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Female: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the health care of the future. This week Mark and Margaret speak with Dr. Adrienne Boissy, Chief Experience Officer of the Cleveland Clinic. She's presiding over the 10th Annual Patient Experience Summit, which brings together experts from across the health industry, hospital administrators, clinicians and patient advocates, examining the need to develop better empathy training for clinicians and health care.

Lori Robertson also checks in the Managing Editor of FactCheck.org looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea. It's improving health and well being in everyday lives. If you have comments, please email us at CHCradio@CHC1.com or find us on Facebook, Twitter, iTunes or wherever you listen to podcast. You can also hear us by asking Alexa to play the program Conversations on Health Care. Now stay tuned for our interview with Dr. Adrienne Boissy, Chief Experience Officer at the Cleveland Clinic here on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Adrienne Boissy, Chief Experience Officer of the Cleveland Clinic Health System. She's a neurologist and staff physician in the Cleveland Clinic-Mellen Center for multiple sclerosis. Dr. Boissy also leads the Center for Ethics Humanities and Spiritual Care. She previously served as Medical Director of the Center of Excellence in Healthcare Communication. She earned her master's in bioethics from Case Western Reserve, her medical degree from Penn State University College of Medicine, and completed her neurology residency and fellowship at Cleveland Clinic. Dr. Boissy welcome to Conversations on Health Care.

Dr. Adrienne Boissy: Thanks for having me.

Mark Masselli: I see that you're presiding over the 10th Annual Patient Experience Summit, the largest independent patient experience summit in the world. I'm wondering if you could talk to our listeners about the evolution of the science of patient experience and why empathy plays such an important role?

Dr. Adrienne Boissy: Well, patient centered care really started really way back when, when the Institute of Medicine had published a report, it was called the Crossing of the Quality Chasm. They talked about six efforts that health care needed to make to make health care more efficient, safe, equitable, and more patient centered. They defined it at that time as care that's respectful, the patient preferences, needs and values and

ensuring those values guide clinical decisions. If you research even the number of studies on empathy, or patient centeredness, specifically, you come up with about 1800 articles since the 1960s. Yet, I still hear stories at times from journals not accepting articles that are focused on the patient experience, because they don't think it's scientific enough. That's pretty worrisome, as you're seeing decades and decades of literature coming out, that talk about the power and the impact, empathy and real conversations can have on patient reported outcomes, medical outcomes, safety, quality. We need to get real that it's not the soft thing, but it is backed by decades of science.

Margaret Flinter: In a recent TED Talk you expressed some concern that the empathy, which we believe is so powerful is perhaps too often dismissed as a soft skill in health care. You've said that empathy needs to be operationalized. Tell us what you've learned in your own practice at Cleveland Clinic about the importance of empathy, and in particular, maybe the measurable impact empathy has had and it's having on patient outcomes?

Adrienne Boissy: I mean, even the fact that you're still hearing empathy called a soft skill, drives me kind of crazy. It's not a soft skill, it is the hardest skill that we do, telling someone you've never met and you're meeting in the first time in the ER that they have ALS, or telling a patient who thinks they have one diagnosis that in fact, they have another. These are not soft conversations, these are exceptionally uncomfortable and they're intimate and they're fragile. I was seeing patients in a very busy practice, I was double booked and I would do my best to be empathic but trying to be efficient with time as well. In many situations where -- and I was trying to have a conversation about their medical care, and I realized that the patients, I'm a multiple sclerosis specialist, and the patients I was seeing, some of them didn't actually have MS.

I wanted to be a good neurologist, so I was honest with them right out of the gates, and I said, the great news is you don't actually have MS. Instead of getting the big hug that I thought I would get, they get really mad. What I realized in that was, they weren't looking for me to get the diagnosis right, they were actually looking for me to see them in their totality as a human, and the label of MS became an identity. What was underneath that was even though they didn't actually have MS, they had suffering. Here was all this suffering that we had neatly applied a label to, what I was actually doing was ripping out their identity. It taught me that people need to be seen as a human before they'll trust you with making a significant change like that. Now I spend a lot more time up front, I empathize, I asked about trauma and how they're coping with the disease before I dive into any of the medical jargon and specifics. That has changed my practice.

Mark Masselli: I was just thinking about the challenges in primary care of how, as you say, to connect with the human sitting across from you with suffering and also the economy of a practice you might be in there for 15 minutes with a patient. You've got an EHR in front of you, your colleagues are burning out. At Cleveland Clinic, you've launched a number of efforts to improve patient engagements and we're just wondering how technology and online social networks, like patients like me help improve this patient engagement?

Adrienne Boissy: Yeah, when we talk about engagement, I think we have to be really careful about what we're talking about. It's used interchangeably, even with experience, and they're not the same thing. One of my favorite examples is you can have the experience of riding a rollercoaster and you could be screaming, throwing your hands up as you're going down the hills, and then by the photograph afterward, or you just sit there with your hands crossed and go through the ride. One person on that ride is really engaged with the experience, and the other is not. Engagement is about engagement with something.

A lot of people use these patient portals as an example to say, oh well the patients engaged because our hospital has patient engagement because 30% of our patients use the patient portal. But if you've never actually logged in to check your labs that are available to you in the portal, we're not maximizing what patient engagement is supposed to be. I think to get to truly engaged patients, it's really about behavior, which means they should be completing an advanced directives. They should know what meds they're on and why, real tangible behaviors that a patient can make to demonstrate engagement. But to fully empower a patient, health care has a responsibility to give them some capabilities back like access to their data, speedy access to appointment, transparency across, availability of their records anytime anywhere, and really control.

Consumers have control, patients don't. They also have fear which will forever differentiate them. Patients like me started as a -- because one of the brothers of the Haywood family was diagnosed with ALS. They were struck by the paucity of resources available for patients. They developed patients like me, it's a organization and there are many others like it that are trying to create communities, right, where healthcare can't go, because those are patients who have the same disease connecting with those patients. In some sense it’s the empathy community, and so it's, I think, done a beautiful job in terms of elevating that. They've also been very effective at being transparent about how they use patient data, which is a hot topic these days. The data can be used for research, and patients with that level of transparency clearly resonate with it. I think that's why you're seeing the explosion of spaces like that.

Margaret Flinter: But Dr. Boise it would seem, we cannot hardly pick up a journal without reading about clinician burnout reports that it's at an all time high and some pretty devastating consequences to those individuals. Cleveland Clinic has such a great reputation as a high performing health system, but I doubt immune to those same stressors. What have you done there that we might all learn from that you think is having or has had an impact on preventing preferably or reducing clinician burnout? Are there programs that you found to be particularly effective in preventing or reducing burnout?

Adrienne Boissy: We've cared about burnout for some time, but I really learned about it the most when we were launching communication skills training for clinicians. In the training, all the sudden, you had these small groups of clinicians, who began sharing this vulnerability in the safe space that we had created, they began sharing the story that just made it incredibly hard to imagine how they show up for work the next day. It struck me at the time that what was therapeutic about the training wasn't necessarily that we were doing reflective listening or anything, but that we were creating a space for those stories to be told. The sensation of what it feels like to have empathy reflected to you, and when you do that, the clinicians never forget it.

We hold them accountable for patient satisfaction scores and tell them to be more empathic, but who's being empathic to them? That question drove everything we developed since then. It's important to note that burnout is not an individual problem, something about the health care system is not supporting these amazing clinicians to be their best. These individual fixes, resilience courses for me, or yoga training, that is a bit offenses, because I studied minutiae for years to become a doc. We need to acknowledge and make sure we're talking about the system and how the system can change. I spoke about a lot of solutions, many of them seem like common sense, having pharmacists do refills for patients who are already established.

Having pharmacist help with pre-authorization or some of the paperwork that often clinicians get left to do, implementing scribes and virtual scribes so that we're not just typist. We also have to look in health care, so some of the things that we've done which other organizations could easily do, would be to recognize the moments that matter for clinicians and patients. Jonathan Bartels out of University of Virginia came up with this beautiful concept, the pause, which is just to take a breath when a patient dies, or ritual called the pause, take a moment and recognize the power you have. We began on our walks, so when a patient donate their organs, all of the caregivers line up in the hallways to honor that patient and the sacrifice they're making to save other lives.

When there's a trauma in our ER, or somebody is hurt, you can call it

code lavender, and a team will arrive on the unit to provide care to the caregivers. I think it's about attentiveness to the moments where you can create meaning, because burnout is associated with the loss of meaning for people. You have these amazing people that want to be caring and healing, and then we make it so hard for them to do that. You hear a lot of talk about the HER, I would say it's not the EHR per se, it's the lack of intuitiveness that it's not making my job any easier, right? It's taking two extra hours to document at nighttime.

Margaret Flinter: Lots of clicks.

Adrienne Boissy: Yeah, and it -- I wouldn't mind the clicks, quite honestly, if it helped me do what I'm there to do. But how does the EHR help me understand what's most important to the patient, right? We're talking about patient centered care and empathy. I haven't met an EHR that does that yet. You wouldn't get so much frustration if I saw the reward of a deeper connection with the patient I'm trying to impact and walk on their journey with.

Mark Masselli: We're speaking today with Dr. Adrienne Boissy, Chief Experience Officer of the Cleveland Clinic Health System. You've already talked about the work that you've been doing on communication skills for physicians and it really came out of the Cleveland Clinic's own experience with this diagnosis, medical errors, even deaths after they review thousands of patients concerns, and recognizing that the health system itself has to do some things to make sure that there's access to data, access to appointments, there's transparency cost. I'm wondering in your 10th conference, have you segued over to sharing some of this with group practices, smaller entities than the hospital systems, if there's any training protocols you've developed that might assist those clinicians in becoming better communicators?

Adrienne Boissy: About a decade ago at the Cleveland Clinic, Toby had declared a patients first and he had elevated the first chief experience officer in the country to represent patient experience at the executive team. One of the first things we did was developed service recovery training. That was for 40,000 people, we put them all in a room over a year and a half, we trained them in that. What we realized from that though, was that the conversations clinicians had can't really be fixed by models that work in hospitality. If I smile and say thank you, or my pleasure, that feels very superficial to most clinicians. We wanted to evolve communication skills training, that works on -- it's called the ready model framework, relationship, establishment, development, engagement. How do you do that? What does it sound like? Empathy is simply meeting the emotion where it is in that other person and taking the time to do that. We've trained about 9000 clinicians, as well as across the globe. We certainly are happy to share that model. Empathy doesn't take much time. Like how long does a hug take?

How long does it touch on the hand take? It takes seconds. Oftentimes you hear buzzwords of empathy in 15 seconds, or 30 seconds, and the truth of the matter is, if you're doing it time stops, and even if you had 15 minutes that one minute will be something the patient will never forget.

Margaret Flinter: You're presiding over the patient experience summit, you've got an improvisation coach from the famous Second City comedy troupe. You have a fellow named Chris Dancy, who's been called the most connected man on earth really focused on how technology gadgets can improve health. But I think my favorite of this is your event called Death Over Dinner, where attendees joined together for a meal, and a really frank conversation about how do we address death and dying with our patients. Talk a little bit about the variety of presenters, what are you most excited about?

Adrienne Boissy: We always begin and end the conference with patients, that's a non negotiable for us. Actually, when the conference started almost a decade ago, we had Charity Tillemann-Dick come, who recently passed. She was the opera singer who had a double lung transplant twice. She sang beautifully about 10 years ago, and then it's unfortunate that now here we are 10 years later, but having just recently passed. It's trying to literally elevate voices like hers, both the profound beauty of empathy and the power that it can have. Death over Dinner is the brainchild of a wannabe architect, name is Michael Hebb [PH]. He came with his idea many years ago around -- he's done this for Barack Obama and many other high profile events where people came together over a table to have really important conversations in an era where everybody's got a phone, are we still talking to each other about the things that matter most?

We have collaborated with him to develop a Death over Dinner for Health Care, meaning if you as a health care provider could have this conversation over dinner about your own imagining for your life and the end of your life, could you then be a more effective enabler of a conversation with a patient? I think it's very powerful. We're going to expose people to the concept of the conversation with death over dinner. I mean, the event is most exciting for me, because actually when I started this work a decade ago, I felt actually quite alone. Sometimes it'd be really hard to keep pushing to amplify empathy in today's world. There's always something newer in technology that's coming, and how do you keep saying this stuff matters? I think when the movement was first starting almost a decade ago, it just felt lonely for me. This event, when you're staring at thousands of people that are coming together to elevate this global conversation, I feel a little less lonely.

Mark Masselli: Thank you so much for speaking today with us Dr. Boissy, Chief

Experience Officer at the Cleveland Clinic Health System. You can learn more about her work by going to Cleveland Clinic.org or you can follow her on Twitter @boissyad. Dr. Boissy thank you so much for advancing the quest to build empathy and better communications into our profession and for your commitment to innovation and care delivery to improve the patient experience and for joining us on Conversations Health Care today.

Adrienne Boissy: Thanks so much for taking the time to speak with me.

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Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori what have you got for us this week?

Lori Robertson: Democratic presidential candidate Beto O'Rourke advocated universal background checks for gun purchases, claiming that state laws mandating universal checks, "Have been shown to reduce gun violence by 50%." But academic research doesn't support that. O'Rourke's campaign said the statistic came from every town for gun safety, but the gun control group told us it has updated its background material on the issue in light of rigorous new research. A study published in the Journal of General Internal Medicine in March found that universal background checks are associated with about a 15% reduction in firearm homicide. The study looked at homicide and suicide rates in all 50 states and analyze the relationship between various firearm laws including universal background checks. But the study stopped short of concluding that the decline was caused by those laws.

There have been attempts in congress to require universal checks, which would cover private sales by unlicensed individuals, including some sales at gun shows and over the internet. But the policy has failed to gain enough support to pass. Research released by every town in 2015 found, "Nearly 50% fewer police murdered with guns, women shot to death by intimate partners in states with background checks." But determining that states with universal background checks have lower rates of certain types of violence is not the same as proving that universe background checks have been shown to reduce gun violence by 50%, the phrase used by O'Rourke.

David Hemenway, Director of the Harvard Injury Control Research Center and the Harvard Youth Violence Prevention Center told us it is notoriously difficult for researchers to tease out the effects of various gun policies in states that often have a combination of policy. A 2017

paper Hemenway co-authored reviewed the available peer reviewed research on gun control laws from 1970 to 2016 it, “Found evidence that stronger firearm laws are associated with reductions in firearm homicide rates. But a reduction in violence of 50%, “Seems much, much too high to me.” Hemenway told us. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, email us at CHCradio.com, we'll have FactCheck.org’s Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Sub-Saharan Africa leads the world in maternal and infant deaths each year. According to an annual report from Save the Children an estimated 397,000 babies died at birth in that region in 2013, and some 550 mothers died per day as well. Most of the causes have to do with lack of access to medical care in these low resource regions, and often the local midwives lack formal medical training to prepare them to conduct interventions in the event of a life threatening event like a hemorrhage or an infection.

Anna Frellsen: We know that 90% of all the deaths that we see today could be prevented if the mother had had access to this really basic skill care during the childbirth.

Margaret Flinter: Anna Frellsen is CEO of the Maternity Foundation, their organization has created an intervention for midwives living in low resource areas. It's called the Safe Delivery App, and it provides comprehensive training for midwives that teach them and guide them on what to do in the event of a birthing crisis.

Anna Frellsen: This is really a matter of building the skills of the health workers who are already out there and empower them to be able to better handle the emergencies that may occur during childbirth, such as the woman starts bleeding or the newborn is not breathing and so forth. First and foremost, it's a matter of finding a way that we can reach to help progress and build their skills.

Margaret Flinter: Frellsen says the real promise of the Safe Delivery Application lies in its ability to provide ongoing obstetric and neonatal training. The Safe Delivery App has been designed to be culturally relevant and easily understood. It's received the United Nations approval for wider deployment. The Maternity Foundation plans to have the Safe

Delivery App in the hands of 10,000 health care workers across the region by next year. A low cost culturally sensitive mobile app that offers immediate guidance and assistance to midwives and health workers empowering them with ongoing support and knowledge that can improve birth outcomes, now that's a broad idea.

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Mark Masselli: You've been listening to Conversations on Health Care, I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peach and health.

Female: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at CHCradio.com, iTunes or wherever you listen to podcast. If you have comments, please email us at CHCradio@CHC1.com or find us on Facebook or Twitter, we love hearing from you. The show is brought to you by the Community Health Center.