Spectrum

Society for Healthcare Strategy & Market Development®

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PATIENT EXPERIENCE

Bringing Human-Centered Design to Healthcare

Designing for (and with) people can lead to new insights and meaningful action.

By Jeremy Beaudry

In 2015, The University of Vermont Medical Center (UVMMC) became one of the first health systems in the nation to focus on creating exceptional patient experiences using human-centered design. Much more than a traditional graphic or product design group, the human-centered design team at UVMMC promotes a much expanded notion of design that positions it as a powerful strategic and creative problem-solving methodology within the complex healthcare environment.

The projects my colleagues and I work on span the design of systems, clinical processes, services, environments, website interactions, communication materials, and tools that support patient engagement. Less than two years into building a rigorous human-centered design practice, UVMMC has applied this approach to several patient-centered initiatives with measurable results.

Here are answers to several questions about our health system's new approach to experience design.

Q ***What is human-centered design?***

A "Human-centered design" describes a methodology and process that begins and ends with accommodating the needs and desires of our end users—the patients, families, providers, and

(Continued on next page)

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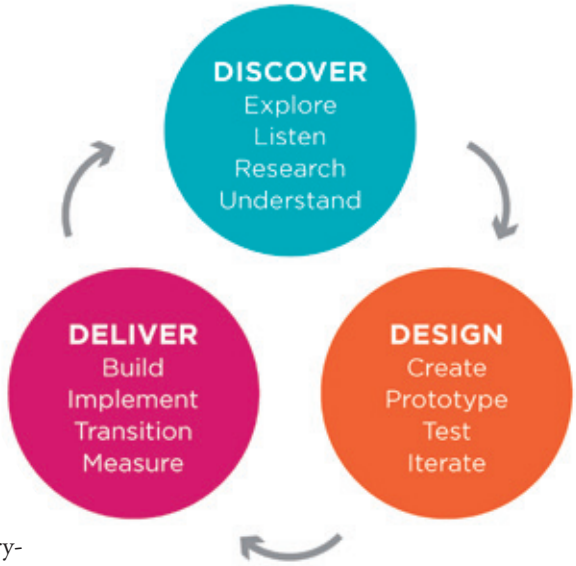
Human-Centered Design

(continued from page 1)

staff who each play a part in the co-creation of healthcare. Our collaborative, action-oriented, and highly visual process is defined by three iterative and often overlapping phases: *Discover*, *Design*, and *Deliver*.



DISCOVER involves various types of research activities in which we learn from our end users about what their experiences are. We then synthesize the resulting insights into a clear definition of the problem we are trying to solve.

In **DESIGN**, we create ideas through sketching and other visual media. We design and build prototypes which can be tested with end users, so that we can learn quickly and iterate through a series of possible solutions.

In **DELIVER**, we transition the solution to the appropriate stakeholders who will manage implementation over the long-term. We also determine the appropriate metrics that will help us measure our impact throughout the project's lifecycle.

Q ***Why is it important?***

A The healthcare field has lagged behind in terms of understanding the customer service experience dimension of how it interacts with its patients. As expectations within other consumer-facing sectors have shifted with more attention on designing exceptional experiences, patients have come to expect the same quality of services and experiences from their healthcare providers. The nationwide conversation around patient- and family-centered care has also created urgency for organizations to truly understand and meet the needs of patients.

A small but growing number of healthcare organizations are using the tools and methods of human-centered design to create seamless, responsive, and even delightful experiences for their patients. With an integrative, patient- and staff-focused mindset, we designers are making sense of the ecosystem of healthcare service delivery and deftly designing the discrete touchpoints—service interactions and environments, patient communications, digital tools, etc.—that come together in creation of the experience of healthcare.

Q ***What are some of the projects you are working on?***

A One project we've been involved with for well over a year is around improving how our patients and visitors find their way around the main campus buildings. We spent several months conducting exhaustive research with staff, patients, and visitors to learn about where the breakdowns occur with our maps, signs, directions, environmental cues, and digital location-finding tools. We also facilitated co-creative workshops with staff and patients to help us come up with new ideas from their perspective. Along the way, we quickly prototyped new ideas for a nature-themed wayfinding system and then tested them in the space of the hospital to further our learning.

Because our research findings and recommendations come directly from the participation and input of our project stakeholders (e.g., staff, patients, and visitors), we have received amazing support from key leaders in the organization who have the resources to make this work a reality. We are now working closely with our partners in facilities management to implement some of the short-term recommendations we made, as well as initiating a "request for proposal" to bring in additional expertise to realize our vision and assist with implementation. With a new hospital building currently under construction, we expect to roll out

our new wayfinding system for the entire main campus by 2019.

A more recent project is focused on supporting adolescent patients with chronic illnesses (e.g., cystic fibrosis and type 1 diabetes) to transition successfully out of our pediatric specialty clinics into adult specialty care. We began by conducting several interviews with patients and families in order to understand what their experiences are, as well as what their hopes and fears are for this journey toward adulthood. To better structure our interviews, we created a visual tool which asks patients to plot on a timeline their actual and anticipated steps within the transition journey. The resulting conversations about what the young patient had already achieved, and what remained, was unprecedented and forms the basis of a structured plan with clear goals.

While this work is in its early stages, we have already identified important insights about what is needed to effectively support young people as they make their way toward independently managing their healthcare. They need recurrent conversations with their providers about preparing for the inevitable transition out of pediatrics into the adult specialty world. They need to be connected with the right resources at the right time so that their specific needs for information are met when it is most directly applicable. And they need pediatric and adult specialty clinics to collaborate more effectively to provide a "warm handoff" that facilitates the transfer of medical information and the patient-provider relationships, which are ultimately about maintaining trust within the system.

Q ***What advice do you have for those who might apply human-centered design principles at their organizations?***

A In the past few years, many healthcare organizations have hired in-house designers with this expertise, as the value of design thinking has become more pronounced and sought after. However, even if your organization or department hasn't done so yet, you can begin to apply the principles of human-centered design in the work that you do.

- ***Build design capacity into your teams.*** Embed project designers who are trained in user experience research and human-centered design methods. Chances are, your organization has at least one or two employees like this. If not, seek out design consultants, facilitators, and trainers who can help your teams learn and practice these skills.

- ***Seek meaningful input from patients and staff in your projects.*** Listen to your end users and employ what you learn from them to guide the development of the project. Better yet, invite them to participate as co-creators in the processes, services, and products you are creating. Bring diverse groups of people together to build shared understanding of complex systems.

- ***As early as possible, create quick experiments to validate your assumptions and test the impact of your work.*** Adopt a rapid, iterative approach when developing or changing existing processes, services, and products. Evaluate these experiments with end users to further your learning and build an evidence-based approach to innovation and system change.

To learn more about experience design, join me for a webcast entitled "Be Like Water: Strategies for Infusing Design in Healthcare Organizations" on May 24. Registration information is available at shsmd.org/design.

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An adolescent patient with cystic fibrosis uses the transition of care journey mapping tool to visualize her journey toward adulthood.

Patients and healthcare providers collaborate in a design workshop to create a prototype.

How to acquire more than 2,000 primary care patients in one year

Learn how one hospital increased primary care visits, generating millions of dollars in downstream revenue.

By Erica L. Neufeld

In 2013, Boston Medical Center (BMC) began a five-year strategy to recruit more than 45 additional general internal medicine and family medicine providers for three reasons: 1) exceedingly long wait times throughout Boston for first-time appointments, 2) primary care patients feed specialty care, and 3) more covered lives were needed as new payment models entered the marketplace.

An increase in providers would lead to more appointment availability—creating an opportunity to actively market these appointments to consumers. This required an innovative approach because of BMC's unique patient population: 50 percent earn less than $22,000 per year; 80 percent are on Medicare or Medicaid; 31 percent do not speak English as a first language; and there is a 50 percent no-show rate for first-time primary care appointments. Still, the hospital was able to successfully attract more than 2,000 new primary care patients in one year who are 30 percent more likely to be commercially insured and show up for appointments 90 percent of the time.

The Research

As primary care providers (PCP) were being hired, significant research was conducted to understand consumer perceptions of BMC, their openness to switching PCPs, how they find PCPs, and what is most important to them in a PCP. We conducted 24 focus groups and then surveyed 800 people in the medical center's 16 primary zip codes. The demographics were aligned with BMC's core patient population in race, household income, and language.

From a recognition perspective, we discovered an opportunity to influence 61 percent of people in the market to seek medical care at BMC based on the following factors:

- 24 percent had been to the medical center for care
- 36 percent were aware of BMC and open to receiving care there
- 25 percent were not familiar with the medical center
- 15 percent outright rejected BMC

Research also showed that patients' expectations of providers fell into three categories:

- ***Attention to detail:*** thoroughness and searching for the root of the problem
- ***Convenience:*** offering all services under one roof, extended hours, appointment availability, and reasonable wait times
- ***Personal consideration:*** patients want to be looked in the eye, listened to, and neither rushed nor judged

When patients were asked what motivated them to go to BMC versus another hospital, there were some surprising answers. Being an academic medical center, having "top docs," and providing all specialties under one roof were neither motivators nor differentiators. Instead, the following were:

- Knowing that providers chose to work at BMC
- Having the best trauma care in the region
- Continued growth
- Connection to a network of 14 community health centers

Campaign Launch

Armed with this information, BMC and our partner agency Small Army conducted stakeholder meetings, consumer interviews, a survey of 309 residents in BMC's primary service area, and industry and competitor research. Based on the research, the Stronger Together campaign launched in December 2014 with the following platform:

At Boston Medical Center, we believe that a community united is a force to be reckoned with. That when those who do the caretaking are themselves cared for, the community grows stronger, healthier, and more vital. We believe there's no greater gift than caring for the ones we love and that when we truly support one another there's nothing we can't accomplish. It's the lessons we learn from each other that make us all stronger. Let's be stronger together.

The first year goal: attract 2,000 new primary care patients with a cost-per-acquisition (CPA) of $500 and a return on investment (ROI) of $1 million. For BMC, that return was calculated by taking the number of new patients, multiplying it by their one-year financial value, and subtracting the total media buy for the campaign. A combination of print, transit ads, digital, and search engine marketing (SEM) were used, with the bulk of the marketing and advertising spend on digital and SEM—these tactics also had the strongest calls-to-action. The remaining dollars were used to build brand recognition. This campaign was and still is heavily geographically targeted to BMC's primary service area.

Measurement and Results

All users were directed to a webpage to book appointments or call to schedule. The plan was to follow users from clicking on a banner ad or calling, to scheduling an appointment, to arriving at the appointment. This turned out to be impossible because users visited the scheduling page but typically didn't take immediate action. Instead, they returned to the site hours or days later and booked appointments. As a result, we decided the best way to measure campaign results is to track the number of new primary care patient appointments billed each month, minus the number of new patients in that month from the year before.

Using this methodology, during the first 12 months of the campaign, 3,145 new primary care patients came to BMC, the CPA was $343, and the ROI was $2.1 million. In addition, these patients were 30 percent more likely to have commercial insurance and 90 percent of them showed up to first-time appointments.

In addition to the impact on the financial bottom line, digital partners and SEM are measured monthly for click-through rates, impressions, call volume, appointment inquiries, landing page visits, and more. When trends are seen, adjustments in buys are made. Finally, calls to action are measured through A/B testing, which is the act of running a simultaneous experiment between two or more web pages to see which performs or converts the best.

For example, we have learned that "Make an Appointment" performs better than "Schedule an Appointment" or "Book an Appointment," and that "Book a Checkup" performs better than "Book Online Now." As the campaign progresses, these kinds of A/B tests help guide calls to action.

The Campaign Today

Stronger Together continues to run as a primary care patient acquisition campaign. Over time, the ads have evolved in language and effect, such as the use of cinemagraphs (one animated element within a banner ad), but messaging and images that related directly to the target audience, the highly geo-targeted nature of the campaign, and the measurement of various actions as well as ROI continue. To date, more than 6,000 new patients have been seen with an ROI of $4.7 million.

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Attract and Educate Parents by Showcasing Physician Expertise

Nebraska Methodist Health System highlights the knowledge of its physicians to match new parents and families with primary care providers.

By Sue Klein

How do you help parents find a great doctor? Every parent has questions from the time they first conceive all the way through the college years. With "Dr. Google" and well-meaning friends and family, parents are often inundated with answers, some of which are incorrect.

Nebraska Methodist Health System operates in an extremely competitive market with three major health systems and a population of just under 1 million people. With three hospitals and 22 primary care clinic locations across two states, Nebraska Methodist is the leader in obstetrics. To meet the challenge of keeping these families as patients once they become parents, our marketing team developed a non-branded strategy that highlights the knowledge of our obstetricians, pediatricians, and family medicine physicians. In late 2011, we launched a unique website branded distinctly separate from our health system.

ParentSavvy.com® was born.

This trademarked brand operates as a community service, providing health and parenting information to all parents—brand-loyalists and "other-brand" loyalists alike. We offer families the ability to ask questions and learn from our doctors—whether or not they are our patients.

ParentSavvy, both as a website and as its own brand, has grown year-over-year and has partnered with many of the leading family-focused organizations across the region. Through these first years, we have learned six key lessons about reaching parents.

1. *Lead with credibility.*

We highlight our physicians' knowledge with relevant answers to parents' questions and concerns. This gives them answers they want and a view into the way a doctor reacts and advises. Parents can choose to read only the information they need or continue on to see all the answers and topics a doctor has published. From that doctor profile, parents can request a first-time appointment.

2. *Write the story they want to read—not the story you want to tell.*

We research areas parents are curious about. Our physicians answer questions and write blogs on these timely topics. Here are some examples:

- Why should I vaccinate my child, and is it safe?
- Is green coffee bean extract safe for teens to drink?
- How can I tell if this is a cold or the flu?

3. *An original, local resource is a benefit to the community.*

We focus on information for parents from our local experts and minimize any syndicated content to maximize the value to search engines. Both patients and non-patients from the community, region, and over 200 countries have been served by ParentSavvy. More than $1 million in community benefit has been contributed by ParentSavvy in parent education, lactation services, and prenatal support. Through our local partnerships, parents can see and hear from our doctors at local family events and venues.

4. *Activate your partnerships.*

Gone are the days of simply placing your logo on something. We replace sponsorships with partnerships. When choosing the local organizations to partner with, we look for an advantage to both partners; a quid pro quo from the association. Then we actively work together to the advantage of parents.

- We share content with our partners and feature their experts' content on our website. This gives parents a source for credible local healthcare information as well as family events and education.

- Partners share information and posts across social media, increasing the reach of all.

- We cross-market ParentSavvy with our partner organizations and meet monthly with them to jointly plan participation at each other's events, including sharing experts and content.

For example, ParentSavvy information and health education is available through Omaha Children's Museum field trips, outreach, and camps. Our partners from the Omaha Storm Chasers have mascot-led reading sessions at the Children's Museum, and we have doctors throw out the first pitch and encourage healthy family activity at special baseball games.

5. *Content can be used beyond just websites.*

We use credible, interesting, timely information from our physicians in advertising as well as on our website.

We pose questions to doctors as online ads, and then link to their answers on ParentSavvy.

"Mommy Minute" advertisements feature a doctor answering a question, produced by and airing on the local ABC affiliate partner of ParentSavvy. Examples are: "When can my child safely start organized sports?" and "How much sleep does my child really need?"

Fifteen-second "Did you know?" animated videos play online and at baseball games to give parents quick information and encourage visits to ParentSavvy.com. For instance: "Did you know… up to 80 percent of lifetime sun exposure happens before you reach 18? Get the facts about sunburn safety at ParentSavvy.com."

6. *Collateral doesn't have to be a brochure.*

We give parents something of value—not a brochure talking about Nebraska Methodist. We look for "refrigerator-worthy" information that is useful. Our brochure is actually a coloring book to keep kids entertained. We focus on the physicians' knowledge and not the brand. Here are some examples:

- OTC medicine dosage cards for ibuprofen and acetaminophen

- "How to bathe your baby" with an animal wash mitt for new parents

- Animal zipper pulls with "How to help your child learn to dress"

This is not your father's marketing strategy. Communicate the success.

A strategy not focused on the brand is a different idea to many. We educate our leaders, physicians, and partners about the value of ParentSavvy and communicate the measurable success of this "un-branded" approach. The executive team is supportive of the community contribution and visibility of ParentSavvy. Doctors have seen new patients based on knowledge they have shared and appreciate the opportunities to reach parents in the community. Our partners look to ParentSavvy as a hub for collaboration between organizations focused on families.

In 2017, Nebraska Methodist plans to increase utilization of ParentSavvy and find additional ways to leverage the services that benefit parents and drive engagement with our physicians.

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ParentSavvy Results

- Over 1,000 consumers visit ParentSavvy.com every day.

- ParentSavvy has more than 6,500 engaged social media followers.

- About 3,500 people subscribe to ParentSavvy e-mails.

- More than 500 parents view physician profiles each month. Parents can then request a first-time appointment with the physician. Nebraska Methodist has seen a 9 percent growth in primary care visits in the past four years.

- The ParentSavvy brand and website have contributed more than $1 million in reported community benefit.

Timing Is Everything

In the midst of a radical transformation, healthcare strategists must consider the 'when' and 'how' to best transition from volume to value.

By Scott Thomas

The implementation of value-based payments and population health is not moving consistently across all health systems. We know change is imminent. The question is, "How much change and how soon?"

This question is even more pertinent from the perspective of smaller, rural health systems with fewer resources. For example, how does a 62-bed independent community hospital in Oxford, North Carolina, approach a changing environment where value now trumps volume? Is there an expectation to take measures to keep patients *out* of our hospital?

Figure 1 provides insight into the shift and challenges associated with transitioning from a fee-for-service to value-based payment platform.

The graph depicts how the value-based model requires elements that run contrary to the traditional fee-for-service model. The new expectation is that we develop a continuum-of-care model that supports the medical home approach to healthcare. Instead of driving inpatient admissions, we instead focus our attention and resources on getting patients back to their primary care providers. We are no longer rewarded for volume, but are at risk for less than quality outcomes. Additional challenges include cash flow and hard costs associated with technology.

My hospital, Granville Health System (GHS), had to decide how much contracting and operational change we could absorb while entering the new environment. We had previously developed some interesting patient-centered initiatives and, as indicated by the graph, we were straddling the two models as we implemented programs and explored new relationships.

How GHS Entered the New Environment

GHS started having discussions around some lessons we were learning in our quality program about how we could develop the system more thoroughly to prepare for the evolving healthcare delivery environment. We committed to success in the pay-for-performance world, and relied on two emerging principles:

1. In the world of pay-for-performance and outcome-measured healthcare, the health system is ultimately responsible for the decisions our patients make. GHS could continue to fight it, or we could redirect resources and embrace the principles of population health.

2. As a small primary care model, we believed if we could reunite the patient with his/her primary care physician and engage the physician, good things would happen.

To accomplish this, GHS began focusing on transitional care in 2012. With the leadership of our board of trustees and direction from our medical staff, the Transitional Care Team developed an incredibly effective, programmatic approach to caring for the community. Since that time, readmissions have remained low as the program continues to grow.

The Transitional Care Program is designed to ensure patients are adequately prepared for the transition from hospital to home by encouraging patient participation in post-discharge care. The program ensures hospital patients have follow-up appointments with their primary care physician, arranges for continued care where appropriate, and offers home visits to assist with recovery after discharge.

The care team meets with the patient and family prior to hospital discharge to develop a personalized plan of care that includes healthy goals aimed at preventing future hospital admissions.

An important role of transitional care is supporting the patient and his/her family's ability to manage care at home. Through referrals from our Transitional Care Program, paramedics with Granville EMS use their existing training and skills to meet clinical

needs of the patient outside of the hospital in a non-urgent setting. The EMS Mobile Integrated Health Program focuses on improving the quality of care for the patient while reducing costs associated with preventable readmissions.

Granville EMS or transitional care nurses and social workers visit patients at home to assess their recovery. The Transitional Care Program allows for a more effective collaboration with all members of the patient's healthcare team, more favorable patient outcomes, and ultimately drives down the overall cost of delivering medical services to the community.

> The program improves collaboration among caregivers, enhances patient outcomes, and reduces costs.

It's been a successful program. In 2015, our team made home visits to 30 patients. In 2016, the number nearly tripled to 86 patients. Recent reported readmission rates for GHS were 1.63 percent. The North Carolina state average during this period was 3.32 percent. This measure includes discharged patients who have to be readmitted to any acute care facility in North Carolina within 30 days after their initial discharge under the same condition. The performance rate for GHS is statistically significant at half the state average.

In addition to the Transitional Care Program, GHS has implemented other programs, such as bedside medication and hospitalist rounding in the long-term care facility to support the reduction of admissions.

Moving Forward

As GHS moves toward engaging the value-based pay-for-performance environment, it will continue to implement programs that support the continuum-of-care model. More significantly, we will partner with networks best suited to support the population served.

GHS will be participating in the UNC Health Care Alliance, a clinically integrated network (CIN). A CIN is an organization of providers (e.g., hospitals, physicians, mid-levels) who collaborate to improve quality, control healthcare costs, and work in partnership to provide coordinated care to improve the patient experience.

GHS's focus through the UNC Health Alliance model is to prepare the health system and population it serves for health management as it develops standardization of care, continues to grow transitional care management, and establishes value-based contracting.

The health system will develop a geographic service area under the CIN to maintain a focus on local community healthcare while working with self-funded companies to support the health of employee populations. This partnership is not a merger—GHS will remain independent and will benefit as it gains the assets of an integrated care platform with the assistance of a larger partner. GHS will increase savings, revenue, and market share by utilizing premium-based contracts and delivering value-based care.

In terms of timing, it really does mean everything. From developing programs like transitional care to exploring networking partnerships, health systems must determine for themselves the time and place to make change.

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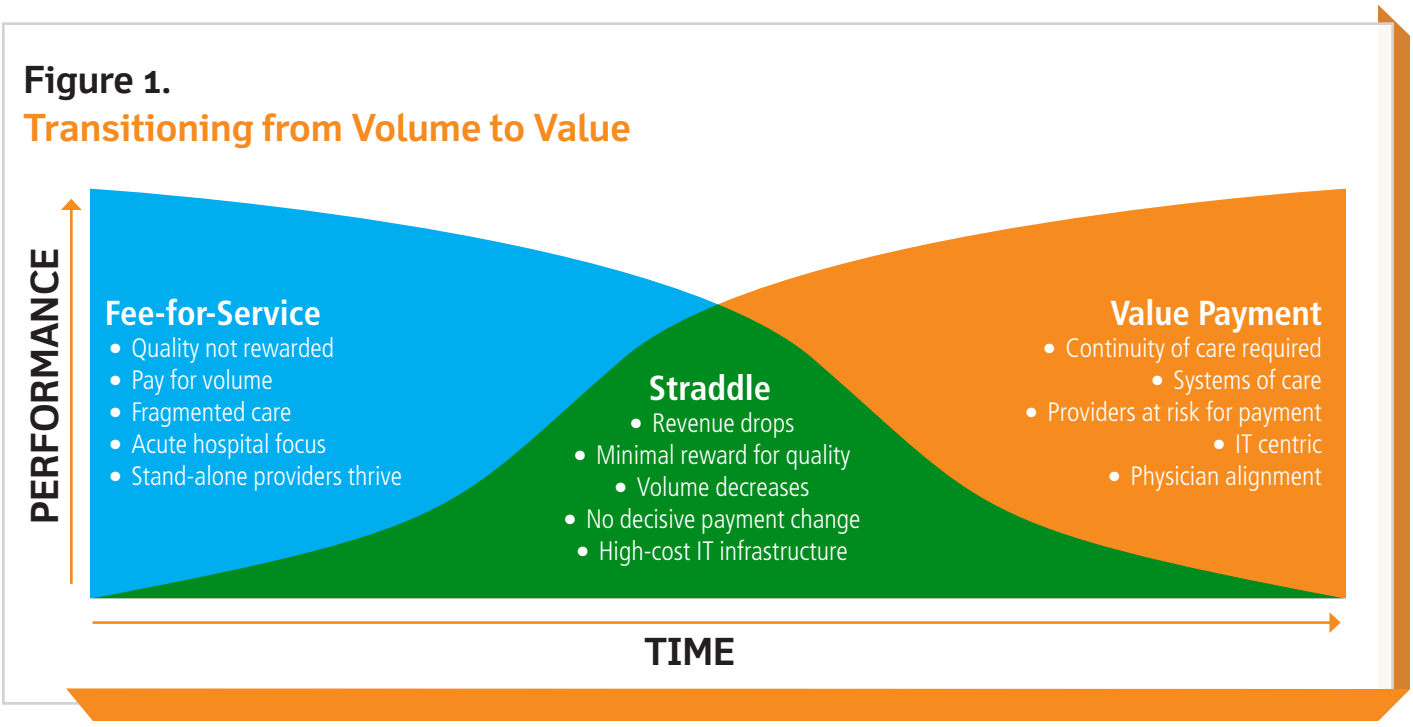
Figure 1.
Transitioning from Volume to Value



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The following questions and answers come from posts on SHSMD's members-only online discussion groups.* To join the conversation, visit **myshsmd.org**.

Going Digital with Employee Communications

Q ***We are considering making all or most of our internal newsletters digital rather than print. What are the best practices for going digital?***

A There is a great temptation to go "all electronic" with publications and newsletters for all audiences but especially for internal audiences. One approach is to use multiple, overlapping communications channels. No single channel will do the job. While it is more work for everyone involved, the results will be better if your internal audiences see/hear the information in multiple ways.

A In the past four years, with five systems with a grand total of 77,000 employees, the most common feedback via surveys and/or focus groups has been: Can we please have our on-paper health newsletter back? Each one of these health systems had shifted from paper to online. Now everyone is adding back a print version—in addition to online. The best solution seems to be to give them what they want, which means two options.

Health System Rebranding

Q ***What are pros and cons of rebranding a health system to "health"?***

A From our research, people think of systems as large, impersonal bureaucracies—not what people are looking for from their healthcare providers. In addition, when we ask people to name health systems in their area, their most frequent responses are the names of health insurance companies or "don't know."

But we've also done studies to understand the impact of dropping the word "system" from a health system's name. Doing so can be confusing, because people associate physicians and hospitals with being sick or injured and are more likely to associate "health" with fitness facilities. As the paradigm in healthcare moves from a focus on treatment to a focus on wellness and prevention, people's associations with "health" will change.

A I worked with an organization that changed its name to "health." While the intent of the name change was to broaden the scope of the organization for population health, etc., the reality was that 95 percent of what exists within the organization today existed before the name changed. For the average consumer in their service area, very little changed relative to what they got from the organization or how they interacted with it.

The lesson learned is that the equity in a brand name comes from the nature of the interaction that audiences have with the entity—the "value" if you will. So shifting from "system" to "health" (assuming no change in the forename) will likely only have an impact if there is also a meaningful and positive change in what those audiences get from the organization.

A Regardless of the name of the healthcare organization, the factors most critical to the financial success and positive perceptions are whether the organization is making measurable progress to reach goals to: 1) lower costs, 2) improve patient outcomes, 3) improve access, 4) improve the health of the community, 5) get surgeons to consistently report low rates of complications, and 6) have zero central-line infections.

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***The answers to the above questions are excerpts from MySHSMD discussions. In some instances, the responses have been edited for grammar and/or brevity purposes for Community Connections.**

If you are interested in editing an edition of "Community Connections," contact **briangriffin@aha.org**.

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