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SWSC 2019 Presidential address "Putting Patients First"

I think it is often tradition, appropriately, to open such Presidential addresses by acknowledging and thanking your mentors. I truly believe, though, that we have many, many mentors in life; and many different mentors in different stages in life and different needs for different mentors. So I won't mention all my mentors today, but I want to honor two mentors important in my career and my membership in Southwestern Surgical.

There is a reason I asked Dr. Edward Nelson to introduce me today, and that is because he is a great mentor to me. I met Dr. Nelson as an intern at the University of Utah in 1995. And since that meeting he has been my teacher, my senior partner, my Division Chief, my Chairman, my friend, and now my neighbor. And every one of those relationships has been a privilege to me. And through all of those relationships, he has been a mentor to me.

When I met Dr. Nelson, I immediately recognized that he is the surgeon that I was going to be. He takes better care of patients than most. He is technically one of the most skilled surgeons I've ever trained with. He is an extremely diplomatic leader. He is kind, and he is supportive. My first presentation as a trainee at SWSC, was with Dr. Nelson, as my senior author. He has shared this lectern as President of SWSC, so he is a mentor in Southwestern surgical to me as well. I hope I have and will continue to try to emulate Dr. Nelson's career in surgery.

I wanted to mention my other mentor in Southwestern Surgical, and that is Ronnie Stewart. I don't know why Dr. Stewart chose me to be the Recorder, following his term, but it's been such an honor to try to follow his footsteps as a Recorder. He was so committed to that position, and remains so committed to Southwestern surgical. I tried to fill only half those shoes. He is the face (and camera) of this organization. I think that one of the reasons that he chose me, is that he wanted to change the phenotype of this organization. He wanted a younger and a female person on the Executive Council to help make forward changes in the organization. He asked me to represent that. Instead of me making changes, Ronnie, your advocacy for the diversity of this organization, by being a promoter and a supporter of diversity, has been far more powerful in implementing change in Southwest surgical then I have been. You have influenced and preserved the future of this organization. Thank you.

So, it is not surprising, with those two as my Mentors, that my topic today is "Putting Patients First". You start to think about this talk two years earlier, and you go to every meeting's Presidential Address, and it all just makes you nervous. You then go back through the previous Presidential Addresses here, and that makes you even more nervous. I wanted my topic to be something that was true to me, but interesting to the broader SWSC audience. So, I started to think about what projects I've done at the University of Utah since I've been on faculty there, excluding oncology, HPB surgery and pancreas cancer research; which this general audience of SWSC is not so interested in. And in this reflection, I realized that a lot of my career has really been trying to put patients first, and make our work serve the patients and meet the needs of the patients.

When you "Google" putting patients first, there are a lot of definitions. This definition is the one that was truest to me: "Putting patients first focuses on the patient's personal needs, wants, desires, and goals so that the individual becomes central to care." (http://lippincottsolutions.lww.com/blog.entry.html/2018/02/06/putting_patientsfir-6cUL.html).

My goal for today, with this talk is to address: 1) did we get away from putting patients first? 2) I think we have, so how did that happen? And 3) was it us or the patients or both? 4) Do we need to change our approach, meaning, should we be putting patients first; are there benefits to doing so? And then, finally, 5) I want to mention briefly five projects that I've been working on the past several years at the University of Utah, trying to improve a patient centric approach.

To start this topic, we must understand our origins. Why we do what we do, and how our profession started. In a simplified generalization, most of us went into medicine to be a healer. A healer is a person who claims to be able to cure a disease or injury using special powers, a person or thing that amends or repairs something, and specifically someone who alleviates a person's distress or anguish (Oxford dictionary). That is what we wanted to be, one who relieves someone's distress. An individual who wanted to serve as a healer has been documented in nearly every culture since the beginnings of mankind. From as early as 7000 B.C. there are archeologic findings consistent with shamans and apothecaries in the role of healers, taking care of their own. There is evidence of Shashtrakarma, the Indian art of surgery as early as 3000 B.C. (Wikipedia, History of Medicine; and Ancient Greek medicine).

In the United States, the first nation cultures had their own healers and shamans caring for their tribe. It wasn't until the 1600s that physicians were immigrating to the United States, from northern Europe, mostly trained in England and Scotland. Still, this early organized and trained group of healers, or the early modern physician, would travel to the patient, make house calls, to care for the ill. Medical care revolved around the patient.

The first organized hospitals opened in the United States in the 1750's. Interestingly, New York, New Orleans and Philadelphia all opened hospitals at about the same time. And this is when medical care started to change to revolving around the institutions and the providers and not around the patients, or serving patients in their own homes. With increases in technology, improved transportation, specifically, the invention of an ambulance; it became easier to transport the patient to the hospital, with immediate access to

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all “modern” technology tools, pharmacy, and supplies; than to transport the doctor to the patient's remote under supplied home. This allowed the hospitals to become more physician centered; meeting the needs of these highly trained and hard-working individuals to provide critical health care to patients in need. This exaggerated doctor-centric approach is emphasized by us, the surgeons, specifically. We are a major part of this hospital and doctor based problem, and one of the leaders in the transition of emphasis from the patient, to the providers; because we need to be in a specialized “operating room”. Patients must come to us, to our healthcare facility, for safe specialty surgical care. This, patients much come to the doctor-centric approach, has led to a sort of arrogant attitude of the physician.

In modern medicine, physicians have become very specialized, are highly skilled and each with extremely unique knowledge and skill set. This advanced training and high stress, high demand work load has led further to an arrogance of physicians. And then, let's be honest, medicine and surgery is particular, is financially rewarding. Physicians are privileged. And there's always been a demand for more physicians and specifically more surgeons.

Through all of this, we have become very paternalistic to patients. Patients must come to a surgeon in their “theater” to be cared for, while they are asleep, and have little ability to weigh-in on the “game-day” decisions made in their best interests, in the operating room. And surgeons become valuable to the healthcare institutions, so the hospital systems are often designed around the highly skilled surgeon's needs, for example: “Doctor's preference cards”, describing how a surgeon likes their surgical field set-up and which instruments they will require. Not what does this patient need, but rather what does this surgeon like? A CEO of a hospital system in Ohio once described patients as hostages of the healthcare system, as they sit in the waiting room in our patient offices and wait for the privilege of being seen (attributed to the CEO of Riverdale Methodist Hospital, Ohio).

That is not a Patients First approach.

Our electronic health record history is a marker for how we have gotten away from the patient This is a really fascinating paper that I, that is worth a read, on the history of health records (*From Papyrus to the Electronic Tablet: A Brief History of the Clinical Medical Record with Lessons for the Digital Age;* The American Journal of Medicine 126, 10, October 2013, 853–857). Originally, health records were just notes for the physicians themselves, to serve as their own teaching notes, or to learn from their own patients. Nearing the 1800s, notes became more about teaching others, residents and students. Some feel that modern hospital records come from the Mayo Clinic (PBS T.V. special; *History of the Mayo Clinic*). The Mayo brothers hired an internist, Dr. Harry Plummer, to join them to serve as an early hospitalist. And Dr. Plummer recognized the disorganization and discontinuity in the hospital as each provider had their own notes about a patient, but no one had access to the other provider's notes. Dr. Plummer recognized a need to assign the patient a “medical record number” and a record in the number could follow the patient. Every provider could add their own notes, but the record would be centered around the patient rather than the providers. Shortly after, in 1910, the Flexner Report was published, on the training of medicine in the United States, and the streamlining and standardizations of medical training in some ways, led to the continuity of a “medical record” for hospital patients across the country. The weakness of these hospital records was that they did not span across patient clinic and outpatient medical encounters. So, jump forward a hundred years, when CMS demands and American Recovery and Reinvestment Act enforce the need for an electronic health record, we now have electronic health records. The goal of an electronic health record would be to follow the patient, to record every medical visit, inpatient hospital stay, and any study, test or procedure. It would capture every medical event that the patient had. How patient centered is that? It is brilliant.

But we failed. The evolution of electronic health records systems has led to systems which do not capture the story of the patient, the communication from provider to provider. Most modern successful health records systems are billings based. With this, unfortunately, what has happened, concluded in the *Brief History of the Clinical Medical Record with Lessons for the Digital Age*; is that “in light of projected benefits, the actual performance of leading commercial electronic health records has been the subject of much criticism in the literature by practitioners, in failing to record the medical events which occur for the patient.

For the sake of this talk, I found a few examples of billing based notes of recent acute care or emergency room visits of patients that I have seen in clinic. The electronically recorded event is a serial of automatically inserted imaging and labs results, a drop-down menu catch phrase physical exam which does not describe the specific patient at all, and a series of diagnosis codes for the assessment and plan. I have no idea what the provider saw, thought, or concluded. These records are NOT patient centric at all. It's not helping us look at the patient more carefully, and it's not helping us take care of the patient together. It is billing based. So, this paper concludes that “physicians must not allow technology to devalue the doctor-patient relationship and the continuity of care in which the patient as a person maintains a place in the memory of the clinician and not just the computer.” This change in our medical reflects the changes in our healthcare systems, becoming system and provider based, not Patients First.

So, what about the patients? Maybe they have contributed to this turn in modern healthcare as well? Maybe it's not just the fault of physician and specifically surgeons. Maybe it's not just the health records' weaknesses. Maybe they have left us as well:

As I was putting this talk together, and one of the chief residents at the University of Utah, now a Thoracic and Critical care surgery fellow, Dr. Megan Bowen, gave a fantastic grand rounds in 2018 titled, “*Postmodernism and its Effect on Medicine*” (medicine.utah.edu/surgery/general_surgery/grandrounds/video.php?video=0_hdcylscf).

I highly recommend you follow this link and watch this video to understand our modern patient.

Dr. Bowen's interest was looking at the prevalence and influence of complementary and alternative medicine. In the introduction of her talk, she addresses exactly what I was interested in the regarding the evolutions of the doctor patient relationships. Fortunately for me, she just did all my research for me, in one hour! She explains that Modernism the period from the late 1800s up to World War II. The era was generally associated with a social emphasis on rational logic and a search for knowledge; knowledge obtained through scientific inquiry in a rational manner. The post-modernism era is after World War II. This era the generalized social feeling is that people (patients) have become disillusioned with data and pessimistic toward knowledge. They have abandoned the search for truth. They feel that the universal truth or the search for universal truth is impossible. Generalized philosophies of the post-modernistic person is anti-intellectualism, anti-science, and a belief in public knowledge. This post-modernistic patient is more likely to believe in a blog-post, then a medical journal publication. These patients believe in cosmetic lotions and essential oils, non-regulatory dietary supplements, gluten-free diets and anti-vaccines; but are not willing to believe in the anti-hypertensive you have prescribed. This modern patient has learned to believe in social lore about untested supplements far more than they believe in you, the practicing “Western-medicine” medical provider.

Drs. Martin and Finlayson, from the University of Utah, published a study on patient pre-surgery education materials (World J Surg. 2017 Jun; 41(6):1447–1453). They evaluated and provided patients different education resources: electronic e-mail and tablet based resources and printed materials. They then surveyed patients for "What information did you use and did you find most valuable before your surgery?" Overwhelmingly, the patients reported that the information they got from their family, friends, or neighbor who may have been through or associated with someone who had been through a similar situation, was the most valuable information that they got for their pre-surgery education. Despite best efforts to try to educate these patients. They don't believe us, and listen to the social "gossip" about health care. This is the post-modernism patient. Many studies have shown that the post-modernism patient would prefer to be seen by a chiropractor than a doctor; presumably because they put their hands on the patient more, listen, spend more face-to-face time, and maybe most importantly, they let the patient do some of their own self-care and participate in their decision making in their care (Am J Public Health. 2002 October; 92(10): 1628–1633/Spine (Phila Pa 1976). 2006 Mar 15; 31(6):611-21/Spine (Phila Pa 1976). 2005 Oct 1; 30(19):2121-8). This is what the post-modernism patient wants. A post-modernism patient would rather be seen on hospital rounds on by a robot (ww.nbcnews.com/id/4946229/ns/health-health_-care/t/robot-doctor-gets-thumbs-up-patients). Eighty percent of patients thought the robot would give them better access to healthcare. Seventy percent of patients thought it would provide better information. And 50% said they would prefer the robot to their own doctor.

Importantly, the post-modernism patient wants to be able to pick and choose their healthcare, they want to be able to add complementary medicine, and be empowered. They wat shared healthcare, shared decision making. Unfortunately, in all of that, though, we surgeons remain inherently paternalistic. We take a patient to the operating room, put them to sleep, and then they don't get to participate in the decisions anymore. Many times we make game-day decisions; we can't wake them up and let them help to decide the next best course of action. So inherently, surgery is paternalistic and facilitates this broken patient-provider relationship.

This is where we are: Patients don't trust us. Patients don't want to believe in us. We and our institutions have gotten away from meeting the patients' needs, rather meeting the physicians' needs. And as a symptom, our electronic health record has gotten away from patient care. We need to go back to putting patients first. Or do we, is there a benefit in trying to do so? I think there is. I think patients would benefit. I think the healthcare system would benefit, and I think we will benefit.

So the patients first, are there benefits?

Patient-reported outcomes have been an interest in health care in the past decade. In evaluating patient reported outcomes and centering healthcare on addressing patient reported outcomes, study after study, can help patients and clinicians make better healthcare decisions, but they can enable a comparison of our performances and stimulate improvements in those services (BJM 2013, 346, f167/N Engl J Med 1995; 332:1338–1344). Every study I reviewed shows that if we address what the patients want us to address, for example, not just take the cancer out of their colon, but make sure they have a colostomy that functions well or don't have a colostomy, or don't go on a ventilator or don't go do a rehab facility afterward, or don't facilitate their financial stresses; if we address all of these things, the human being, if we put the Patient First and not their disease, the patients Do Better (JCO Vol 26, 8, Mar 10, 2008/N Engl J Med 1995; 332:1338–1344/J Clin Oncol. 2016 Feb 20; 34(6): 557–565). This patient-centric approach has been shown to decrease morbidity and decrease length of stay. We can decrease readmissions. We can decrease discharge to long-term care facilities We can improve their perceptions of our care. We improve survival, and there are even studies that show that we improve cancer-specific overall survival (American Journal of Physical Medicine & Rehabilitation: August 2013; 92, 8 p 715–727/Anesthesiology 11 2014, Vol.121, 937–947). If we coordinate the holistic care of the patient, it is putting Patients First.

What does this mean? It means controlling their comorbidities, reconciling medications – stopping their tobacco use, addressing their financial and social stresses, and improving our efforts with education. That is putting Patients First. If we do all of this, we improve their engagement. We improve their education. We improve shared decision making, and we improve their satisfaction with more efficient care. These multimodality prehab interventions have been shown, as before, to decrease morbidity, improve health outcomes for the patient, psychologically and physically, and decrease readmissions.

So the patients clearly would benefit if we would take care of the whole patient. What about the system? Is the system going to benefit? Should we, and our healthcare systems be investing in this? We looked at our own institution and found out when we invested in this, we were able to decrease surgery cancellations, length of stay, post-operative complications, which is expensive for the healthcare system, we improved our observed to expected morbidity outcomes, and improve our utilization of resources and cost containment. At the University of Utah, inpatient and outpatient operating rooms, we had about a 2%–5% day of surgery cancellation rate. Mostly outpatient, quick turn-over cases; which is at the national standard, a small percentage. That means that 95% of our cases go on as scheduled. But what we found is that there is actually a significant cost associated with that, due to the down time in FTE's (RN, tech, CRNAs, residents, anesthesiologists, and surgeons) not being utilized; but also cost of the room, instruments that are open and so on. We calculated that we could lose up to $8 million a year with only a 2% cancellation rate; which is a small fraction of an institutions operational budget, but not a small number. And that doesn't include missed opportunities like timely surgery, alignment of personnel, efficient utilization of resources, and it also doesn't include professional fees. So, more than $8 million lost, annually, and in patient satisfaction; in the institution with only a 2%–5% same day surgery cancellation rate. In follow-up, we evaluated what was the cause of most of these cancellations? Could they be prevented? We found that 44% of our cancellations were due to a poorly managed comorbidity or a patient that wasn't well-informed or oriented to when and where they needed to be on the day of surgery. We felt that the majority of this 44% could have been preempted with a well-organized preoperative clinic to improve patient pre-op assessments and patient education. By putting the Patient First and understanding their medical and social issues, addressing better patient education and information, we may have decreased institutional surgery cancellation losses but at least 30%. By putting the Patients First, we can save resources and finances for our healthcare system.

But what about us, the health care providers; do we benefits from a Patients First system? We all went into this profession because wanted to be healers. The College of Medicine in Phoenix website says: "Do you want to make a difference in people's lives? Does having a positive impact on the ability to help others drive you? If you answered yes, then you're on the right track. Medicine is a career driven by service, and you are tasked at putting others first." But that's why we chose this career, to be a healer, to alleviate a person's distress or anguish. A study out of Sierra Leone surveyed why people in Europe went into a medical career (Glob Health Res Policy. 2017; 2: 34). Seventy-five % reported they wanted to help people and another 70% said they were just interested in medicine.

That's why we chose this long and often challenging career path. So, we when find ourselves clicking endlessly in the electronic health record or getting bogged down in health CPOE and administrative issues, and we don't feel like the patients are melding with us, and we don't feel like we're taking good care of the patients, we are going to burn out. We are healers. We want to take good care of our patients. Better patient satisfaction improves our outcomes and our own outlook.

I had the privilege a month ago to go to the 2019 AHPBA, and Dr. Barbara Bass was giving a wellness and balance talk. The title of her talk is "We Must Be Well To Do Well". As I was listening to her talk and thinking about this talk; I realized that the opposite is also true. We must do well to be well. If we take good care of our patients and if we make that bond with patients again where we can feel like a healer, we won't burn out. There is evidence to support this. Studies on this topic concentrated on the electronic health record, which sort of sounds like it's become the punching bag of my talk, but that's not my intent. But you've probably seen on NPR – a physician from the upper Northeast, who wanted to remain unnamed, who started a Twitter handle, EPICEMRparody, and writes sarcastic tweets from the perspective of the medical record. I found this example: "I have mixed feelings about tablets. Sure, he's gazing at the screen like he's supposed to, ignoring the patient. But he could easily turn around (and face the patient). There is potential for bad outcome here." All of these tweets are super sarcastic and supposed to be from the perspective of EHR, but this is an example of providers expressing their frustrations with where we are in health records, and how we are getting away from patients.

The AAMC put out an announcement in 2018 that shows that there is a significant physician shortage predicted. The report hypothesizes that half of the shortage will be due to fewer people are going into medicine due to presumed job dissatisfaction, and the other half will likely be due to individuals leaving the field mid-career; citing electronic health record frustrations as a major part of the problem. Almost 60%of providers surveyed said healthcare needs a complete overhaul and 40% say they see more challenges than benefits and are therefore leaving their careers. Physicians who use the electronic health record and CPOE were less satisfied with the amount of time spent on clerical tasks and are at higher risk for physician burnout. There is evidence, though, that if we get back to taking care of patients, being healers, our burnout rates go down. In 2001, "Crossing the Quality Chasm" was published, and in 2000, "To Err is Human"; reports from the Institute of Medicine Committee on Quality in healthcare. These reports indicate that our quality outcomes in healthcare in the United States are not adequate. Six main targets that every healthcare system should address to improve quality are cited. And one of them is patient-centered care. We must put Patients First to improve overall healthcare.

Putting Patients First, really putting Patients First, means ensuring that patients will have continuity of care with a healthcare professional who the patient knows and trusts, shared decision making, and agreed plan and transparency in their plan and maybe even their costs (Br J Gen Pract. 2015 Mar; 65(632): 108–109). Shifting away from a provider-focused to patient-focused care takes sustained effort and endorsement from the healthcare organization. Elemental to the delivery of patient-centered care are structures and processes in the healthcare system (Int J Qual Health Care. 2011; 23(5):510–515/Holt, Nurs Forum. 2018; 53:555–566).

I've been privileged in the last ten years, to have my healthcare system be really quite supportive and really driven in quality care. Most providers at the University of Utah have been through Lean training. And quality is an emphasized value at the University. So I have been supported working on several patient centered projects in the past few years.

One of these projects was my Lean training project, one of these project required and FTE to support, and my institution has been behind it. It has really been a fantastic privilege to be so support by the University of Utah to develop these patient centered projects. And to be truly patient centered, it requires the institution's support and investment.

The first of five projects I would like to highlight is one we did 15 years ago, it is now a common approach, which many of you have adopted; but it is important so I want to mention it; and that is to provide patient coordinators or navigators and algorithms or pathways of care. In my practice 40–50% of my patient travel from out of state to our clinic, and if we didn't have the visit well organized with appropriate studies needed coordinated and so on … patient became hostages to my clinic. We would make them stay for days to get scans, biopsies, and other provider consults. They were trapped, if they wanted care. So, we hired patient coordinators, and sat down with our team, utilizing the NCCN guidelines as our road map, and wrote algorithms for new patient visits. Pathways that coordinate and collate patient care and studies that are already done and need to be done for efficient visits – with all the necessary providers in the same visit. With this program, we have significantly improved our efficiency. We have shortened the days needed for visits and patient travel time. We significantly reduced redundancy in labs and imaging. We improved our EPE (exceptional patient experience – patient survey) scores, and an unexpected outcome is we improved referring provider satisfaction. If a patient was referred from a nearby state, and their visit was well organized, they would give that feedback to their referring provider and the provider was then happy to refer more satisfied patients our way. Patients appreciate this more organized care, and recognize that this is putting them first.

My next project was to address "Doctor's Preference Cards" (DPCs) for surgical planning. Our DPCs guide what should be opened for a surgery, what instruments sutures would be used. The DPCs were paper based and did not flow from one operating room to another, often inaccurate, and inconsistent from provider to provider. So we decided to take a common case and make it Patient Centered by improve cost and consistency and therefore patient safety by standardizing the DPCs. We concentrated on laparoscopic cholecystectomies and appendectomies. We had at least 10 providers who may perform these procedures at all hours in our hospital system, and therefore with different support teams and at all and wee hours of the day. So consistency would easily improve patient safety and costs. So we made the DPCs electronically based, we surveyed all the providers and collated all their preferences with costs apparent to them and had them work together to design a standardized approach to the case with safety, cost containment and consistency in mind. For lap choles, this resulted in 20 items being removed from different provider's DPCs, and 30 items from lap appy DPCs; resulting in an average savings of up to $100 and $400 per case, respectively. Annualized this was calculated at more than $36,000/year saved for the institution, and more consistent and safer all-hours patient care for these common add-on cases.

The next project I have been working on is a modified preoperative clinic, this would be a drop-in same day pre-operative assessment clinic to address patient co-morbidities, but to all address the holistic patient; assessing and if necessary meeting their social, financial, physical therapy, smoking cessation, dietary, diabetes control, and case management needs; all in the same drop-in clinic. We call this the Surgery STRIVE clinic, which we describe as Strong for Surgery on steroids. STRIVE stands for **S**trengthening **T**oward surgery, enhanced **R**ecovery, an **I**nformed patient, **V**alue-driven care, and an **E**xceptional experience for the patient. This Surgery STRIVE, will address all phases of a surgical

patient's care, and this pre-op clinic is the first phase of this care to be integrated to ERAS peri-op care and ultimately to enhanced interactive patient education and post-op assessment tools. But this project in particular concentrates on the prehab or the pre-op care. In a multi-ancillary or holistic care of the patient, looking at reconciling their meds with pharmacy pre-op, clearly evaluating their comorbidities, case management involved with any patient, any patient who has financial stresses or concerns about their insurance can see financial counseling services. Endocrine will see every patient who is at risk for being a diabetic. Smoking cessation, nutrition, anesthesia, occupational therapy and physical therapy assessments, and social services discussions as needed. This is a drop-in clinic, so the patients can be seen the same day the decision for surgery is made. We have written an algorithm and screening questions for the above services. If any patient flags the service in the screening question, the appropriate team will see them. For example, if the patient notes that they are a smoker with financial questions about their insurance coverage, they will be assessed by the anesthesia team, smoking cessation team, and financial counseling; all in a single coordinated clinic, all centered around the patient's needs.

The next two projects are in the very early stages of development. The first is coordinating a single simplified new patient intake survey form. We realized that every single clinic has their own version of the new patient form, and as patient move from clinic to clinic they find themselves filling out this form multiple times. As we know, 80% of those standardized history assessment forms are exactly the same; family history, social history, meds, allergies. We ask the same questions over and over again. So our goal is to make an institution wide, single new patient visit form, that patients will only need to fill out once in a several year period. When a novel clinic appointment is made, the providers can see that previous history in the electronic health record and maybe update or confirm the data at check-in, but not require the patient the reproduce the form. This would not only be patient centered and a patient satisfier, but will also make the electronic health record work for us.

So, the last project that we've just started, that I am very excited about is redefining our patient coordinators (or navigators) to work for the patients rather than working for us. We have defined patient surveillance algorithms to streamline patient follow-up care, but coordinating the implementation of this and organizing surveillance studies, visits and preventing redundant studies and provider visits was not happening well. So now, our patient coordinators will be assigned a patient. When we see the patient in clinic, we schedule the proposed follow-up and call the patient coordinator to schedule it. The coordinator can then notify us that a similar imaging study was already scheduled within a few weeks of our proposed study and the one of the two can be canceled to improve the efficiency of the patient's care. In addition, patient become familiar with the coordinator and know that if they ever have questions about follow-up or studies or concerns about coordinated care; they can call that single phone number or electronic patient contact and their care will be coordinated. The University and Huntsman have supported this. They increased 1.5 FTEs for patient coordinators for our group. We have figured out how to have our electronic health record help us make this work, with the coordinators having their own patient lists, and easy identification in the chart of who the primary coordinator is in the care team. In our pilot studies we have received excellent feedback from patient regarding more attention to their needs, coordination of care, and confidence with a single contact source.

So these are the five patient-centered protocols that we have been working on. Patient care pathways, standardizing Doctor's Preference Cards, a patient-centered pre-op clinic, a single new patient visit form, and patient care coordinators working for the patient. I recognize that these are all small steps. I recognize that I did not address the many of the electronic health record frustrations, but maybe I've us realize the value we have in patient satisfaction and efficient and effective patient care, which may improve the value of healthcare to us, our institutions, and our patients.

I will emphasize again that shifting away from a provider-focus to patient-focused care takes sustained effort and endorsement from your healthcare organization. I've been privileged to have that endorsement from the University of Utah and Huntsman Cancer Institute. Putting patients first heals the post-modernism healthcare relationships. It makes patients the center of their healthcare system which is what the post-modernism patient wants. Improved coordination of care from all of us improves our efficiency, improves patient education, patient satisfaction, improves our career satisfaction, and probably has some financial return for our healthcare system. To improve modern health care, we must keep putting Patients First.

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