CONSUMER EXPERIENCE IS A TOP PRIORITY for health system executives. A great experience can improve loyalty and strengthen a health system’s brand, supporting patient retention and Medicare bonus payments from positive HCAHPS scores. A focus on improving the consumer experience is being driven by disruptive care alternatives that attract consumers with convenience and lower costs, the digital transformation occurring in other industries that changes consumer expectations for healthcare services, and the continued shift of services outside the walls of the hospital. Stephen Mooney, president and CEO of Conifer Health Solutions, discussed this topic with four healthcare executives at the Modern Healthcare Leadership Symposium on October 11, 2018.
Stephen Mooney: The Beryl Institute defines the patient experience as “the sum of all interactions shaped by an operational organizational culture that influence patient perceptions across the continuum of care.” How do you define the patient-consumer experience? What top initiatives are driving your organization to improve it?

Randy Oostra: I think whenever you use the word consumer, we immediately define the consumer as a patient, but I don’t think a person defines themselves as a patient. That’s probably the biggest problem we have in healthcare, it’s how we look at people. Take any young person that works for us: they don’t define health and well-being from a patient perspective, they define it from a consumer perspective. What I worry about is that we’re already going at it the wrong way: healthcare leaders are thinking of “consumer-friendly” initiatives for patients, as opposed to thinking, what do consumers really want?

Teri Fontenot: Agreed. We’re working on redefining patients as guests and consumers. As a women’s health system, most of our work is elective, so our patients have a choice. Patients are very discerning now, and it’s not just the younger generation. More of them don’t want face-to-face interaction—they want to know how to stay healthy and many prefer not to come into the hospital unless it’s necessary. We’re focusing on statewide telehealth for the high-risk and subspecialty services we offer. Locally, access is available through online scheduling and virtual visits, but there is still an opportunity to expand through technology. Our medical staff is still primarily private practice, so convincing them that we need to be making consumer-friendly changes can be difficult because it forces them to do something that’s out of their comfort zone, is inconvenient or has a cost. But, adoption typically accelerates once three or four physicians buy in and others begin to see the benefit.

Pamela Abner: I think for us, it’s the culture. We’re in New York City, which has so many different populations, people and backgrounds. We’re constantly stressing the importance of bringing each patient’s respective culture into the way you treat them. We’ve educated our staff on unconscious bias—it’s not just doing an education session and walking out of the room and thinking everyone’s miraculously better. We encourage our staff to always be thinking about the biases they bring into the room every time they speak to someone. We talk to staff about how to speak to patients and families and how to ask open-ended questions so as not to offend. There’s too many different populations of people to assume that everyone’s care is falling into the same arena.

Dennis Dahlen: Our largest campus is in Rochester, Minnesota, where Mayo Clinic was founded more than 150 years ago and where the population is fairly homogenous and non-diverse, so we’re doing lots of work on unconscious bias, most of which has been eye-opening. One of the more impactful moves we made this past year at Mayo was a choice to not accommodate patient requests that stemmed from bias against their caregivers. This was a big deal for our leadership because of Mayo Clinic’s patient centricity but was a bigger deal for our staff, as it showed them we have their back in support of diversity and inclusion.

SM: How do you culturally shift your organization to be consumer-centric? How do you measure progress and understand whether it’s working?

DD: Many healthcare leaders grew up as legacy hospital providers, with ideas on the patient-provider relationship formed solely in the context of the time a patient spends as an inpatient, an incredibly intimate setting. If you think about where most healthcare dollars are spent and with the march of technology and advancement of medicine, most of the interactions are not intimate and don’t need to be. We have to get past this need for an intimate relationship and the effort to build all of our processes around it because people don’t...
always want it. I’m not sure I want it. The strategy has got to be, ‘How do you get the organization to adopt the mindset of the consumer which desires easy, fast and, well-informed care?’

TF: There are specific tactics in our strategic plan for which the board and executive team have made a commitment. We talk about it in terms of improving population health and community health. People in these categories are consumers initially, but often become patients. Once we identify a need that we can focus on, measurable goals and timelines are set and monitored. The goals, process and progress are shared with leaders and their teams.

PA: It's about being respectful and providing the care that patients need and how they want to receive it. We want to constantly customize our thinking around the individual and what the patient needs, versus just applying one kind of an approach.

SM: How are the niche, specialized players in your market, like urgent care clinics and freestanding EDs, addressing the needs of your consumers? How do you compete effectively?

RO: You see all these folks that you compete with, and they are quick and they are nimble and they don't have the necessity to focus on all that we have to. You worry that we're not changing fast enough. You think about the complexity of our organizations — all the things we're focused on — and then there are urgent care providers who just do that all day long. And, for us, you worry that we're not able to put in the time and resources that others can, just because of the complexity of what we do.

DD: I think one of the biggest issues here is how we look at the patient from our traditional viewpoint, and how folks that are taking business away from legacy providers look at it very differently. They're testing our ability to get out of our four walls and think incrementally. I think for healthcare, these disruptive players have got to be one of our biggest concerns, but also opportunity. They're moving quickly, they have a much smaller footprint and they are looking at things very narrowly in their efforts to create better access with more convenience. The future is more likely a series of niche providers that are connected via data and communication. What's left over are things nobody wants to do or services that are not economically attractive.

TF: What you're all saying is true. I've worked in general hospitals and it can be like a Whack-a-Mole game. The focus often shifts to whatever's trendy or feels like a competitive threat. Our hospital will be 50 years old next month and it can be a struggle to remain in our lane and not be distracted by new opportunities. Every time we update our strategic plan, we start with a deliberate conversation about expanding into services outside of women's health or continuing to build depth and geographically expand within women's services. We keep coming back to the latter. I think there's a role for specialty hospitals, and the benefit for general hospitals is partnering with these organizations that are focusing on specific populations without trying to absorb them.

It's about being respectful and providing the care that consumers need, how they want it. We want to constantly customize our thinking around individuals versus just applying one kind of an approach, depending on what that patient may do.”

Pam Abner
VP and Chief Administrative Officer
Mount Sinai Health System
SM: Have you had discussions internally about the future of patient data, and patients’ ability to take ownership over their medical data?

DD: Today we all believe the medical information that we’ve collected on patients, gathered on patients, is really ours. That foundational concept seems to me a limited duration scenario. Sometime very soon, patients or consumers will own their own data, it will be portable, and there may even be a cost to utilize it in research. Changes on that front hold promise for price and convenience, moving past what is today mostly a barrier to customer service.

RO: Think about all the data though. You’ve got medical information, you’ve got personal screening information, you’ve got CRM data, you’ve got predictive analytics, you’ve got genetic information. As a consumer, you’d want that all integrated into one. How that gets done is fascinating. If that ever comes together, I would hope that healthcare organizations are at the center of that, not somebody else. We must move fast, because I think there’s a tremendous market around consumer centricity.

SM: How about the physician role in patient engagement, today and in the future? How do you think the physician plays into the emerging era of healthcare consumerism?

TF: We’re asking physicians to rethink the way they’ve practiced for many years. They are constantly being asked to do things that are uncomfortable or negatively impact their productivity, but they are still ultimately responsible for that patient’s care. But, in women’s health, physicians and patients have a special, often life-long relationship, so physician support is critical.

PA: I think the physician role in patient engagement can vary so much in our environment because it depends on who we’re speaking about. I don’t believe that every patient has the same comfort level and health literacy to say to their physician, “you know what, this isn’t working for me, I’m going elsewhere.” Some people will, but others will say, “I’ll take what I can get,” because they don’t even understand how to navigate the system.

RO: Whether it is culture, data, technology or services, you have to ask the physician again to do “one more thing.” How do we create a more comprehensive approach that says, “we’re going to wrap this around the clinician so that as you practice, the consumer piece will fit in very logically and hopefully make your life a lot easier?” That’s as opposed to just telling them, “you need to be more consumer-friendly.” It’s about surrounding clinicians with an organization and infrastructure that delivers an amazing experience.

Randy Oostra  
President and CEO, ProMedica Health System

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