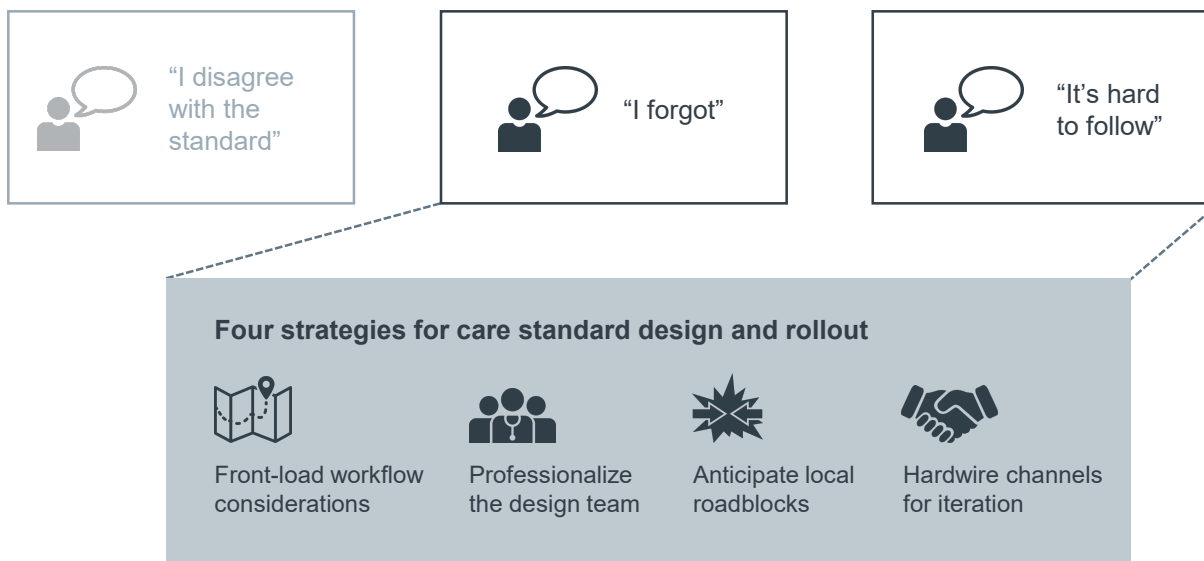
We strongly recommend that all organizations implementing ERAS use this tactic to scale their efforts. Organizations with an existing CVR infrastructure can leverage their care standard design process for all ERAS protocols to expedite rollout and save clinician time. For organizations without an existing CVR infrastructure, this tactic requires up-front time and staff investments, but establishing this infrastructure will jump-start ERAS efforts and broader care standard creation.

Create ERAS protocols that account for physician workflow

Once leaders cultivate physician buy-in for ERAS, they must address the two remaining adherence barriers: physicians either forget to follow the standard or struggle to integrate the standard into their workflow.

To address these challenges, leaders must proactively address physician workflow and create ERAS protocols that are easy for physicians to follow. Organizations that have already invested in care variation reduction can use the same strategies to design and roll out ERAS protocols. The four key strategies to effectively design and roll out care standards are outlined below.

Key reasons providers don't adhere to care standards



For in-depth guidance on care standard design, read our research reports [Create Care Standards Your Frontline Will Embrace](#) and [Embedding Care Standards in Frontline Physician Practice](#) available on [advisory.com/pec](https://www.advisory.com/pec).

The following pages outline how Keck Hospital of University of Southern California (USC Keck), a 401-bed acute care hospital in Los Angeles, used similar strategies to set up an effective ERAS design and implementation process.

A standard process for ERAS design

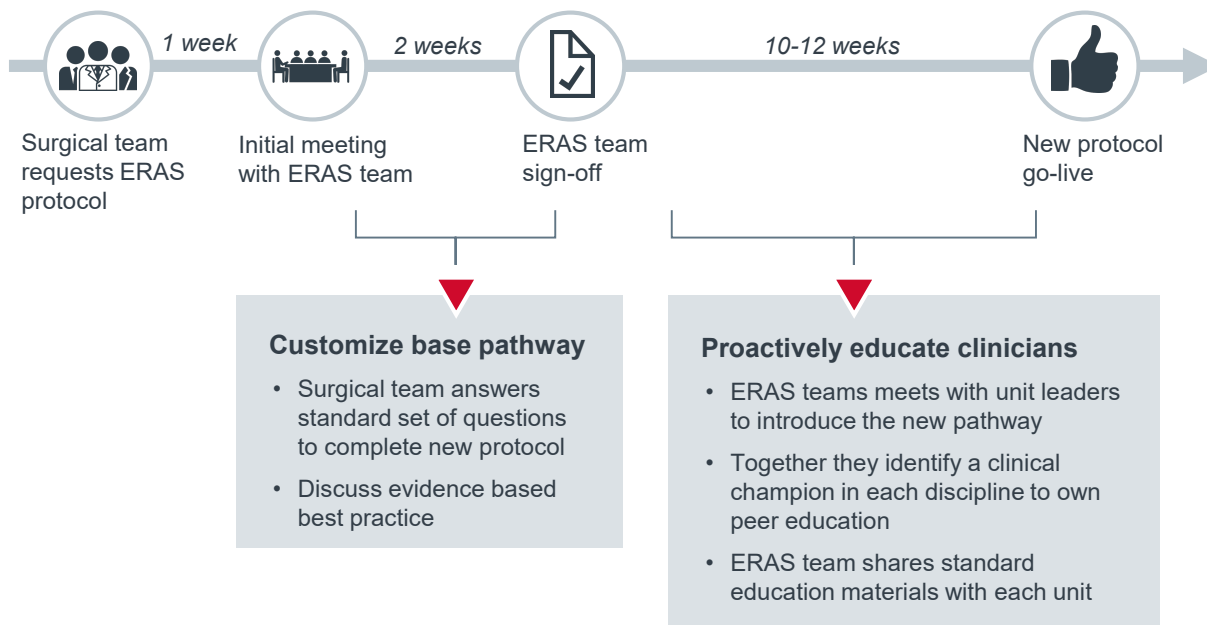
Component 1: Front-load workflow considerations during ERAS design

Organizations must proactively identify how new protocols will integrate into existing clinical workflow to facilitate a smooth ERAS rollout.

Keck Hospital of the University of Southern California uses a standard 90-day, physician-driven process to ensure they account for the clinician perspective before rollout. Interested surgical teams initiate the process by contacting USC Keck's centralized ERAS team to request a new protocol. Once the new protocol is approved, the surgical team is given an ERAS "base pathway," or template, to fill out over two weeks to create the protocol.

Once the ERAS team approves the protocol, they pass it to the IT department. While IT builds the protocol into the EHR, the ERAS team jump-starts clinician education to uncover concerns and equip clinicians to use the new protocol.

USC Keck's 90-day ERAS protocol development timeline



If you want to learn more, USC Keck is available to partner and consult with you on your current ERAS strategy. If you are interested in networking, contact your research advisor.

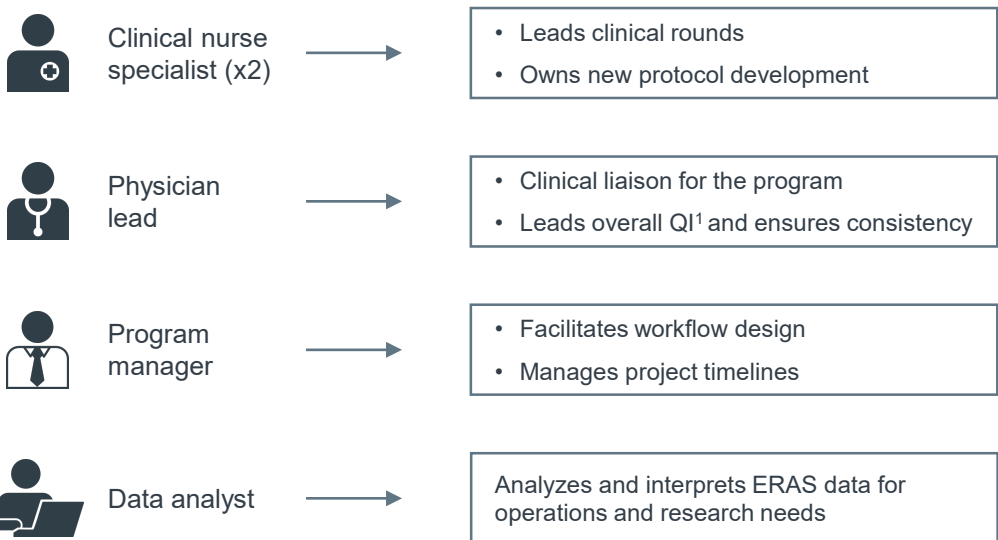
A centralized ERAS team does the heavy lifting

Component 2: Professionalize the ERAS design team

Physician involvement is necessary—but not sufficient—for successful ERAS protocol design and rollout. Organizations need a centralized ERAS team to manage operational tasks and oversee protocol implementation across the organization.

The roles on a design team vary based on the organization, but we recommend using USC Keck's ERAS team as a guide because it pairs clinical expertise with process improvement experts.

USC's centralized ERAS management team



For guidance on building an interdisciplinary design team, see Tactic 4: Dedicated Design Team in our research report [Create Care Standards Your Frontline Will Embrace](#), available on [advisory.com/pec](https://www.advisory.com/pec).

For organizations with an existing CVR taskforce, consider recruiting those individuals to oversee ERAS design and rollout as well. For organizations building a team from scratch, we highly recommend recruiting internal experts before hiring externally.

Base pathway allows for efficient customization

Component 3: Anticipate procedure-specific roadblocks to ERAS implementation

At USC Keck, the ERAS team uses a base pathway—a condition-agnostic ERAS protocol template—to efficiently involve physicians in protocol customization for specific procedures. The base pathway includes fundamental components of ERAS, such as guidance on basic post-operative pain medication and ambulation timelines.

However, the base pathway provides ample room for customization and condition-specific nuance. To account for that nuance, surgical teams complete a three-page questionnaire, and the ERAS team's clinical nurse specialist inputs their responses into the base pathway to complete the protocol.

Sample of USC's ERAS thoracic lung surgery inpatient pathway¹

Enhanced Recovery Lung Surgery Pathway				
Any variation from pathway must be addressed during rounds.				
Inpatient Admission				
	Day 0	Day 1	Day 2	Day 3
Inpatient Teams				
Level of care	ICU/Tele	Transfer to telemetry/General Care after AM rounds	Telemetry/General Care	Telemetry/General Care
Patient-Centered Goals:	Pain/Nausea controlled per patient report			
	Sits in chair x1 and with meal, walks in hallway at least once, uses IS appropriately	Sits in chair with meals and as tolerated, walks in hallway at least three times per day, performs IS 10x/hour while awake		
		Verbalizes pain management plan	Verbalizes discharge instruction	
Order Sets:	Lobectomy Order Set			
Patient Education:	Continue home ASA through perioperative period	Home Pain Management Regimen	Thoracic Discharge Instructions	
Oxygenation:	Incentive Spirometer 10x per hour while awake/deep breathing exercises, oxygen therapy as needed to keep saturation greater than 90%			
Nutrition:	Solid diet			
IV Fluids:	Saline lock			
Symptom management:	Pain medications in following order: non-opioids, mild opioids, strong opioids. Use adjuncts as appropriate <ul style="list-style-type: none"> Acetaminophen 650 mg by mouth every six hours around the clock 			

Customized pathway serves as a guideline to all inpatient care clinicians

Base pathway components include basic post-operative pain medication, ambulation, nutrition, and hemoglobin protocols

Starting with the base pathway allows the ERAS team to efficiently incorporate physician input before launch, but it's not the only time that USC solicits feedback about the protocol.



To learn more:

A larger pathway excerpt and USC's patient education materials can be found on advisory.com/pec/electivesurgpx.

1) Illustration simplifies pathway layout for teaching purposes.

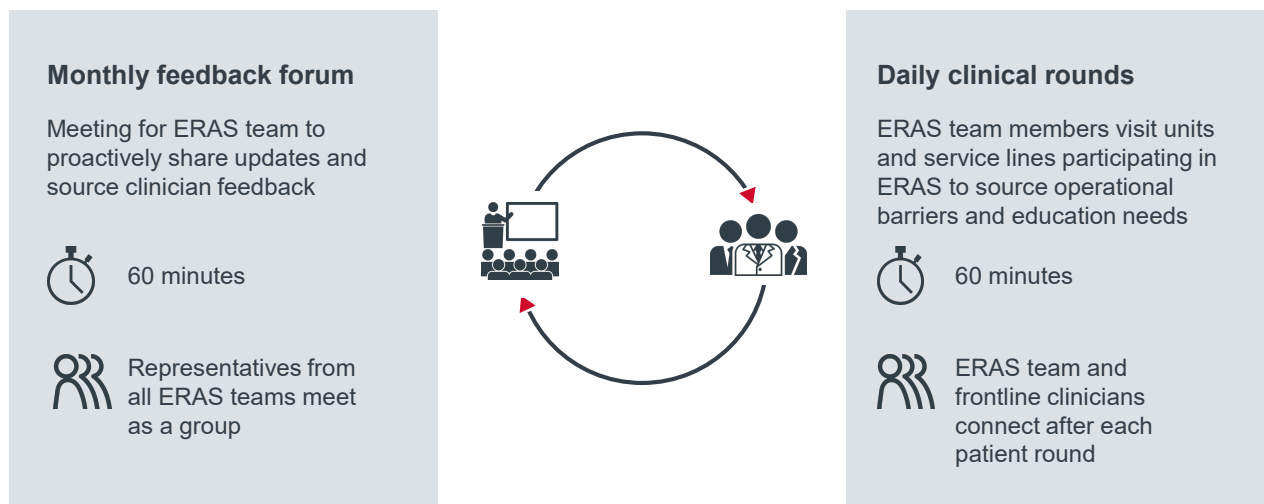
Source: Keck Hospital of USC, Los Angeles, CA; Physician Executive Council interviews and analysis.

Regularly source and share clinician feedback

Component 4: Hardwire channels for protocol iteration

A well-designed protocol is necessary for physician adoption, but no protocol is perfect from the start. USC Keck's two-part frontline feedback loop allows for continued iteration of ERAS protocols post-rollout.

USC Keck's frontline feedback channels



Monthly feedback forums keep clinicians informed of ongoing rollouts and widespread protocol changes. USC opens feedback forums to all staff, and the ERAS team intentionally recruits representatives from all parties involved.

The ERAS team also conducts daily rounds to source in-the-moment feedback about ERAS successes, identify opportunities for improvement, and uncover remaining education gaps. For example, a clinician's comment about medication-related discharge delays during rounds prompted the ERAS team to create an expedited ERAS pharmacy pathway—lowering length of stay for all ERAS patients.

From base pathway to practice

USC Keck's physician-driven approach to ERAS implementation led to notable quality and patient experience improvements.

Currently, ERAS is live across eight of USC Keck's service lines, and the waiting list for new protocols continues to grow.

USC Keck's ERAS success

≈21%

Reduction in length of stay across procedures

50-80%

Reduction in postoperative opioid use across procedures

Themes from patient feedback



Satisfied with experience



Satisfied with length of hospital stay



Less post-operative pain than non-ERAS patients

Widespread service line participation

Live ERAS protocols



Thoracic



Robotic radical prostatectomy



Minimally invasive cardiovascular



Gynecologic oncology



Colorectal



Complex spine



Head/neck



Partial nephrectomy

ERAS wait list¹



Vascular



Orthopedic oncology

1) As of May 9, 2019.

Tactic 4: Patient-reported outcomes collection

Tactic in brief

Collect patient-reported outcome measures (PROMs) to improve quality and experience for elective surgery patients. The goal is to align patient and provider expectations for surgical outcomes by measuring quality from the patient perspective.

Rationale

Physicians and patients often use different metrics to evaluate the quality of care. For example, physicians generally define quality by traditionally reported quality measures (e.g., length of stay for a knee replacement), while patients largely evaluate quality as it pertains to quality of life (e.g. whether or not they can still play tennis). This dynamic can lead to misaligned expectations for surgical outcomes and diminish the patient experience. Collecting PROMs helps physicians better understand their patients' goals and set clear expectations from the start.

Implementation components:

Component 1: Identify and communicate how your organization will use PROMs data

Leaders clarify the primary use case for PROMs data and communicate the purpose to physicians and staff to cultivate buy-in before rollout. For example, PROMs data can help physicians customize clinic visits or demonstrate the value of care to patients.

Component 2: Make it easy for patients to complete PROMs surveys

Surgical teams develop user-friendly PROMs questionnaires and give patients multiple opportunities to complete the questionnaires throughout the surgical journey.

Tactic assessment

PROMs data is a powerful tool for providers and organizational leaders to improve care. However, collecting data can lead to survey fatigue for patients and providers alike. Consider piloting a PROMs survey within a specific patient population and using the data to make the case for large-scale investment to administrative and clinical leaders.

Who defines clinical quality and experience?

Hospitals and patients often use different metrics to measure quality, resulting in misaligned expectations. Physicians generally define quality by standard outcome measures like avoidable days and readmissions. Meanwhile, patients often focus on how their care affects their quality of life, such as whether they can play tennis post-op. The lack of a shared quality measure makes it difficult for patients and clinicians to work toward the same care goals.

Good quality to a physician...



Procedure started on time



Below average length of stay (LOS)



...isn't always good quality to a patient



Doesn't have enough range of motion to play tennis



Can't pick up their grandchild

To better understand patients' perception of their care, progressive organizations use Patient-Reported Outcome Measures (PROMs) surveys to measure functional well-being and health.

PROMs surveys are validated questionnaires that assess quality from the patient's perspective. For example, PROMs evaluates mobility by asking the patient to rate their satisfaction with their ability to do activities outside the home rather than how many steps they can take without sitting down.

PROMs 101: Representative questions

- 1 "Are you able to turn a key in a lock?"
- 2 "Are you able to bend down and pick up clothing from the floor?"
- 3 "Are you satisfied with your ability to do things for fun outside of the home?"



For a list of free, validated PROMs questions, visit the [PROMIS website](#).

CMS has started incorporating PROMs into their Medicare reporting requirements¹—signaling an industry-wide shift to evaluate quality from the patient's perspective. However, despite widespread agreement with the need for a patient-centered quality measure, many providers hesitate to collect PROMs due to clinician data overload and patient survey fatigue.

Organizations successfully collecting PROMs start by clarifying how they'll use the data they collect and putting guardrails around survey design to boost response rates.

1) Patient-reported functional outcomes make up 12 of the 2019 Merit-Based Incentive Payment System quality measures.

Source: Health Measures, PROMIS Measures, <http://www.healthmeasures.net/explore-measurement-systems/promis>; Physician Executive Council interviews and analysis.

No shortage of PROMs use cases

Component 1: Identify and communicate how your organization will use PROMs data

Leaders must proactively communicate how they will use PROMs data to improve patient care. Partners HealthCare, a 10-hospital system in Boston, Massachusetts, identified four use cases for PROMs data, shown below.

Partners HealthCare's four "Cs" for PROMs application

The infographic is a light gray rectangular box containing four sections, each separated by a horizontal dashed line. Each section features an icon on the left, a bolded title, and a descriptive paragraph.

- Clinic visit customization**: Accompanied by a building icon with a cross. Text: "Physician reviews PROMs data prior to visit and uses information to guide conversation with patient, inform shared-decision making, and generate referrals, if needed."
- Compare internal performance**: Accompanied by a scale of justice icon. Text: "Organization identifies variability and opportunities for protocol improvement by comparing performance across providers, time, clinic, treatment modality, etc."
- Convince patients to choose partners**: Accompanied by a ribbon award icon. Text: "Organization uses PROMs data to demonstrate value of care over competitors in the market."
- Contract with payers**: Accompanied by a document icon labeled "CONTRACT". Text: "Organization uses PROMs as fodder to partner with government or payers on performance improvement initiatives."

The four use cases are not mutually exclusive, but if your organization doesn't currently collect PROMS, we recommend selecting a primary use case to gain clinician buy-in and guide survey design.

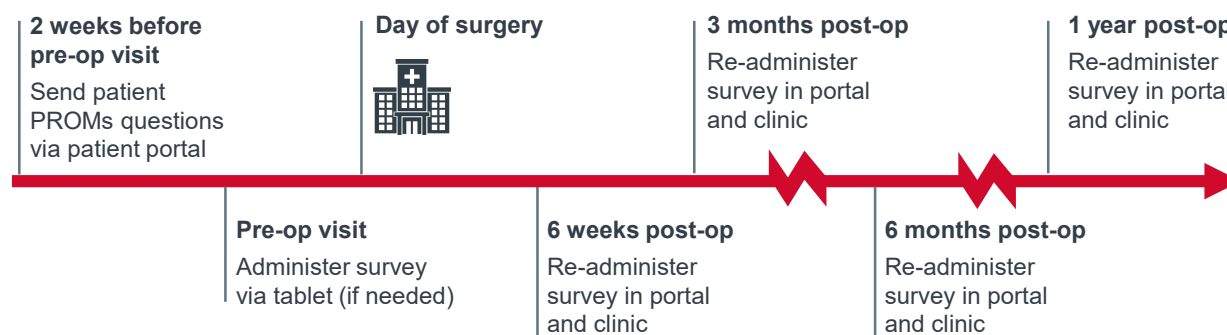
For example, one of the most compelling use cases for physicians is clinic visit customization. Reviewing patients' PROMs survey responses before a visit allows physicians to provide targeted feedback on the patient's concerns and set realistic goals throughout their care.

Making data collection doable

Component 2: Make it easy for patients to complete PROMs surveys

To meaningfully use PROMs data, organizations need a sufficient volume of patient responses. The challenge is that patients are already inundated with paperwork, and many fail to complete patient surveys. To boost response rates, Partners makes it easy for patients to complete PROMs surveys at multiple points across their care journey.

Partners' PROMs collection timeline for gynecologic oncology surgery



At Partners, surgical teams repeat PROMs surveys to measure how well patients' outcomes align with their goals over time. To minimize the burden of taking surveys, Partners limits them to 30 questions and gives patients multiple opportunities to fill them out. Partners sends surveys via the patient portal before a patient's appointment. They also provide tablets in waiting areas for patients who don't frequently use the portal or didn't have time to complete the survey before their appointment.

How to make PROMs surveys easy for patients to complete

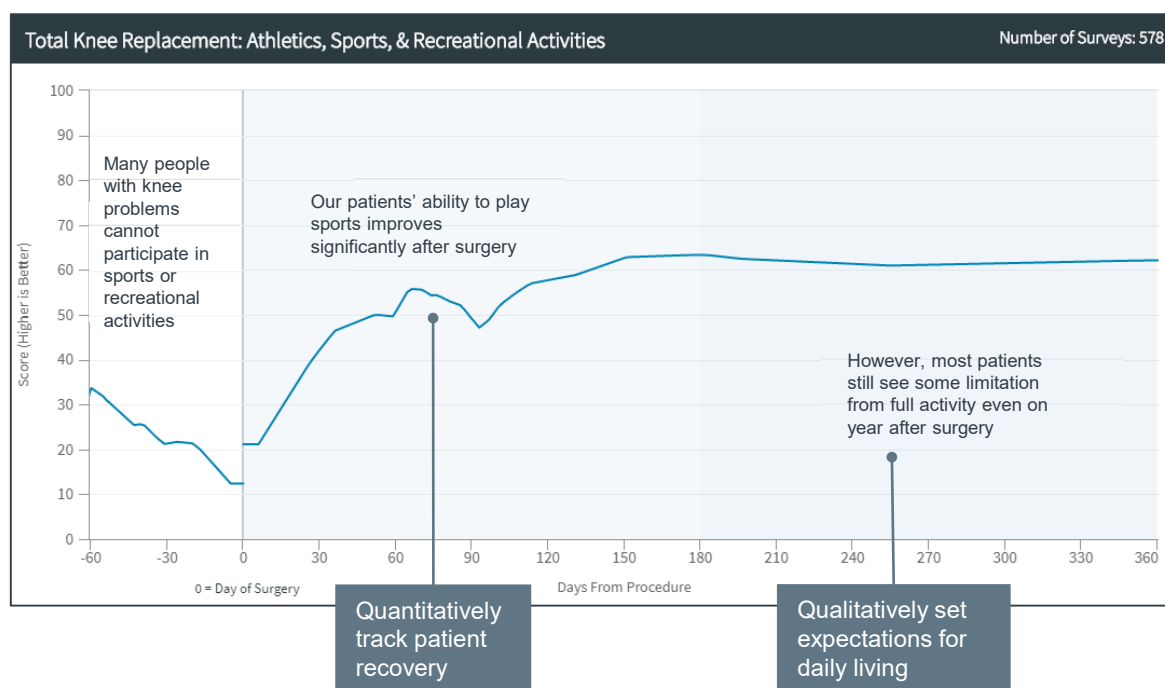
- Keep surveys to 30 questions or fewer
- Explain the value of PROMs so patients know what to expect
- Offer tablets in waiting room for patients to complete survey

PROMs give patients greater transparency

Not only does Partners use PROMs data to customize patient visits, the system also shares data with patients to help set expectations. Leaders at Partners recognized that elective surgery patients were increasingly shopping for care, but were struggling to identify high-value sites of care based on the available quality data.

In response, Partners started posting trended PROMs data on their website. The PROMs data—and narrative guidance on the chart—show patients what to expect based on their peers' experience.

Snapshot of Partners' PROMs public data for total knee replacement



While PROMs data doesn't replace key quality metrics that organizations regularly collect, it expands the definition of quality to better align patient and clinician expectations.

Available within your membership

The Physician Executive Council has developed many resources to help leaders improve patient experience. Select resources are shown here. All resources are available to members on advisory.com/pec.



Research report: Deliver a Quality-Driven Patient Experience for Polychronic Patients

Learn five ways to personalize support for polychronic patients by proactively identifying and addressing often overlooked care needs.



Infographic: 5 myths physicians believe about patient experience

Discover the factors that most inflect patient experience and how physicians are uniquely positioned to positively influence them.



Live on-site presentation: Deliver a Quality-Driven Patient Experience

Learn how to fundamentally shift your patient experience strategy by leading with quality improvement initiatives that simultaneously improve patient experience and engage medical staff in the process.



On-demand webconference: 'Influencer in Chief': How to win physician buy-in for your patient experience efforts

Understand the physician's unique role in patient experience as the leader of the care team and how to make the case for physician engagement in your patient experience initiatives.

Available online

To access these resources or order hard copies of the publications, please visit the Physician Executive Council's website: advisory.com/pec

Advisors to Our Work

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