Perspective Shifting: Engaging Leaders-of-Leaders in Patient and Caregiver Experience

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Abstract
Leadership drives quality, experience, and engagement. It is the responsibility of the organization to equip its leaders with ongoing education and professional development. This case article explores the development, implementation, and impact of an immersive patient experience leadership education course across a large, integrated health system. Placing senior leaders on the “other side of the hospital bed,” they were able to emotionally connect and personalize to the human side of health care. Post-course surveys validated that experiential role play was a positive and insightful method to teach and bring heightened awareness to patient and family member experience.

Keywords
leadership, development, patient experience, experiential learning, empathy

Introduction
Transformative leaders drive and foster organizational culture. In health care, effective leadership impacts quality outcomes and patient experience (1,2). As a unique subset within the health-care ecosystem, senior clinical, physician, and administrative leaders require specific ongoing professional development. To support this imperative, the National Center for Healthcare Leadership is dedicated to optimizing the health of the public via leadership, interprofessional, and cross-industry perspectives and evidence-based practice (3). The Duke Healthcare Leadership Model is grounded in the core principle of patient centeredness and includes competencies of emotional intelligence, teamwork, selfless service, integrity, and critical thinking (4). Sonnino wrote, “Outcomes research has shown that healthcare leadership training is most effective when it takes place over time, is comprehensive and interdisciplinary, and incorporates individual/institutional projects allowing participants immediate practical application of their newly acquired skills (5).” This article describes an innovative, experiential educational program focused on teaching patient and family experience to a leaders-of-leaders subset.

Historically, leadership has evolved from an authoritarian model, to a collaborative approach, empowering teams to accomplish goals (5). The concept of “followership” has been described as a leadership characteristic—how effective a leader is able to engage and utilize team feedback to make informed decisions (6). Within the complex health-care industry, leaders must be knowledgeable, flexible, innovative, pragmatic, and forward thinking. The organization is therefore responsible for ensuring they are equipped with ongoing technical, interpersonal, and critical thinking development opportunities.

Northwell Health is a large integrated health-care organization comprised of 72,000+ employees, 23 hospitals and 750+ ambulatory practices across New York State. The system Office of Patient & Customer Experience (OPCE) led by its Chief Experience Officer and Vice President has a mission to inspire, challenge, and lead the organization to design and deliver experiences patients and families desire. In 2019, Northwell’s internal corporate university, Center for Learning and Innovation, realized a systemic need for high-impact leadership development resulting in the formulation of a leader-of-leaders program. Participants included individuals

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Table 1. Patient Experience Course Curriculum Agenda.

| Time            | Duration, minutes | Plan                                           |
|-----------------|-------------------|------------------------------------------------|
| 8:00-8:30 AM    | 30                | Breakfast, welcome, introductions, & patient story |
| 8:30-9:00 AM    | 30                | Setting the stage for patient experience        |
| 9:00-9:45 AM    | 45                | Shifting perspectives: experiential learning component |
| 9:45-10:00 AM   | 15                | Break                                          |
| 10:00-10:45 AM  | 45                | Shifting perspectives debrief                  |
| 10:45-11:30 AM  | 45                | The state of Northwell’s Patient Experience    |
| 11:30 AM-12:00 PM | 30            | Lunch, gratitude activities & closing thoughts |

with titles such as Chief Operating Officer, Associate Executive Director, Chief Physician, and Vice President. Chosen for their influential role in change management, each performed a self-assessment to identify which servant leadership characteristics and/or organizational focuses are their individual strengths and opportunities for development. The survey included topics such as empowerment, motivating others, engagement, finance, patient experience, and so on. As a result, program pathways were individually crafted with varying course topics. This article will only discuss the Patient Experience course component.

Description

Knowles’ Adult Learning Theory is based on 4 principles: involved learners, active participation and experience, problem-solving, and immediate relevance and impact (7). Leveraging those principles, OPCE created a 4-hour course held twice at two Northwell hospitals. Since the 17 participants represented the depth and breadth of the organization, significant time for introductions and networking was intentionally designed. Patient letters were read aloud, showcasing the power of storytelling, experience successes, and missed opportunities. Through didactics, presentations, and small group activities, participants learned the evolution of patient experience, the art and science of experience design, high-level experience metrics and performance trending along with Northwell’s patient experience strategy, organizational focuses, and future planning.

Immersive role play, entitled “Shifting Perspectives” was the program’s hallmark component; see agenda in Table 1. Each leader participant was assigned to a role of either “Patient” or “Family Member,” and given persona cards with a temporary identity—name, date of birth, chief complaint, past medical history, occupation, and personal life details. In this context, the “FamilyMember” is referring to a care partner and/or close relative of the patient, such as husband or daughter. Team members from the system and hospital patient experience teams acted as the frontline “Healthcare Professionals,” roles such as nurse, radiology technician, physician assistant, and so on.

The 45-minute role play occurred within actual patient care areas including Emergency Departments, Ambulatory Surgery, and inpatient units. We specifically did not use mock learning environments, one that simulates or emulates a hospital unit or department, because we believe leaders needed to see firsthand the reality of patient care. “Healthcare Professionals” were given specific positive and negative interactions to perform, verbal and nonverbal. “Patients” wore hospital gowns, identification bracelets, were transported via wheelchair, laid on stretchers and hospital beds, and actively engaged in admissions and physical assessments. “Family Members” followed alongside the “Patient” acting as supporting advocates and care partners. All participants were instructed to remain in-persona throughout the entire scenario.

Throughout the role play, “Patients” and “Family Members” journaled observations, feelings, and reflections on a provided document. They were also given specific tasks or questions to complete during role play (ie, complain about noise, express anxiety, ask relevant questions). Immediately following, a facilitated debrief occurred, still in-persona. Participants were guided to openly discuss their experience and how it will influence them as leaders moving forward. The session concluded with a series of recognition activities, such as a gratitude circle and writing “Thank You” cards emphasizing the appreciation of leadership efforts of participants throughout the course, highlighting the connection between engagement and experience. Leader participants and “Healthcare Professionals” then enjoyed a meal together, prepared by the hospital’s executive chef, where an emphasis was placed on our organization’s commitment to food as care.

Results

Course impact was measured via debrief themes and postcourse evaluation surveys. The in-session open discussion revealed deep appreciation for the opportunity to firsthand experience hospital departments. “Patient” and “Family Member” participants shared how they felt in their roles—scared, overwhelmed, and vulnerable. Most commented how they have a newfound emotional connection to employees, patients, and family members. Positive interactions, attitudes, and behaviors of the “Healthcare Professional” were noted and appreciated; however, the negative interactions had a lasting impression and therefore, impacted overall experience. In one scenario, a “Healthcare Professional” downplayed a “Patient’s” expression of anxiety, replying with a sentiment of “it’s not too bad.” During the open discussion, this passive comment had the biggest impact of the “Patient’s” overall experience because how a lack of empathy made the care feel “robotic” and “disconnected.”

Leader participants voluntarily completed an electronic postcourse survey, including 7 Likert-scale questions and 2 open-ended prompts. Participants (n = 12) reported “strongly agree” for all questions; Table 2. Participants provided
positive feedback, further reflecting upon the impact of role playing, the interactive nature of the course, the presenters, design, and detail of the experiential learning component. Suggestions highlighted the desire for a longer experiential learning component, the possibility of playing the roles of both patient and family member, and having the course as a requirement for all health system employees. One leader participant stated, “This course was not only the best training and learning session I have had here at Northwell, but in my entire career.”

Lessons Learned

Investing in leader-of-leaders is essential to an organization’s success. Utilizing an innovative and experiential-based program enabled perspective shifting and deep reflection. Representing clinical, nonclinical, and administrative functions, leader participants were intentionally taken out of their comfort zone and exposed to realities of frontline health-care delivery. This led to enhanced organizational awareness and fostered an environment of best practice sharing. Participants left the session acutely tuned into how environment shapes clinical interactions, focusing their teams on reducing clutter, improving signage for wayfinding, and eliminating unnecessary noise. They validated the importance of relationship centered communication skills along with the power of empathy and humanism, leading to more educational offerings and huddles being offered to frontline teams. Engaging patients and families in the decision-making process was a major takeaway from the participants. In their reflections, they repeatedly verbalized how listening to the “voice” of patients and families can improve processes and best serve our diverse communities. An unintended consequence has been the overwhelming amount of interest to bring this opportunity to various health-care settings and organizations because at the core, it exposes leaders to how patient and family experience is holistic—an accumulation of culture, process, hospitality, and accountability. By engaging leaders-of-leaders there is an absolute ripple effect. When they are more knowledgeable, aware, engaged, and inspired, they will bring forth those tenants to their daily leadership responsibilities.

Conclusion

At Northwell Health, we believe that every person, every role, every moment matters. This program is highly transferable to various health-care settings and organizations because at the core, it exposes leaders to how patient and family experience is holistic—an accumulation of culture, process, hospitality, and accountability. By engaging leaders-of-leaders there is an absolute ripple effect. When they are more knowledgeable, aware, engaged, and inspired, they will bring forth those tenants to their daily leadership responsibilities.

Acknowledgments

The authors acknowledge the Northwell Health Center for Learning and Innovation for their vision in creating a forum for interdisciplinary leadership development. Dedicated patient experience leaders, Michelle Rossetti of Long Island Jewish Valley Stream Hospital (LIJVS), and Cheryl Miranda of Huntington Hospital (HH) and their respective teams played an essential role to the program’s success. The authors also thank Sven Gierlinger, SVP Chief Experience Officer, for his support as well as the leader participants for their time and contributions.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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