



People

- LEADING THE WAY: CUTTING EDGE HUMAN RESOURCES
- WORKFORCE PLANNING, *A. LOVEGROVE*
- GREAT LEADERS EMBRACE CONFLICT, *S. JOHNSTON*
- EARLY HUMAN RESOURCES INVOLVEMENT IN M&A ESSENTIAL FOR SUCCESS, *F. ROEBROEK*
- PATIENTS MENTORING EXECUTIVES, *D. CRYER & C. DAVIS*
- CHALLENGING PARADIGMS, *A. SPIRO*
- LEARNING WITHOUT LIMITS, *M. LESTER*
- TEACHING ULTRASOUND IMAGING ONLINE, *J. VAN ZANDWIJK*
- *USA RADIOLOGY WORKFORCE*, *E. I. BLUTH*
- PURSUING A CULTURE OF SAFETY, *W. O. COOPER*
- APPRAISALS IN HEALTHCARE, *A. LAYLAND & N. LEENA*

GENDER MATTERS IN
CARDIOLOGY, *A. MAAS*

COPING WITH COMPLEXITY,
M. MELLET

HOW TO MAKE SENSE OF DIGITAL
CHAOS, *J. L. GIRSCHICK*

AWARD-WINNING DIABETES
CLINIC WITH VBHC APPROACH,
H. VEEZE

GROUNDBREAKING PAIN

MANAGEMENT INITIATIVES IN
EUROPE, *D. QUAGGIA*

THE RECERTIFICATION PROCESS
OF A CHEST PAIN UNIT,
T. RASSAF & M. TOTZECK

ECARDIOLOGY, *H. SANER*

HARMONISATION OF LAB
MEDICINE ACROSS EUROPE, *D. HIMLI*

CLINICAL LABORATORIES

IN BRAZIL, *E. G. RIZZATTI & J. M. TSUTSUI*

MAKERSPACES, *O. BREUER*

THE NEED FOR CLINICAL AUDIT,
J. SCHILLEBEECKX

NATIONAL TELERADIOLOGY
SYSTEM OF TURKEY, *Ş. BIRINCI & M. ÜLGÜ*

TRUMP ON DRUGS: PART 2,
J. SALMON



Patients Mentoring Executives

Mutual Benefits

Patient-centric healthcare has come strongly into focus in recent years. Efforts by healthcare organisations to be more patient-centred include a range of measures, such as patient councils and feedback sessions. Sibley Memorial Hospital in Washington, DC, which is part of Johns Hopkins Medicine, has pioneered patient mentoring of executives. *HealthManagement* spoke to patient advocate, Donna Cryer, and Chip Davis, CEO of Sibley Memorial Hospital, about their experiences of this innovative mentoring programme.



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How did the idea of mutual mentorship come about?

Richard "Chip" Davis (CD): At a leaders' retreat for our institution, in January 2015, Donna was part of a patient panel. We are very patient-centric at our organisation, but we think we learn from patients when we interact closely with them. Afterwards Donna and I had a chat, and she recommended that we get together on this idea of a patient mentor. As a CEO I had felt strongly about patient involvement for a long time, and we had done a number of measures here, including creating advisory councils and so on, but I really loved the idea of having a patient mentor myself. Donna comes frequently to our organisation for care, so I thought she had a great lens as someone who really knows our organisation, many of the departments within it, and I was very enthusiastic to accept that opportunity.

Donna Cryer (DC): At that panel there was a specific question on how to maintain the focus after the meeting. The answer was to have patient mentors for the CEO and for those heading different departments. Sustainability is really the key distinguishing factor of what we have created. Many institutions have different one-off activities, but to create something that sustains that sense of patient centricity over time is what makes this different.

What benefits does the mentorship programme offer?

CD: It's invaluable for executive leaders, in particular CEOs, to have frequent and direct contact with patients. One of the things that can happen in leadership roles is that if you don't seek it out you get filtered information coming through the organisation.

When Donna comes in on a monthly basis and tells me about a recent experience she might have had coming into the emergency department (ED) or elsewhere in the facility it's particularly illustrative for me. It allows me to have unfiltered information and direct feedback from her.

DC: The benefits for me as a patient and as a patient advocate who's been working on systems-level change for a long time have been so healing. I have inflammatory bowel disease, am more than two decades post liver transplant, and recently had both knees replaced. I've had many contacts with the health system, both as an inpatient and with ambulatory care. Not all of those interactions have been positive, so to have the ability personally to sit down and truly be heard was healing on a personal level.

On a professional or advocacy level to be with someone who was so receptive to the perspective, the ideas, recommendations and observations and most importantly was in a position to effect change has been tremendous for me. Also I have learned a lot about how the ideas I might have as a patient or in talking with other patients have to be integrated into all the other priorities and constraints of actually running a hospital day to day. To get that insight from the CEO perspective on what it really takes to run this enterprise was very educational.

What are the challenges?

DC: With anything innovative, to bring form and substance to this, time is an issue and Chip and I are very busy. Carving out and protecting this time shows our commitment to working to bring a focus. It's mutually beneficial to discuss both larger landscape issues in healthcare and apply them, to define things that

resonated and benefited both me and Chip and to link the patient narrative to actual business challenges.

CD: I agree. We both make it a priority, because we feel that there is significant value in those discussions.

What makes an effective patient mentor?

DC: You need to be able to transcend your own personal individual experiences into recommendations. It helps to have a diversity of healthcare setting experiences so you have comparators, and to have examples of things that worked and what didn't at other places in order to bring knowledge of the healthcare landscape so you have context for what is going on with hospitals and health systems today. Patient mentors need curiosity and the ability to listen. If you are truly mentoring or coaching someone, you need to listen, to extract what their points of pains, of joy and of pride are in the institution, areas where you can effect some change, be helpful, make the most impact, how to apply your experience to them and be able to draw out, conduct and facilitate a very mutually and fluid conversation. Soft skills as well as more substantive healthcare knowledge are very helpful.

“IT IS NOT ABOUT GOING IN AND FINDING FLAWS”

What training is provided to patient mentors?

DC: We are in the process of developing a mentorship curriculum (Cryer et al. 2017). Prof. Peter Pronovost at Johns Hopkins is helping us move it forward in conjunction with the Sibley Foundation and the Innovation Hub at Sibley Memorial Hospital. The curriculum will entail soft skills such as coaching as well as substantive knowledge of patient- and family-centred principles and touchstones in the evolving healthcare landscape. We are looking for people who are advanced in their advocacy journey, who are experienced patients with a diversity of conditions. Patients who have a connection to Sibley Memorial Hospital and the Johns Hopkins system will be helpful for the initial cohort going through the curriculum. The first participants will need the ability, inclination and some experience in three areas: coaching skills, a substantive knowledge of patient-centred principles and knowledge of healthcare and the healthcare landscape.

How do you each prepare for your monthly meeting?

CD: Preparation is not onerous. Through the month

if I have some questions or if I know that Donna has gone through the radiology department, for example, I will jot down a note and ask when we meet about her experiences. Sometimes if we're thinking about launching a new programme or a new effort, I will run the idea by her, and ask how patients might perceive it. One of the values of this partnership is that it challenges my mental model of patient care. I might think I know what the best option might be, but when you really ask the patients, surprisingly sometimes their thoughts are different. If we are really trying to create a patient-centric care delivery model, patients need to be the driving force in that. The message that it sends to our organisation when Donna and I are taking the time to meet and have been doing so for two years is very favourable to the rest of the organisation. People are more sensitised to a very patient-centric perspective if they know that all of us are really seeking that.

DC: My preparation is similar. I am very grateful to Chip for allowing me to reach out to other departments in the hospital. I have had conversations with everyone from radiology to orthopaedics to the emergency department and being able to probe and question has been really helpful. Choosing from my own experiences I put forward things that might be helpful. I also try to bring in articles. I have assigned Chip reading from time to time, either something from the healthcare landscape or local, to articulate the larger patient perspective really well. It's always a joy when we realise we have both read the same article and are talking about it. These are not just from healthcare, but borrow from other industries—hospitality, restaurants, service, really anything that helps the person-centred perspective that can infuse into healthcare.

In some of our sessions we divide it in half and meet individually for the first 30 minutes, and then in the other 30 minutes meet members from other departments we are discussing. This is really helpful, as we drill down deeper into how to apply some of these recommendations more specifically.

Can you give examples of changes that have come about at Sibley following discussions with patient mentors?

CD: As Donna has had knee replacement surgery at Sibley, I asked her to give her insights and assessment of the experience during and after the procedure. She came up with some great ideas on pre-surgical education, and the way in which it was being coordinated. We met with the clinical and administrative leadership of our orthopaedic joint replacement programme. They were very pleased to get the input and incorporated a number of changes. That's happened in a number of areas, such as the ED. If Donna comes into the ED,



she'll drop me a note afterwards about the experience, and if there are opportunities that we've identified that we can improve, we try and do that in a rapid cycle way; we don't need to set up 28 meetings with all the different constituents to do everything. We go ahead and implement it.

Formal patient mentorship is focused on CEOs. This is because one of the things that happens to executive directors and CEOs of hospitals is that they can become increasingly isolated from the daily patient care experience if they don't proactively seek that out. If you're just relying on information that you are getting from some of your direct reports that may or may not clearly paint the picture of what may be really happening.

“ALL THAT'S NEEDED—
AN OPEN HEART AND
AN OPEN MIND”

DC: That has been so exciting for me to see as I've gone around the hospital. Well before our first year ended the things we talked about I would see them translated across the Innovation Hub and into the hospital itself. That is so gratifying and satisfying for somebody who has had all these thoughts and recommendations pent up for so long. To see them come to life and be able to benefit other patients brings such meaning to this. It's been everything from ideas about peer mentoring to use of video and other communications, care coordination, through to more patient-centric quality measures, measures that really matter and that advance care rather than create more administrative burden and that make sense from the patient and institution perspective. We have discussed sharing best practices and data among physicians to improve outcomes. Also, we were able to surface some really wonderful things going on in the hospital and highlight them, so that staff receive recognition for patient-centricity from the CEO. It is not about going in and finding flaws. Sibley gets a lot of things right, so to be able to find undiscovered gems, and ask if they need more resources or whether they can be scaled up to affect even more patients positively, was an exciting part of this as well.

How would you convince another hospital to start a patient mentorship programme?

CD: I would be very straightforward and tell them: “Just do it!” It does not take a lot of convincing, and if it does I would suggest there may be other issues

going on if CEOs and the executive leadership don't see value in direct and ongoing interaction with patients. I would identify the value proposition I have been able to personally get out of this as well as our organisation.

DC: An organisation that has a culture and position where they want to evolve and they have mechanisms for making change and for getting feedback back to patient mentors are important considerations for their readiness. A point of frustration is if this was just conversation. I've had these in past with other institutions; they've had a committee for 18 months and weren't really prepared to take on a culture of patient-centredness in an authentic way. Improved self-assessment of their readiness and commitment to patient-centred change throughout their hospitals and systems is all that's needed—an open heart and an open mind. ■

Donna R. Cryer, JD, is president and CEO of the Global Liver Institute, the innovation and collaboration platform for the liver community. She serves on the Executive Committee of the People-Centered Research Foundation, the Boards of Directors of the Society for Participatory Medicine and the Personalized Medicine Coalition, as a patient representative to the U.S. Food and Drug Administration and the ABIM Gastroenterology Specialty Board. Her community service includes roles on the Boards of Trustees of Sibley Memorial Hospital/Johns Hopkins Medicine and The Taft School.

Richard O. Davis, PhD, is president and chief executive officer of Sibley Memorial Hospital. Prior to joining, Dr. Davis was vice president for innovation and patient safety for Johns Hopkins Medicine, executive director of the Johns Hopkins Medicine Center for Innovation in Quality Patient Care and of Johns Hopkins Medicine's Access Services and director of The Johns Hopkins Hospital's East Baltimore Ambulatory Operations. He serves on the boards of trustees of Johns Hopkins Homecare and Johns Hopkins Pediatrics at Home. He is on the faculty of the Johns Hopkins University Bloomberg School of Public Health Division of Health Policy and Management and the Business of Medicine programme of the university's Carey School of Business.



REFERENCE

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