Transforming the Patient Experience:
Consistently Delivering Safe, High Quality, Patient-Centered Care

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Overview

- Defining the Patient Experience
- The interdependency of safety, quality, and patient-centeredness
- High reliability organizing principles
- High reliability as an operating system or “chassis”
- Implementation examples
- The quadruple aim

Please note that the views expressed by the conference speakers do not necessarily reflect the views of Health Forum and the American Hospital Association.
Challenging Environment

- Increasing transparency of quality, patient safety, and cost performance and linkage to reimbursement

- The new healthcare consumer

- Competition for market share puts the focus on improvement of actual outcomes of patients (and efficiency)

- Imperative: achieve consistent execution and excellent results across multiple dimensions of performance

- Focus on meeting the needs of patients cost-effectively
The Patient Experience: More Than Just Satisfaction

- To meet the needs of patients:
  - Recognize the interdependency among safety, quality, and the patient’s experience of care

- Overall patient experience depends on consistently delivering on all three

- High Reliability: Delivering safe, high quality care with empathy and understanding for every patient every day

- Physician and employee engagement as the foundation
Better Clinical Outcomes

- Patient Experience is positively associated with clinical effectiveness and patient safety

  - Positive Associations 429 studies (77.8%)
  - No Association 127 studies (22.0%)
  - Negative Associations 1 study (0.2%)

British Medical Journal, 2013: [http://bmjopen.bmj.com/content/3/1/e001570.full#T3](http://bmjopen.bmj.com/content/3/1/e001570.full#T3)
### Table 2. Adjusted Association Between Hospital Star Rating and Patient Outcomes

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>Risk-Adjusted Mortality Rate, % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality Rate</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>11.2 (11.2-11.3)</td>
</tr>
<tr>
<td>2</td>
<td>10.7 (10.7-10.7)</td>
</tr>
<tr>
<td>3</td>
<td>10.5 (10.5-10.5)</td>
</tr>
<tr>
<td>4</td>
<td>10.4 (10.3-10.4)</td>
</tr>
<tr>
<td>5</td>
<td>9.8 (9.7-9.9)</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>22.9 (22.8-22.9)</td>
</tr>
<tr>
<td>2</td>
<td>21.8 (21.7-21.8)</td>
</tr>
<tr>
<td>3</td>
<td>21.0 (21.0-21.0)</td>
</tr>
<tr>
<td>4</td>
<td>20.2 (20.2-20.2)</td>
</tr>
<tr>
<td>5</td>
<td>18.7 (18.6-18.8)</td>
</tr>
</tbody>
</table>

Abbreviations: HRR, hospital referral region; ICU, intensive care unit.

* Adjusted for hospital size, teaching-status, profit-status, rural/urban status, ICU, and HRR fixed effects. Risk-adjusted patient outcomes were estimated using predictive margins. \( P < .001 \) for trend for both comparisons and was calculated by using the number of stars as a continuous variable in regression models. Regression models were weighted by the number of hospitalizations for each hospital. Our final sample consisted of 2434 hospitals for mortality analyses and 2430 hospitals for readmission analyses, after excluding hospitals with missing data on adjustment variables.
Effective Communication

- **Improves patient satisfaction**
  
  Like et al., 1987; Kaplan et al., 1989; Ong et al., 1995; Weinman et al., 1998

- **Decreased patient emotional stress**
  
  Roter, 1995

- **Improves adherence/compliance**
  
  DiMatteo et al., 1993; Squier et al., 1990; Brashers et al., 2000; Ciechanowski et al., 2001

- **Improves health outcomes**
  
  Woolley et al., 1978; Patrick et al., 1983; Stewart et al., 1995

- **Reduces medical errors and malpractice**
  
  Levinson et al., 1997; Lester et al., 1993; Beckman et al., 1994; Sutcliffe et al., 2004

- **Improves physician satisfaction**
  
  Suchman et al., 1993, Educ for Health, 2004
Engaged Physicians & Employees Impact HCAHPS

Employee Engagement Improves Patient Experience

Physician Alignment Improves Patient Experience

Top Decile  Bottom Decile

High Physician Alignment  Low Physician Alignment

Rate Hospital (0 - 10)  Recommend this Hospital

Reliability From Our Patient’s Perspective

Don’t harm me

Heal me

Be kind to me

... in that order

(Imagine your loved one here)
High Reliability Organizations (HROs)

“operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents.”

Managing the Unexpected (Weick & Sutcliffe)

Risk = Probability \times \text{Consequence}
How Safe is Healthcare?

- **Dangerous (>1/1,000)**
  - Health Care (1 of ~600)
  - Driving In US
  - Scheduled Commercial Airlines
  - European Railroads
  - Nuclear Power

- **Ultra Safe (<1/100K)**
  - Bungee Jumping
  - Mountaineering
  - Chartered Flights
  - Chemical Manufacturing

Total lives lost per year vs. Number of encounters for each fatality.
How Safe Would I Feel Being Treated as a Patient?

Percent of Responses to Question: I Would Feel Safe Being Treated as a Patient Here

Strongly Disagree | Disagree | Neither Disagree nor Agree | Agree | Strongly Agree
--- | --- | --- | --- | ---
2.5 | 5.9 | 11.9 | 49.7 | 29.9

Percent of Responses to Question: I Would Feel Safe by Position

<table>
<thead>
<tr>
<th>Position</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration/Management</td>
<td>10.0</td>
<td>42.1</td>
<td>47.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending/Staff Physician</td>
<td>19.0</td>
<td>42.7</td>
<td>38.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LVN/LPN</td>
<td>19.1</td>
<td>48.6</td>
<td>32.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Asst./Nurse Practitioner</td>
<td>16.9</td>
<td>55.4</td>
<td>27.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>23.8</td>
<td>51.7</td>
<td>24.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Res. Physician/Physician in Training</td>
<td>28.4</td>
<td>48.4</td>
<td>23.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strongly Disagree + Disagree + Neither Disagree nor Agree | Agree | Strongly Agree
--- | --- | ---

Journey to Reliability - Process + People

Optimized Outcomes

Human Factors Integration
- Intuitive design
- Obvious to do the right thing
- Impossible to do the wrong thing

Reliability Culture
- Core values & vertical integration
- Behavior expectations for all
- Hire for fit
- Fair, just, and 200% accountability

Process Design
- Evidence-based best practice
- Focus & Simplify
- Tactical improvements (e.g. process bundles)

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East Coast System Serious Safety Event Rate

80% SSER Reduction
74% Reduction in Lawsuits and Claims
Significant reductions in VAP, CLABSI, CA-UTI, Falls, others
Characteristics of a Reliability Culture

- Everyone exhibits a personal responsibility for safety
- Leaders demonstrate a commitment to safety
- Psychological Safety, Trust, and Respect
- Organizational Fairness/ Just Culture
- A questioning attitude is cultivated
- Widespread use of teamwork
Reliability Culture - Genius of the AND

Safety Focus + performed as intended consistently over time = No Harm

Evidence-Based Process Bundles + performed as intended consistently over time = Clinical Excellence

Patient Centered + performed as intended consistently over time = “Satisfaction”

Financial Focus + performed as intended consistently over time = Margin

RELIABILITY CULTURE
“Failure Prevention”
Using the High Reliability Chassis

1. Create and articulate a shared vision
   - Put the patient at the center of care
   - Patient safety as a core value
   - Include safety, quality, and patient-centeredness

2. Design leadership method and staff/physician behaviors with the vision in mind

3. Identify high-leverage structures/tactics
   - Look for opportunities to use a single structure/skill to improve all three
     - Start meetings with a message/story
     - Daily house-wide huddle
     - Leadership rounding
     - Unit coaching
     - Teamwork skills
High Reliability Principles

- Preoccupation with Failure
- Reluctance to Simplify
- Sensitivity to Operations
- Commitment to Resilience
- Deference to Expertise

Investigating Near Misses
Root Cause Analysis
Daily Safety Huddle
Simulation
Leader Rounding

20
HRO Principle #1

Preoccupation with failure
Preoccupation With Failure
Case Study

Investigating near misses
HRO Principle #2

Reluctance to simplify
Reluctance to Simplify Case Study

Root cause analysis and event investigation
HRO Principle #3

Sensitivity to operations
Sensitivity to Operations
Case Study

Advocate’s Daily Safety Huddle
HRO Principle #4

Commitment to resilience
Commitment to Resilience Case Study
HRO Principle #5

Deference to expertise
Deference to Expertise Case Study

Leader rounding
Round to Influence (RTI)
a High Impact/Low Investment Leadership Method

A technique for reinforcing a vital behavior or performance expectation linked to a core value

- Focused on building a culture of reliability that creates safety... and quality, satisfaction, financial performance, etc.

- The key word in RTI is Influence
Leader Rounding for Outcomes 2014

- **Influencing Questions:**
  - Focused on a specific topic
  - Provides stories to connect to a core value
  - Information for leaders when dealing with an unfamiliar or difficult subject
  - **Not intended to be read to associates**
RTI Script: Prepare to Influence

**Greeting:** Hello! Do you have a few minutes for a brief conversation about ________

<table>
<thead>
<tr>
<th>Core Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Relate to our core value of safety protecting patients and employees from harm</td>
</tr>
<tr>
<td>❑ Tell a story or share facts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can Do’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Review practice expectations and share facts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Ask, “What makes this hard to do?”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Questions to foster commitment actions:</td>
</tr>
<tr>
<td>✔ What will you do to make this your habit?</td>
</tr>
<tr>
<td>✔ How will you help others do it?</td>
</tr>
<tr>
<td>✔ STOP if you see a safety risk</td>
</tr>
</tbody>
</table>
High Reliability Principles and the Triple Aim

- Preoccupation with Failure
  Improving the Individual Experience of Care

- Reluctance to Simplify
  Improving the Health of Populations

- Sensitivity to Operations

- Commitment to Resilience
  Reducing the per Capita Cost of Care

- Deference to Expertise
What is Missing from the Triple Aim?

- Burnout in US physicians increased from 45% in 2011 to 54% in 2015
- 60% of physicians are considering leaving clinical practice
- 70% of physicians knew a colleague who left practice due to poor morale
- 51% of US registered nurses felt their job was affecting their health
- 1 in 3 US nurses felt like leaving the healthcare workforce
The Quadruple Aim

1. Improving the Individual Experience of Care
2. Improving the Health of Populations
3. Reducing the per Capita Cost of Care
4. Improving the Experience of Providing Care
   - Workforce engagement – joy and meaning in work
   - Workforce safety

Three Key Questions for the Fourth Aim – from Paul O’Neill

1. *Am I treated with dignity and respect by everyone, everyday, by everyone I encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade or number of degrees?*

2. *Do I have the things I need: education, training, tools, financial support, encouragement, so I can make a contribution this organization that gives meaning to my life?*

3. *Am I recognized and thanked for what I do?*
Summary

- Safety as a core value
- Key elements of patient experience
  - Safety, Quality, and Patient-Centeredness
- Organize care using high reliability operating principles
- Use the “chassis” to improve the other dimensions of the patient experience
- Use high reliability structures/approaches for multiple purposes
- Quadruple aim - physician/employee engagement