Thank you all for joining on behalf of Doctor Nita Ahuja, our interim Cancer Center director at Yale Cancer Center, doctor David Fisher. Want to invite everyone to sit back and enjoy this? It’s going to be a wonderful presentation by Doctor Jessica Dudley. But before we get to Doctor, Dudley wanted to talk about the Iris Fisher Lectureship which was endowed in 1999. And since then, we’ve been very fortunate.
to have some pretty amazing speakers.

I think last year was Doctor Ethan Bosch, when I remember Doctor Fisher has over a 60 year history with Yale School of Medicine. He was and is the first medical oncologist for the New Haven community. It was in private practice, but then came over full time faculty in 1995. Obviously he’s had countless contributions to the Yale School of Medicine. It was in private practice, but then came over full time faculty in 1995. Obviously he’s had countless contributions to the Yale School of Medicine. He was and is the first medical oncologist for the New Haven community. It was in private practice, but then came over full time faculty in 1995. Obviously he’s had countless contributions to the Yale School of Medicine.

But really important for today is Doctor Fisher’s wife. Iris was the diagnosis,
sarcoidosis and incurable disease and really a lot of the decision making in terms of you know what types of treatment and quality of life in terms of her personal well being are really immortalized in this in this lectureship. So you know, it's it's really phenomenal that we get to do this every year and bring them, you know, fantastic faculty. And people around the country and around the world to to be able to present we of course wish that doctor Jessica Dudley was here in person.
but maybe we’ll get a rain check.
Or, you know, inviter.
Invite her in the next couple of months
Moving on to doctor Jessica Dudley, she’s the Chief clinical officer for Press, Gainey, and you know this is what the focus
of her talk is going to be on.
But really, I wanted to take a few moments
just to talk about my personal relationship with Doctor Dudley. She was my chief medical officer when I was on faculty at Brigham
Women’s physician or organization.

And really, you know, looked up to her as my mentor. She really helped me navigate many crises, whether it was in the care of our patients in my area specifically and in breast cancer patients, and he really even personally through some of the things that I had to go through. And you know, a huge loss for the Brigham, you know, real amazing game for a press ganey. And it’s absolutely phenomenal that...
that she’s here with us today.

I did want to share one quick picture because I’m not dressed up,

but this was my 2010 clinical collaboration award.

That I want from was awarded by the Brigham Women’s Physician Organization.

I had a little bit more here.

There Doctor Dudley has not changed a bit,

and with that I’d like to pass on the floor to Jessica.

Thank you so much for being very proud of you, but ’cause I was
NOTE Confidence: 0.9903127
00:03:21.678 --> 00:03:23.790 thinking about when I took the job
NOTE Confidence: 0.9903127
00:03:23.790 --> 00:03:25.561 at the Brigham hold and I'm just
NOTE Confidence: 0.9903127
00:03:25.561 --> 00:03:27.513 trying to get to the to my slides.
NOTE Confidence: 0.9903127
00:03:27.520 --> 00:03:29.794 When I took the chief medical
NOTE Confidence: 0.9903127
00:03:29.794 --> 00:03:32.030 officer job at the Brigham.
NOTE Confidence: 0.9903127
00:03:32.030 --> 00:03:33.686 In my job description,
NOTE Confidence: 0.9903127
00:03:33.686 --> 00:03:35.756 actually was hosting that gala
NOTE Confidence: 0.9903127
00:03:35.760 --> 00:03:38.730 and I know I thought, you know,
NOTE Confidence: 0.9903127
00:03:38.730 --> 00:03:40.320 I had this big population health
NOTE Confidence: 0.9903127
00:03:40.320 --> 00:03:42.057 background and was very focused on care,
NOTE Confidence: 0.9903127
00:03:42.060 --> 00:03:43.890 innovation, and then the gala,
NOTE Confidence: 0.9903127
00:03:43.890 --> 00:03:45.864 which was a wonderful event to
NOTE Confidence: 0.9903127
00:03:45.864 --> 00:03:47.960 celebrate all of our physicians.
NOTE Confidence: 0.9903127
00:03:47.960 --> 00:03:49.570 But having to pick out a dress
NOTE Confidence: 0.9903127
00:03:49.570 --> 00:03:51.480 to go to the Gallic you just
NOTE Confidence: 0.9903127
7
brought back a lot of stress, 
but that’s it’s all good. 
It’s all behind me now. 
Great, so thank first one. 
So honored to be here to speak 
And thank you Doctor Fisher for this 
incredible honor to be presenting 
at this specific grand rounds and 
Mira and all for inviting me here. 
I am really excited to spend this 
time with all of you and I have quite 
a few slides and my goal is not to 
kind of bury you in these slides. 
My goal is to hopefully engage 
you in thinking about.
These issues, and I think things that you've probably come to know, think about quite a bit, but hoping that by the end of this, maybe I can shine a different light on it and share a little bit of a different perspective and one that hopefully going forward we can work with each other and continue to grow.

Richard, sorry to present.

You're showing like the next slide. OK, so let me work on that 'cause I was worried about this and I'm trying to get it in.
Sorry yeah it’s supposed to be in the slideshow mode, but it sounds like it’s not. Not yet. Hold on one second. Give me a second. Give me one second stop share. And I have that sound on share screen and then this should pop it into. Is it still? Are you still getting my notes page? Oh, got it, you’re great. OK, let me know if they pop up ’cause I’ll just kill it if that happens. Seems fine, OK, great.
OK, let’s get going.
So I called this two sides of the same coin.
UM, patient experience and clinician engagement.
And I came to press ganey Asmira was saying two years ago and I don’t think I really understood then what I do understand now.
Which is it really is two sides of the same coin meaning and and I can like feel that, but I’m going to show you data to hopefully convince you of that.
I’ll also.
Add my bias, which is the coin does not exist without the foundation of
a really engaged clinical workforce.

And that also means that the Clinton clinicians have to be able to do their jobs well and have to be well, so we'll go through that.

I know that you know all of you are still addressing the challenges of kovid, and I suspect that's going to be with us for awhile, and I'm going to share with you.

Our data for both patients and the workforce regarding kovid, but then I really want to spend time showing you things that organizations are doing to solve for a lot of the challenges that have appeared and
Hopefully give you some ideas and possibly think a little bit more about how you’re solving these challenges. Because I know having talked to you, you’re already pretty much on your way to addressing a lot of these issues and have been for a long time. So some of you may have seen this slide, but this is really the UM perspective that press ganey has when we use the term patient experience, a lot of people say patient satisfaction,
but we’re really focused on calling the full experience and making sure when we’re using that language, we are absolutely talking about quality, safety, Clinical Excellence, and then we know none of this happens without the foundation of the care team. And it’s a team and I know you all in cancer care. Know that probably better than anybody else in medicine and then the other point is, while we often capture data in specific settings, we know patients are getting their experience across the continuum often when they’re not even
00:08:08.388 --> 00:08:09.820 actually directly getting care.

00:08:09.820 --> 00:08:12.641 So I just want to put that definition out there.

00:08:12.641 --> 00:08:13.850 I also know that we all have our own story,

00:08:18.160 --> 00:08:20.296 even as clinicians of being patients

00:08:20.296 --> 00:08:22.080 and experienced care in care,

00:08:22.080 --> 00:08:25.070 often in our own systems.

00:08:25.070 --> 00:08:25.964 And you know,

00:08:25.964 --> 00:08:28.050 I think all of us as caregivers

00:08:28.116 --> 00:08:29.536 kind of often cross our fingers

00:08:29.536 --> 00:08:31.170 and just like hope it goes OK,

00:08:31.170 --> 00:08:33.291 'cause sometimes we know how many things

00:08:33.291 --> 00:08:35.685 have to go right for it to go well.

00:08:35.690 --> 00:08:37.958 And this was just an experience

00:08:37.958 --> 00:08:40.130 I had over the summer.
My husband finally was able to get an elective surgery completed in June and we actually did it at one of our organizations where I practiced and I’m going to say. Overall, everything went very well, so we got in there. The nurse after the doctor checked us in said the doctor forgot to mark which side of your body we’re going to do this procedure on. She needs to come back and do it. I’m paging her now and I was like so relieved as a patient that as a family member that that happened and there was no hesitation from the nurse.
And I thought that’s so awesome. They have their safety culture down. And then an anesthesiologist came by and he said hi, I’m Josh, I’m your lead anesthesiologist, I have these four other people. He introduced all their names and talked through what everybody was going to do. So I had another kind of OK, great like they have team culture. This is all good and then he got through surgery and we were in the pack. You and this nurse was just all over it. My husband was totally out of it so I came in there and she was just
explaining everything to me in a very kind of incredibly constructive.
Detailed way, which is exactly what I needed and I said wow,
you know this is you’re so helpful. Thank you so much and they’ve been doing this for a long time and she said,
I’ve been here for 20 years but I’ve only been in the pack you for nine months and I said well, what happened?
She said well COVID happened and after you know nine months or so of COVID in this unit after I’ve been here for 20 years,
I just couldn’t do this. Anymore, and in fact all of our colleagues have left. There’s only three of the senior nurses remaining and I was going to leave altogether. She said, but then I remembered when I first came here 20 years ago. They said to me nurses are like potted plants. They come, they stay, they never leave. And that was not how I was feeling at that moment.
but I was able to get some support and engage with my colleagues. The hospital sponsored some very informal peer groups and that helped me realize I did want to stay and I’m actually thrilled to be working down here. I needed a change of scenery, but I’m still here. So I just wanted all of you to know that I know for many this has been like an incredibly challenging time. On top of, you know, an incredibly challenging, probably decades of careers for many. And I’m worried because I don’t want folks to leave and I loved
00:11:25.608 --> 00:11:27.984 the image of that potted plant
00:11:27.984 --> 00:11:30.887 and I just wanted to share that.
00:11:30.890 --> 00:11:33.620 So I’m going to share some patient
00:11:33.620 --> 00:11:35.585 experience findings and then I
00:11:35.585 --> 00:11:37.763 will go ahead and share some
00:11:37.767 --> 00:11:39.767 workforce findings and then we’ll
00:11:39.767 --> 00:11:40.976 talk about solutions.
00:11:43.160 --> 00:11:45.302 So you know, most of you probably
00:11:45.302 --> 00:11:47.474 that press ganey has a lot of data
00:11:47.474 --> 00:11:49.530 and I’m going to like briefly flat,
00:11:49.530 --> 00:11:51.826 flip up a slide to show you that,
00:11:51.830 --> 00:11:54.550 so you can believe me when I tell you we do,
00:11:54.550 --> 00:11:56.760 but I don’t want to ping, you know pain,
00:11:56.760 --> 00:11:59.282 you make it painful for you to have to
00:11:59.282 --> 00:12:01.873 sort through all the data when we look

21
00:12:01.873 --> 00:12:04.610 at our kind of hundreds of thousands
NOTE Confidence: 0.862338569090909
00:12:04.693 --> 00:12:07.486 and millions of comments from patients
NOTE Confidence: 0.862338569090909
00:12:07.486 --> 00:12:10.990 and we look at them across all settings.
NOTE Confidence: 0.862338569090909
00:12:10.990 --> 00:12:13.370 Inpatient ambulatory emergency medicine.
NOTE Confidence: 0.862338569090909
00:12:13.370 --> 00:12:16.940 And then all different outpatient sites.
NOTE Confidence: 0.862338569090909
00:12:16.940 --> 00:12:19.740 Ultimately there are a few big themes
NOTE Confidence: 0.862338569090909
00:12:19.740 --> 00:12:21.999 that really shine through and I
NOTE Confidence: 0.862338569090909
00:12:21.999 --> 00:12:24.194 put them on this slide and they’re
NOTE Confidence: 0.862338569090909
00:12:24.194 --> 00:12:26.410 very similar to what I felt with my
NOTE Confidence: 0.862338569090909
00:12:26.474 --> 00:12:28.594 husband in the story I just told you
NOTE Confidence: 0.862338569090909
00:12:28.600 --> 00:12:30.679 the first is about keeping me safe,
NOTE Confidence: 0.862338569090909
00:12:30.680 --> 00:12:33.722 so marking that side of the face known that
NOTE Confidence: 0.862338569090909
00:12:33.730 --> 00:12:35.714 you know balls aren’t going to be dropped.
NOTE Confidence: 0.862338569090909
00:12:35.720 --> 00:12:36.968 That’s really critical.
NOTE Confidence: 0.862338569090909
00:12:36.968 --> 00:12:41.079 Of course, the working together.
NOTE Confidence: 0.862338569090909
00:12:41.080 --> 00:12:43.276 Is of course the most important,
because this is a team sport and then the caring piece and I know you all have worked really hard. I think across your system on the carrying on communicating the caring piece which is a huge component of that, but that all like doesn’t happen unless we have this engaged workforce. This is the data that we’re going to skip, so you don’t have to like try to figure out the slide, but I have one for inpatient ambulatory emergency medicine. It has gone through it all and those trust me that in that purple box.
are those three themes of keep me safe work together and care for me. They look slightly different. 'cause in the inpatient setting it’s, you know, the room clean is the measure of safety in that setting. But trust me, these themes are the same. Yeah, come across all of the settings so. This is now data you may not have seen because this is some newer data from COVID and we recently acquired a company that’s able to take unstructured data. So comments that people put into surveys that patients put into surveys and then organize that.
So instead of just anecdotally remembering the last thing that somebody said or trying to sift through these, you know, literally hundreds of thousands. Or in this case 18 million Comments that were collected. We can actually now using this kind of pet to patented technology, extract the real themes and this is just to show you that these themes of gratitude of kindness and empathy they are shining through in this COVID time mid more than we’ve ever seen before. This is from our national data. We do have your data,
so yells data and this is just a kind of graphic way of grouping the comments. So when we look at your positive comments from this past year, these are the main themes. So this kind of courtesy, respect, kindness. That’s that. The size of the box represents the proportionality of them, and that is what patients take the time to write. And about, yes, of course. Skills and knowledge are important. And yes, of course some of the logistics, but the big bulk of the positive
feedback is in the space of the caring, courtesy and respect, and those are just a few quotes that you can read.

Their doctor axe is the kindest, most courteous and knowledgeable physician, kind and knowledgeable, etc.

So of course we want to hear it all, and these are the negative comments. And honestly, and I’ve seen your data to the positive comments are almost always more than the negative comments like the volume of them. We tend to focus on the negative. Can’t help ourselves with that.
But trust me, the passives are outweighing the negatives when we look at the negative comments though. You know they’re slightly different, very focused on what I’m going to call logistic and reliability and scheduling is that biggest block here, and we have seen this a lot in COVID, and we know how hard it was for everybody to change. innovating and deliver care in a very different way. I’ll tell you one place where we’ve really seen challenges around logistics was
initially in the telemedicine paste space, which patient actually loved, and we had a ton of positive comments about connecting with providers. I’m feeling so grateful that was able to happen, but a lot of frustration with using the technology that comes up in this. You know, very inefficient as far as managing time for patients, and then these delays down there. And I meant to tell you, please, if you want put questions in the chat and I’ll try to respond to them as we go.
OK,

so this is also a newer slide you probably haven’t seen, and it’s a little bit complicated.

It’s how we group our data and flow it,

but this is your data, by the way,

this is y’all’s data, so this is really trying to demonstrate that even when you have patients who are very loyal,

so that blue ball on the left says that you’ve got of the 30,000 patients that were included in this particular.

Measurement that 87.1% of them, which is benchmark at the 76 percentile.

This is the cohort that says,

you know I’m going to score
00:17:33.826 --> 00:17:35.010 this the highest possible.
00:17:35.010 --> 00:17:37.656 You know my and that loyal
00:17:37.656 --> 00:17:38.979 to this organization.
00:17:38.980 --> 00:17:41.344 And that’s I’m giving it the
00:17:41.344 --> 00:17:43.759 highest possible or top box score.
00:17:43.760 --> 00:17:44.936 What happens, though,
00:17:44.936 --> 00:17:48.571 and what we’ve been looking at now is
00:17:48.571 --> 00:18:01.702 that when patients have friction points,
00:18:01.702 --> 00:18:05.268 so hassle experiences before their visit,
00:18:05.268 --> 00:18:08.747 to recommend or loyalty to the practice.
00:18:08.750 --> 00:18:10.570 So in this example,
00:18:10.570 --> 00:18:13.166 a little more than half they
00:18:13.166 --> 00:18:14.430 didn’t have the friction.
And I’ll tell you what those points are in a minute and their scores went up even higher. So even more likely to recommend 90th percent 99th percentile. But a little less than half did have some friction, and their scores go down, so they then score you at 73.2 the 9th percentile. This is for friction points that happened before my visit. Those are things like courtesy of registration staff, ease of contacting, registration staff, ease of contacting, the appointment. Providing information about delays and wait time at clinic.
Those are all the components that make up this before friction points. And then, UM, the care happens. And there's another kind of logistics piece that happens, or can create friction during the care. And again, all of this is outside of the experience with the care provider, the cleanliness of the room is one of the examples in this space, so when that doesn't score, when that is not kind of up to snuff, per the patient, the score drops even further. So you go down to this.
34.3 or the first percentile.

It’s forgiving, though patients are forgiving, so if you, even if you have all those friction points before the visit, but then you deliver on the cleanliness of the room, you kind of come back up here to this. Hopefully you all followed me on this with the take home message being like these friction points. These hassles really impact overall experience and how patients rate their experience.
I know not no surprise to you all and I also know that hassles are impacting all of you. But I think it’s really important that we’ve now can show this with the data because it enables practices. Or units to really focus now on these areas that otherwise might have gotten kind of wrapped up and bucket did it and we wouldn’t have that level of detail. OK, so in a shift to clinician specific findings. So just like we have a lot of data on patients, we actually have a tremendous
amount of data on clinicians. And honestly, I didn’t even realize this when I came to press ganey. I knew that we had a good amount of data on the workforce like I know that press Gainey was survey our employees, but I didn’t realize that we have the largest clinician database in the country also. So we are serving approximately 125,000 physicians annually. And about 50,000 advanced practice providers, so it’s a very big data set.
we’re also now able to kind of look and dive deep into that data set to see,
at least at the aggregate levels,
what’s most important to physicians and what’s most important to APS.
And so we did that by looking at one of our survey driver questions,
which is intent to stay for three years. So we asked that question,
and when we asked that of our physicians,
these three themes kind of surface these three themes kind of surface
to the top.
So the first for physicians is about kind of certainty and success of the organization,
them feel most confident and about.

And this is the number one key driver for actually both male and female physicians is the certainty of the organization’s success.

So the second key driver it’s again the same for men, male and female physicians is work life balance and this. This is literally that this location supports me and balancing my work life and my personal life. And and I think this is really about, the importance to all of us that we are in this profession.
And want to be in it, but it has to kind of be a part of our lives because we all have lives outside of it.

And if our organization can’t help deliver that, that makes it really difficult for us to want to stay. And then the third one, which is again, this creates this link and not surprising. I’m sure to anybody here is that the location provides high quality patient care and service. That is an absolute driver like we
need to know that if we’re going to stay at our organizations. So for APS it’s similar, but a little bit different, and these are the themes and I think that that’s probably a good way of thinking about APS in our data in general, and I actually often feel like APS is kind of the last cohort because they spend a lot of time. I think our AP spent a ton of time with physicians, but they’re not always measured with them, and there are some differences and. They’re not really sitting in with any other,
so we’ve been really active at looking at them both separately and then aggregating their data into this clinician space. But for APS and again, we’ve looked at it from male and female AP separately.

But these are the big four themes that we find for their kind of interest and intent to stay for three year period.

I feel like I belong in this organization. I like the work that I do. Then we have the patient quality and service that had.
Also, we just saw with the physicians and then another interesting driver here is this respect. And confidence in our leader, both the direct person I’m reporting to and then senior management overall, and that’s become. I think that’s a really interesting insight into thinking about kind of where many of our AP’s are connecting and what is going to be really important to keep them. And and I will answer questions. So the great question. So if I’m if I’ve showed you any like,
yell any data,
right now it’s Yale New Haven Health.
Overall, I do have and I can send it
to Terra the Smilow specific data.
So I had that I have like a smile,
a specific breakout for those that circle
picture with the hassle factors drivers.
It actually looks quite similar to Yale,
New Haven but better.
In certain areas,
and maybe a little bit different
in a couple of others,
and I will make that point about the data in
general to actually like make change happen.
All of us need to look at that data
at the practice level in order, I think to really ultimately understand what’s driving what the drivers are for each practice. So this is the everybody’s moment for interaction. So if you could take a second and look at this picture and tell me where you think you are and if you like you can say like this where I think I am and or this phases of disaster slide. Some of you may have seen this before. You know I use this early on in the pandemic.
It's not. It's not COVID related at all, it's a. Kind of used for national disasters? Or are there other instances? And it's on the kind of stamps and mental health support site. So what it shows is and I'm waiting for anybody who's ready to type who's already ahead of me. But what it shows is as an event unfolds. There's this kind of anticipation and we saw this across the country. By the way. We formed a caregiver collaborative right when COVID started last March,
and we included lots of folks from New York, Connecticut, New Jersey who got hit hard, fast, and the rest of the country was kind of sitting and waiting, so we actually lived through this. And then there was the heroics and the honeymoon period where lots of support and cheering and people felt like, OK, we got this, and we have treatments. Now and then we got a vaccine and we can do this and then this kind of disillusionment phase. So I’m looking here and I see a lot of people saying like five.
not a lot of people, but I see five from most people and some people are saying six and I'll tell you, this is. I've also showed this slide with a lot of folks and there's been a lot of force. I showed it a couple weeks ago and I got the feedback that my slide is wrong. And that I need to fix it and make it up. This kind of downward sloping bucket needs to happen again and again and again. 'cause that's how they are feeling right now, but I will say most leaders feel like they're somewhere between five and six.
that they can see a light.

So we have a, uh, a colleagues at press ganey,

who actually lead a lot of our safety work,

and I think some of them worked with

have worked with you guys over the years.

Are HPI safety Consulting Group

and a number of them have military

experience and they spent a couple

months kind of looking at our data

talking to folks around the country

and really landed on why they think

health care workforce experience

during COVID is actually been.

Far more difficult than UM,

experiences in the military,
and for these four reasons and the kind of relentlessness of the experience that you can’t get go home especially early on and get away because there was so much concern about safety and exposing families for women or for men who are the kind of principle caregiver for their. If they have kids or a. Parents that they’re caring for that going to work and coming home was around the clock the entire time and really felt relentless. And then what? We’re seeing a lot more is this.
oppositional piece that I think is driving a lot of compassion, fatigue, and secondary trauma for many folks right now. So this is, uhm, I don’t think anybody seen this. You might have seen it, it was tweeted a couple weeks ago, but it’s not yet published. This is from this epic research data of 350 organizations that are using at Beck. And there they were just tracking the percent difference in digital messages that are coming from patients directly to providers right now to physicians. And they have.
There’s been a 157% increase in that volume of digital. Messaging now it’s not an absolute, so you could have had four messages a day before and now you have seven messages, but it’s a huge shift and the glass half full piece of this is like fantastic patients have finally figured out how to use the portal. That’s great. The glass half empty is Oh my goodness we built it, they came but we didn’t actually figure out how to manage it. So it’s this overwhelming amount.
and this is when I talked to my colleagues in primary care.

They are overwhelmed by this amount of messaging and lack. They haven’t had a chance to build the system to manage this influx appropriately.

So I wanted to share with you just a couple of the terms that we use a lot.

1 is resilience and this is really this ability to recover or adjust when challenging things happen.

And we measure resilience with two different sets of metrics.

One is about activation and it’s the ability to kind of get charged up, ready to go and find meaning.
in every encounter, and then the other is to decompress to be able to go home, recharge and recover. Absolutely need to do both if we want to remain resilient. So I’m sorry for the like small font on this, but I do want to point out and I’m going to talk about engagement in a minute that physicians of all the professions in the hospital scored the lowest for both resilience and engagement. Will talk about engagement in it and for resilience. So this is physicians down here.
This score overall score is made up of two components. Activation physicians are great at getting activated and treating each patient individual as individuals and finding meaning and where physicians really are struggling is their ability to decompress to be able to go home and disconnect from work communications to be able to sleep, recover, and be able to come back the next day. And this is what we’re going to talk about. I will make one. I’ve seen the resilience data for this past year and the one flip that I thought was interesting is teaching faculty.
have now dropped below physicians. Their resilience is lower. Again due to decompression. So now, as tough as this is, we are seeing places where there are some kind of hopes and bright spots, and I'm going to call this one of them. So this is looking at engagement. So engagement is how we measure. We have a six out of six questions that we use to measure kind of an individual’s likelihood to go above and beyond with the organization that they’re working, and we capture things like pride and likelihood to recommend.
00:32:40.636 --> 00:32:41.928 the organization and send.
NOTE Confidence: 0.9009948825
00:32:41.930 --> 00:32:44.594 Family there and so as you can see from
NOTE Confidence: 0.9009948825
00:32:44.594 --> 00:32:46.988 this over the past couple of years,
NOTE Confidence: 0.9009948825
00:32:46.990 --> 00:32:49.377 although there is a cohort that’s having
NOTE Confidence: 0.9009948825
00:32:49.377 --> 00:32:52.137 a dip down and engagement and we are
NOTE Confidence: 0.9009948825
00:32:52.137 --> 00:32:54.661 seeing this and and from many that
NOTE Confidence: 0.9009948825
00:32:54.661 --> 00:32:57.013 the engagement scores are going down,
NOTE Confidence: 0.9009948825
00:32:57.020 --> 00:33:02.656 there is a group of organizations
NOTE Confidence: 0.9009948825
00:33:02.656 --> 00:33:05.085 where physician engagement is actually
NOTE Confidence: 0.9009948825
00:33:05.085 --> 00:33:08.770 going up during the pandemic,
NOTE Confidence: 0.9009948825
00:33:08.770 --> 00:33:12.058 and I like to think that’s because of UM,
NOTE Confidence: 0.9009948825
00:33:12.060 --> 00:33:13.425 honestly,
NOTE Confidence: 0.9009948825
00:33:13.425 --> 00:33:16.155 the concept of high reliability.
NOTE Confidence: 0.9009948825
00:33:16.155 --> 00:33:18.990 And, uh, leadership.
NOTE Confidence: 0.9009948825
00:33:18.990 --> 00:33:21.055 Stopping and recognizing that they might
NOTE Confidence: 0.9009948825
00:33:21.055 --> 00:33:23.070 not have the answers for many things,
but those on the front lines probably do.
And actually creating the space to listen and take that information and act on that.
And we’ve seen all across, and I actually seen ’cause Michael shared with me the the depth and breadth of the communication approaches you all had throughout your pandemic where you knew your frontline voices could work, I think greatly informed decisions that were made, and that’s something that you know we don’t often see UM.
And when like times are normal in healthcare.

So, so we now need to like I want to focus on how do we move forward and address these challenges. So I do think these are four major challenges facing most organizations right now and we're going to go through. They're actually pretty connected because when I use the term well being, it's it's far more than my individual well being. It's thinking about the organizational kind of well being as well. But I suspect that these issues of trust,
00:34:23.120 --> 00:34:25.745 uncertainty and staffing are ones that you're all challenged by. 
00:34:25.745 --> 00:34:28.370 I will say then I'll get to this later that the accountability for like 
00:34:28.370 --> 00:34:31.074 addressing and solving these challenges can’t just happen at an individual 
00:34:31.074 --> 00:34:34.126 level or at an organizational level. 
00:34:34.126 --> 00:34:36.996 It’s gotta happen. 
00:34:36.996 --> 00:34:39.929 Also at a leader level and at a team level. 
00:34:39.929 --> 00:34:42.611 These problems are too complex and for some of them. 
00:34:42.611 --> 00:34:43.814 Like getting like I talked 
00:34:43.814 --> 00:34:47.540 about earlier to the unit of measurement that’s most important, 
00:34:47.540 --> 00:34:49.020 and that might be your practice in your
The clinic is going to be really critical if we’re going to solve these problems. So I have. I’m going to talk a little bit about well being and these first three slides are a case study from an organization that decided they wanted to really go deeper to understand what was driving for things. They were very worried about resilience, both activation and decompression, and this was for their clinicians. Their AP is and physicians. They were also very focused on productivity and on intent to stay.
'cause they really don't want to lose.

A single physician or AP, given the challenges right now, so they had a very kind of robust look at this. They did kind of what many people do is as the engagement survey, but then they’ve dug deeper and they’ve dug deeper into the data, and they’ve dug deeper into listening to their front lines. And then they’ve used this information to help prioritize and begin to build their road map going forward.
So this is just a schematic for the data, and I don’t want to get lost in this. ’cause trust me, it’s a lot of detail. But basically we are taking survey data, so the minutes that people are in it and the time of day that they’re in it. We’re also looking at productivity data from your human resources platform, and we can integrate all of that together and then surface. What are the key drivers for these areas that were very focused on addressing? And this is again a schematic that’s just trying to show you. It is not going to be one.
thing that pops out.

Uhm, and most things fall, I think into these three big areas.

What we can learn by going deep here though, is the actual impact.

And what will happen?

The likelihood of something happening if we go to fix it.

So for example,

for this group.

There was a.

It became very clear that a huge driver of the challenges for doctors to decompress was around the EMR efficiency and proficiency.
and the challenges of resources and workflow in the clinic. And this came out when we looked at their decompression data and saw that, like those people who are doing really well versus those who weren’t, it was due to things like the amount of time that they were spending charting or how many days until their next appointment was available. And those who were kind of swamped. We’re doing far worse than those who weren’t. So again, things that you would think, OK, I get it. But the fact that the data revealed then gave them something to kind
00:37:41.208 --> 00:37:43.493 of stand on to try to then help
00:37:43.493 --> 00:37:44.878 address what the challenges are.
00:37:44.878 --> 00:37:47.182 Lots of other areas and I think these
00:37:47.182 --> 00:37:49.738 are probably ones you’re well aware of,
00:37:49.740 --> 00:37:51.492 which is the role of leadership
00:37:51.492 --> 00:37:53.150 and addressing kind of culture.
00:37:53.150 --> 00:37:55.571 And then what do we do to better
00:37:55.571 --> 00:37:57.260 support individuals and teams?
00:37:57.260 --> 00:37:58.737 And actually some of those things came
00:37:58.737 --> 00:38:00.839 up when we were looking at the earlier data.
00:38:03.300 --> 00:38:07.260 So I was going to show this video,
00:38:03.300 --> 00:38:07.260 but I’m a little worried I’m going to run
00:38:07.260 --> 00:38:09.843 out of time so I’m not going to show it.
00:38:09.843 --> 00:38:12.036 even though I think it’s really powerful and
00:38:12.040 --> 00:38:14.312 I will send it and anybody can watch it.

NOTE Confidence: 0.9543305375

NOTE Confidence: 0.9543305375
It's a really wonderful 3 minute heartfelt video and I'm using it as an example.

Of how important it is, and then I know, you know this to feedback these comments from patients.

The positive ones so your providers can hear them and remember just how important they are and the work that they're doing,

how much they are changing people's lives and these.

This is not just physicians,

it's transport folks,

it's the helicopter, EMTs,

and they're all reading letters.

Of patients that that were written to them specifically,
and they're all kind of recognizing.

Gosh, I didn’t realize I needed this.

Thank you, but I did and it really makes a difference.

There are a couple other areas in well being that we’re seeing folks do,

and again I suspect you’re doing some of this here.

I would say the concept of peer support has kind of never been more important,

and it can be like simple or it can be very complex and we are seeing organizations do all variations of this.

These the kind of themes of what happens with peer support and why
it’s so important or what I wanted folks to just focus on for a minute. But it for sure is true that well one we as colleagues know each other and might pick up and sense things that you know somebody that you don’t know wouldn’t necessarily pick up on. And we also, unfortunately, there is still often a stigma around getting help, and this is something that you know we all have to work more aggressively to fix that stigma around. The need for emotional support. And there’s been.
And I’m really hopeful right now that we are going to change the paradigm around them. And that’s something that I’m working really hard for us to focus on and address that. We have to make it easy for folks to access mental health and meet them wherever they’re at. This was created by an organization, actually Valley Health. This is what these three examples that I threw up here show this first one, which may be hard to see this resilience check in list. This was created by an organization, actually Valley Health.
System in New Jersey they copy catted from an organization in the Pacific Northwest in our mountain and Intermountain did it as a going home. Checklist Valley Health did it as a coming in checklist but the goal was we need to remind our colleagues that we are here for them that they need to check in and make sure they're OK and that there are resources to support them and will meet them where they're at. You know, Columbia has a very comprehensive program. I suspect you all have a pretty comprehensive program for
accessing mental health when folks really need professional support, and then the bottom one is an example from New York City health and hospitals that have really built a kind of pyramid type model to try to capture for their entire workforce workforce and those who need support and create a buddy system and then really work their way up the pointy part of that is the seeking help from a professional. Coaching is another area that we are seeing folks kind of lean into more actively than before, and I think part of that is
this recognition that wow,

you can do this virtually and it works really well.

Some organizations are building that, others are outsourcing it.

If you build it internally, you have this like win win opportunity because most folks who take the time and coach also get a benefit.

Trust after well being was another area, and it’s something that we’re all working really hard.

And I know it’s again you all have.

You know, maybe have trained up more folks in
NOTE Confidence: 0.873897575789474
00:42:20.213 --> 00:42:21.830 communication than any other organization,
NOTE Confidence: 0.873897575789474
00:42:21.830 --> 00:42:23.720 at least that I'm aware of,
NOTE Confidence: 0.873897575789474
00:42:23.720 --> 00:42:26.224 and I think like,
NOTE Confidence: 0.873897575789474
00:42:26.224 --> 00:42:26.850 uhm.
NOTE Confidence: 0.873897575789474
00:42:26.850 --> 00:42:28.866 Keeping that dial turned up is going
NOTE Confidence: 0.873897575789474
00:42:28.866 --> 00:42:30.850 to be really important on this.
NOTE Confidence: 0.873897575789474
00:42:30.850 --> 00:42:33.094 This is really talking about communicating
NOTE Confidence: 0.873897575789474
00:42:33.094 --> 00:42:35.220 and connecting with the workforce,
NOTE Confidence: 0.873897575789474
00:42:35.220 --> 00:42:36.450 so not let’s put it.
NOTE Confidence: 0.873897575789474
00:42:36.450 --> 00:42:37.320 It’s so critical.
NOTE Confidence: 0.873897575789474
00:42:37.320 --> 00:42:39.350 Of course we do that for patients,
NOTE Confidence: 0.873897575789474
00:42:39.350 --> 00:42:41.324 but it’s really critical we do
NOTE Confidence: 0.873897575789474
00:42:41.324 --> 00:42:43.700 it right now for the workforce,
NOTE Confidence: 0.873897575789474
00:42:43.700 --> 00:42:46.360 so this is rounding reliably,
NOTE Confidence: 0.873897575789474
00:42:46.360 --> 00:42:48.600 so not just times one and there’s
NOTE Confidence: 0.873897575789474
no way like a senior level leader could round on every. Unit or department? I mean they can and they do and we see folks around the country doing that. It will take them a year right to get to everybody. So this is where again this rounding has to happen and at a very like small team level so that that leader is present and hears from their team how they’re doing, how they’re not doing. We have seen this for nurses, physicians, APS and just like showing that you are
present that you care that you’re listening.

That you are transparently communicating back what you can fix and what you can’t has really gone a long way for folks and something that you know.

The trick with this is to do it reliably, meaning the same on a consistent way overtime, not just times one or once a month.

I suspect all of you are pretty familiar with. I don’t know ’cause I have a mix when I tell people about this. This concept of psychological safely I know Mary is ’cause we took a
course together and Amy Edmondson

NOTE Confidence: 0.867998148888889

is one of the folks who really talks

NOTE Confidence: 0.867998148888889

about this a lot using examples from.

NOTE Confidence: 0.867998148888889

All sorts of other industries,

NOTE Confidence: 0.867998148888889

especially spaceflight, but the important,

NOTE Confidence: 0.867998148888889

but she’s also really done a lot

NOTE Confidence: 0.867998148888889

of her work in hospitals.

NOTE Confidence: 0.867998148888889

In fact, that’s where she started,

NOTE Confidence: 0.867998148888889

and this concept.

NOTE Confidence: 0.867998148888889

This is a picture of Gramercy

NOTE Confidence: 0.867998148888889

Tavern in New York,

NOTE Confidence: 0.867998148888889

because even in a restaurant where you

NOTE Confidence: 0.867998148888889

think the stakes might not be so high,

NOTE Confidence: 0.867998148888889

although this pretty expensive restaurant,

NOTE Confidence: 0.867998148888889

so the stakes are pretty high

NOTE Confidence: 0.867998148888889

to get it right,
the expectation is that the wait staff on their first shift. An will ask for help at least 10 times and they are encouraged to do that so their leaders. They’re kind of team lead. Models that it is OK for them to help ask for help. In fact they expect them to do it, so they’re framing this. In that way they the leaders demonstrate that they are far from perfect, and then they thank people when they ask for help. So this kind of psychological safety concept,
the set of tools or things that we need to train our leaders in and we this the clinicians. On this call you our leaders, whether you may have a leadership title, or not for sure whatever practice you’re in, I’m sure you are perceived as the leader, so knowing how to have the skills to help other people speak up and engage them and support them is really critical. This is from an organization that actually is one of our top performers. It’s a large system and they have been on a journey just like you. Just like many organizations have for many years to improve both
patient experience and then in the last three or four years very focused on their workforce, specifically their clinicians and aips. But when they started their journey back in 2012, they’ve been very Desperate, they came together and they were very focused on how do we become a system? How do we create that communication? How do we create some bit of sameness but also permit some local autonomy? They ultimately embraced high reliability as they’re kind of building block foundation for doing this work.
They have been rigorous about measurements and then in the last few years they’re kind of solved for the clinician well being challenges. Has been both a fix the system and then assist the clinician UM approach, but I did want to just spend a second on high reliability. I know you have a framework here. Actually asked Michael about this, ’cause I talked to press Gainey colleagues who had years ago. Worked with folks and we used this acronym and Michael whipped out a card and showed me that
Indeed you do have this and I think this is a very helpful way of remembering those high reliability behaviors that are so important if we want to deliver care to every single patient and get it right every single time. And so these communications, all of you work to practice work to do already. How do we kind of hardwire that end so that we do it not just with patients, but even as we’re working to support our workforce even as we’re working to find ways to be more efficient.
and to deliver care, that is of the highest quality. So this is the performance of Super performers and these are the highest percentiles that we have for employee experience. This rising tide of physician engagement and then patient experience. So, I am actually going so for staffing I'm going to mention. Just very briefly, there is no silver bullet, just like there is no silver bullet with any of these things. We work with organizations,
many of them. They’re all everybody is struggling right now with staffing and it’s mostly nursing or like Technical Support and then like respiratory therapy or other kind of skilled positions. Where folks are choosing to leave and do something else, or dramatically cut back their hours or go and do the same thing but in a site of care that’s easier than the rigors that they’re experiencing where they’re currently working. So this all for this, honestly.
are those the same concept of high reliability, really taking the time to communicate.

So one of our Western California based health systems have set up ways of communicating and listening to. Nurses beyond the rounding they are surveying them actually every quarter to make sure they get their voices heard and then they are responding immediately and again. It’s with this communication, even if we can’t solve exactly what you’re asking for. Here’s what we’re doing and why. For most places,
figuring out how to what’s called force multiply so that really is this concept of practicing at the top of your license. So how can we take the stuff off of the Physician PA nurses plate that they don’t have to be doing and support them within another set of resources. So in some places folks that had stopped using LP ends or pulling LPN’s back in to provide that type of support figuring out how to change the inbox messaging system. So all of those messages aren’t going to directly to the provider
00:50:01.530 --> 00:50:03.238 are examples of this.
NOTE Confidence: 0.901395215666667
00:50:03.240 --> 00:50:03.633 Uhm?
NOTE Confidence: 0.901395215666667
00:50:03.633 --> 00:50:06.384 I do and I'm seeing some of
NOTE Confidence: 0.901395215666667
00:50:06.384 --> 00:50:08.289 the questions in the chat,
NOTE Confidence: 0.901395215666667
00:50:08.290 --> 00:50:10.170 so one of them is about how do
NOTE Confidence: 0.901395215666667
00:50:10.170 --> 00:50:11.957 we get leadership to respond
NOTE Confidence: 0.901395215666667
00:50:11.957 --> 00:50:13.625 to concerns with action,
NOTE Confidence: 0.901395215666667
00:50:13.630 --> 00:50:16.726 which I think is a really great questions.
NOTE Confidence: 0.901395215666667
00:50:16.730 --> 00:50:18.610 So we're going to get to that in a minute
NOTE Confidence: 0.911233355294118
00:50:18.658 --> 00:50:20.516 and I'm going to get to that, actually.
NOTE Confidence: 0.911233355294118
00:50:20.516 --> 00:50:22.620 After my next slide,
NOTE Confidence: 0.911233355294118
00:50:22.620 --> 00:50:26.859 so we've covered a lot and I think
NOTE Confidence: 0.911233355294118
00:50:26.859 --> 00:50:29.217 it's really important to remember the
NOTE Confidence: 0.911233355294118
00:50:29.217 --> 00:50:31.283 connection between working to support
NOTE Confidence: 0.911233355294118
00:50:31.283 --> 00:50:33.683 our clinicians and the work you're
NOTE Confidence: 0.911233355294118
00:50:33.751 --> 00:50:36.306 already doing to take care of patients.
I’m going to start with this concept of removing the hassles because we know that’s what’s making it so challenging for folks to decompress the patient quality and service. Kind of that’s the kind of sweet spot for all of us and then really focusing on trust and belonging. And that includes the psychological safety that we were talking about. This is what’s going to, like propel us forward and kind of enable us to be successful. Really, for.
Every single thing, whether it’s safety, whether it’s engagement of our people, whether it’s looking at resources, being able to deliver these types of aspirations reliably every time, so that every individual, whether it’s a patient or a caregiver, is really what we need to hardwire and then to answer the question in the chat. This is how I think we need to change our thinking on this. So instead of thinking of UM solutions that belong and this, is something I mentioned earlier,
either to an individual like go,

get yes Jessica, if you’re struggling,

here’s the number.

Go get the support you need and

we have it available for you.

We need to recognize that every layer

here plays a role in almost all of

the things that we’re talking about.

So there is a role and everybody

actually needs.

To have some ownership and

accountability for that,

and this is where the measurement

is so important.

So there are things that the
organization can take ownership of, and I've listed some of them over here. I would say the biggest opportunity right now is in addressing the workflow and operational inefficiencies that folks are challenged by. That's what we saw with the patient hassle data. The friction points in the clinic, and that's what we hear all the time from those. Who are practicing that? We have got to stop and retool. How we're doing this work so that we can keep doing this work? I think we skip a lot the two layers.
in the middle and this to me is going to be the game changer here. How do we build stronger teams and how do we grow leaders? Because at the end of the day you may have a very senior level C-Suite of folks, and that’s great, and they’re going to keep your kind of ship steady. But the real work is going to happen at this level, so training these folks making sure they have the data and the support that they need to advance this work. And yes,
it may be a negotiation if they need resources.

And how do they get those resources so that they can, you know, do their job and be the leader and advance with their team.

And then I do as you all know already, if we don’t take the time to take care of ourselves first, we can’t do any of this work and giving ourselves kind of permission, not just permission, but insistence that we take that time to take care of ourselves first is absolutely critical.
but for our teams and for organizations, and of course, for our patients.

K So I think I’ve gotten to my last slide with my one minute left. Hopefully you all followed me through this. That and there’s a reminder in the chat about recording CME attendance, but hopefully all of you you know are with me on this kind of two sides of the same coin. Two different perspectives, but really the same set of solutions for addressing patient experience and really supporting clinician engagement.
The importance of measurement, especially if we’re going to hold all of those layers accountable. I don’t think can be overstressed, and it’s also really critical to use it so we can prioritize. Not have kind of a shotgun like approach to what we’re doing. I think I’ve gotten it all in, so I’m going to stop. Thank you all for your time and uh, Thank you, Mara. Thank you so much, Jessica. This is fantastic and. You know will open it up for even
though I wear it one o’clock maybe

You know I have one that wanted to see if.

The work that you and Lisa Rodan Steen did at the Brigham,

looking at gender differences

and burnout and fulfillment,

is that was that’s specific to the Brigham.

Or do you see that translatable really across the country

with your press ganey? Such

a great question.

Thank you for bringing that up,

so I think some is very translatable across the country and I would
love to come back and talk to you about the gender differences. 'cause I really worry about them a lot. And then some was very. It was specific to our data and I don’t know if that’s gonna come kind of. Beach, something that we’re going to see everywhere, but certainly in our data nationally and also the work that we have been doing with the Brigham data. We are seeing the themes of the challenges that female physicians have with being able to decompress with feeling like they have the support and resources they need.
that they need to get the work done in the time that they have. We have lots of good data that show that female patients probably take more time and female physicians. Often have more female patients. You know, physicians often take more time, so there's a lot of drivers in this space. One of the things that we found in that paper was the lack of self compassion and how female physicians score. You know, worse on that than male physicians, and actually, that explained a lot of the difference.
and I think that that is true,
and that is a societal challenge and a lots
been written on that in other industries.
The kind of how women tend to
kind of set a really high bar
and then beat themselves up.
The kind of how women tend to
I mean play with men do this too.
But it’s more common,
I think in a lot of women,
certainly something we found in our data.
Uhm, Doctor Fisher or anyone
else with last moment questions?
I know we’re out of time and again,
thank you so much.
Just the cover coming down even
though you’re not here in conquered,
but hopefully we'll be able to bring you here soon to visit us in person.

Thank you so much for having me and I would love to come visit.

Thank you everyone.