MD to MD Coaching: Improving Physician–Patient Experience Scores: What Works, What Doesn’t

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Abstract
With increasing national focus on patient experience scores through public reporting and the Value-Based Purchasing Program, hospitals and medical groups are challenged with initiating sustainable programs to improve their scores. Our system initiated 3 pilot programs to determine which approaches and techniques would be the most beneficial. The pilot trails included: (a) MD to MD 1:1 coaching with monthly MD-specific individual reports; (b) all staff patient experience training sessions at two of our urgent care centers; and (c) physician group patient experience training at one of our outpatient clinics. This article describes our 3 pilot initiatives and results that have been obtained.

Keywords
patient/relationship-centered skills, communication, value-based purchasing, physician engagement

Introduction
Public reporting of patient views on their experiences with physicians has prompted some physicians and physician groups to focus more attention on improving patient experience scores. Many groups have started to provide financial incentives for physicians who meet certain metric goals. However, imposed metrics without the necessary tools to help the physicians improve only lead to aggravation and continued resentment toward patient experience initiatives. In addition to physicians being affected, the CMS Value-Based Purchasing program now includes 25% of its value in the patient experience arena, and therefore, hospitals are now under increased pressure to improve their scores or face substantial financial losses.

For physician buy in, providing information on the question of “What’s in it for me?” is an integral component in any change management initiative. Stelfox et al showed that physicians in the lower third of patient experience scores were 110% more likely to face a medical malpractice lawsuit than those in the top third. Seventy-five percent of these cases were related to communication failures (1).

Therefore, having a positive patient interaction not only helps to maintain market share and improve financial reimbursement but also helps to decrease the threat of litigation. The value of physician to physician communication cannot be overemphasized particularly in regard to conversations regarding statistical significance of the survey results and the sometimes inherent resistance to change that is often encountered with new initiatives.

Program Description and Objectives
The purpose of this study was to investigate processes that would engender and sustain improvement in individual physician experience scores. The researcher hypothesized that physicians and groups who sought assistance would have the greatest improvement in their patient experience scores due to a vested interest in their personal scores versus those who were forced to have coach assistance and may resist change.

Key initiatives included:
Pilot 1: Feedback on communication style: 16 physicians were included in this trial and were identified by their division directors due to their low patient experience scores. Two groups were identified, the first was a self-referral group and the second was considered a “forced coaching” group. In the first study group, 11 physicians personally reached out to the physician coach when they desired a shadowing session or assistance with using key phrases in their consultations.

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practice. The second study group in this pilot included 5 physicians who were informed that they would have an MD coach shadow with them for a few hours and provide focused, real-time feedback after review of their score cards. They were not given the choice as to whether they would like to have this bedside shadowing and were not required to personally contact the physician coach. The coach contacted them directly to set up a time to see patients with them in their practice. Baseline patient experience scores were obtained based on when the coaching request was received.

The physician improvement tips were deliberately kept simple and focused and started with the “Big 3”—Knock, Sit, Ask. Knocking shows that there is respect for patient privacy; sitting makes the patient feel as though the physician is not rushed; and asking the question “What is your greatest concern?” addresses the patient’s true reason for seeking medical attention. In a study by Johnson et al, patients overestimated the time a physician spent with them by 15% if the conversation was held sitting down. Conversely, patients underestimated the physician spent with them by 8% if a similar conversation was held with the physician standing (2).

Physicians in both groups had their monthly patient experience reports reviewed in person with them with the physician coach. Tips were offered on key areas where improvement was most likely to be easy to accomplish. These physicians were then observed in their own practice settings while seeing real patients. The physician coach was introduced as a member of the patient experience team visiting from the corporate office. Feedback was given privately after each patient was seen and not directly in front of the patients or caregivers. Alternatively, the physician coach modeled the behavior by using some key phrases that were pertinent to the encounter. After each patient visit, the physician coach spoke with each patient/caregiver to obtain real-time feedback as to how their visit was. This feedback was then given to the physician. No checklists were used when coaching physicians as this was felt to be daunting and intimidating and would inhibit physicians from reaching out for assistance. The coaching sessions were intentionally kept as stress- and anxiety-free as possible. These interventions allow feedback that is more targeted and robust than possible with just monthly reviews of physician-specific patient experience reports at division/department meetings.

Pilot 2: The first urgent care study group participated in a 1 hour full staff educational sessions that focused on review of the patient experience survey, review of the data, provision of simple key phrases, and when possible evidence-based literature to support the recommendations. Eighteen physicians were in attendance during these sessions. The second urgent care study group also participated in a 1 hour educational session but did not include all staff levels and was primarily physicians with a few staff nurses who were available to attend. In this pilot, 13 physicians were provided with their specific monthly patient experience reports in order to provide direct feedback. In addition, the hope was that the data would result in some self-correction after the patient experience teaching sessions were held.

Pilot 3: In our outpatient, primary care clinic, similar two 1-hour group training sessions that were held for pilots 1 and 2 were held with the MD coach. In addition, the clinicians were provided with their monthly MD-specific individual Press Ganey patient experience scores. Approximately 18 physicians from pediatrics, family medicine, and internal medicine were in attendance.

Results

In the first pilot, physicians who sought this individualized coaching improved their patient experience scores by an average of 56 percentile (Table 1). Those who were forced by their division directors to go through the process only marginally improved with an average increase of only 7.6 percentile. Table 2 illustrates an example of post–team coaching improvement in both the nurse and MD scores of 2 primary care physicians and their nursing partner. This highlights the importance of mutual managing up techniques in improving the scores of both the physicians and nursing staff.

In the second pilot, overall urgent care physician group scores increased by an average of 19 percentile (69th to 91st percentile and 70th to 86th percentile, respectively) over a 1-year study period. In addition, in the first urgent care, the overall score of the urgent care improved from 25 percentile to 50 percentile during the same study period and sustained the following year.

In the third pilot at our outpatient clinic, overall physician scores improved by 29 percentile and improved from a pre–pilot fiscal year 2015 percentile rank of 41 (mean score 93.2%) to an ending fiscal year 2016 rank of 70th percentile (mean score 94.7%).

Lessons Learned

Tools to improve doctor–patient communication—physician to physician coaching, real-time targeted feedback, and ongoing monthly individualized review of patient experience scores—are most useful when they are part of a concerted

| Table 1. MD Improvement After Self-Referral: 11 Physicians With an Average Improvement of 56 Percentile on the Question of Clinical Provider Standard of Care. |
|-----------------------------------------------|
| Mean precoaching score | 84.5% | Mean postcoaching score | 92.% |
| Precoaching percentile PG DB rank | 25.3 | Postcoaching percentile PG DB rank | 81.5% |
| Abbreviation: PG DB, Press Ganey database. |
and sustained improvement effort in which the physician personally seeks to improve. Our results highlight the importance of physician buy in to any change management process. Prioritizing improved communication by providing monthly individualized reports as well as blinded department individual physician results so that physicians can see where they stand in comparison to other department peers creates a culture that values the voice of the patient.

Furthermore, group staff training sessions with a focus on “managing up” can significantly improve physician patient experience scores as well as improve overall site scores. “Managing up” is an essential part of any patient experience improvement effort as it not only provides the patient with confidence in the team that is taking care of them but helps to build team morale which is vital in this ever-changing and increasingly stressful health-care environment. Physicians are facing up to a 55% burnout rate in certain specialties (3); therefore, having a supportive environment is critical.

**Conclusion**

This study highlights the importance of ongoing attention to the data with direct physician support. The provision of practical and easy-to-implement tips as well as a focus on monthly individual MD-specific feedback reinforced that small behavioral changes can dramatically improve the percentile rank with relatively minimal changes in the mean score.

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**References**

1. Stelfox HT, Gandhi TK, Orav EJ, Gustafson ML. The relation of patient satisfaction with complaints against physicians and malpractice lawsuits. Am J Med. 2005;118:1126-33.
2. Johnson RL, Sadosty AT, Weaver AL, Goyal DG. To sit or not to sit? Ann Emerg Med. 2008;51:188-93.e1-2.
3. Carol Peckham/Medscape Lifestyle Report 2016: Bias and Burnout. 2016. http://www.medscape.com/features/slideshow/lifestyle/2016/public/overview

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