INFUSING DESIGN THINKING INTO PROBLEM SOLVING AT UNIVERSITY HOSPITALS OF CLEVELAND

PROCESS BOOK – DESIGN IN MANAGEMENT: CONCEPT AND PRACTICES
APRIL 2016

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IN PARTNERSHIP WITH
ABOUT THE PROJECT

The Department Of Strategic Innovation is trying to infuse design thinking within University Hospital’s entire system and feels that rather than focusing on all 27,000 employees at once, it can focus the human-centered design work on just one area of the system.

Our sponsor, Chrissie, recognizes that there needs to be incentive for the organization to support the PFAC’s; the way to gain this support is to prove the insights generated by the PFAC’s and subsequent strategies implemented by the organization have yielded positive results. The issue preventing this from occurring is the current lack of structure inside the PFAC’s. Our team will look to help create this structure and ultimately prove the value inherent to leveraging the specific insights and experiences of patients and families within the PFAC to help build a stronger organization.

What does the Process Book contain?

The purpose of the Process Book is to reveal the thought processes and pathway followed by our team as we explored the project. It showcases where ideas first came up, where different ideas and options were considered, and the final decisions that took place over the course of the work.
Kickoff Meeting 1

- Outcome - They want to differentiate
- Human Factors - embed
  - keep innovating
  - small & large scale innovation
  - but always disparate, never centralized through 1 portal
- Tech Transfer [Clinic Model]
- How to change the behavior
- Think about innovation from Human centered approach
  - Focus on strategic partnerships
  - Optimize outcomes
  - Improve care delivery
- I need to do something
  - walk w/ innovators
  - small pilot studies
  - then figure out where to go
  - from there
- 9 months in since start of dept
- 6 relationships in Play
  - behavioral - provider + patient
  - sports institute
  - hand, microbe, etc
  - machine learning + supply chain
- Difficult to measure & analyze
- Once something looks successful, you hand it off to the stakeholders
Total Joint Replacement group
- Pilot group
- "Bundled" model
  - take patient journey (experience vs episode)
  - want people to be in and out
  - do not want return visits

2. Patient experience
3. VIP
   - Value Improvement Process
     - easily 10 bottlenecks
     - supply chain
     - rig out inefficiencies
   - In the end it will all flow towards patient experience.
   - but all goes through and with humans in the experience
   - the human element comes through
   - Need to think about suppliers not as suppliers but as partners
   - challenge to engage w/ community hospitals
- Identity w/in the org
- Inability to make metrics concrete - Return on innovation

- 51 things going on
  - but not really a way to measure/report/identify
  - Dashboard
  - hierarchy of relevance
  - overlay of risks
- Ability to recruit internal champions
  - Need to get that buy-in from these
- Meeting times
Kick Off Follow-up Meeting

IIH - Debrief

What is the issue
- You have a core group of people who are providing
  Introduce design to a group of 27,000 employees

- Understand
  "Embrace innovation"

- Problem - how does the central operation control the remote ops?
  - Need to embed @ local level
  - Need to get local adoption
- Central ops needs to be involved
  - But only from the outside
- Need to encourage self-start mentality
  - Hundreds
Issue #2 - NI

- What is strategy going to
- How to influence an entire institute - across locations
- Need to highlight concrete success

- Access to NI is through central ops
- and a small piece of central at that

- Needs more refinement from Kip
- Kip is concrete and specific
- David is high level

Need to know the exact problems
with the Neurologic Institute
Not from central
Patient Pathways (patient segments)

- What are the kinds of patients?
- Patient experience

- Diff divisions w/in NI

NI - how do they ID & solve problems

- TQM - design product
- QC - quality circles

- Does central Ops really know what they need to do?
  Need to make it the local groups idea and not central

- Success will radiate through the org
  if we can show it

- Clinic - Hi Tech
  * = UTH - community based
  - Family medicine
- VA - Patients for Life
  - Long term relationships
  - Different view on responsibilities
2. Consequences
1. Immediate product
2. Teach + inform
   Central ops
   how to do it going forward
Meeting New Direction

- Chief Experience Officer - CXO
- New Unit

- Low patient satisfaction scores
  - Effects reimbursement
  - Need higher scores
- If bad exp - people fill out the survey

- Patient and Provider
  - Survey - Center for Medicaid
  - 22 questions or so
  - Patients as consumers
  - Transparency
  - H Care - Impatient
  - Executives say no tied to these scores

Process Book
Infusing Design Thinking Into Problem Solving
- Patient + Family Advisory Council

- Hearing the patient voice
  - 23-25 groups in U1T
  - I am very engaged

- Selection/governing process for who to let in
  - Usually very good or bad experiences
  - Limits available people

- More community
- More family

- PFAC - who isn’t represented
  - Need to go after unmet needs

- Need to go to people who are not part of your current system
  - Find people who don’t currently use U1T

- “Re-calibrate”
  - Balance traditional + new

- Wrong metrics
  - # groups, # people, # meetings
- Leader of PFAC
- passionate parent of special needs child
- willing to help & learn

- Toolkit for PFAC
  - how would a designer create this toolkit?

  Zolanski

  CEO - Joan - Pediatric Pediatrics
  - internal hire

- #1 priority this year
  - patient satisfaction & patient experience
  - 50% percentile for satisfaction year

- HCAP PDF - for questions
outside of credit scores
- how else to measure success?
- what can drive these scores?

CMS - Center for Medicaid + Medicare Services

- looks to other industries
  - how engage of emerging audience
  - break out of company
  - create new markets

- falls to patients you know
  - get outside perspective
  - what mechanisms can you use to guide feedback
  - how does that work?
  - how can that apply to...
Meeting and Forming a Problem Statement

- Chrissy
- many/all orgs do this	hey all don’t do it well
- medical error - 3rd leading cause
do death
- 450k Americans/year
could be avoided
- Chrissy
- Lil/NLN
- works w/ HR representative

- Mother in HC Quality
- over 40 years
- started Quality Institute at CC

- 2 groups - not chronic
Patient + Family Engagement (PFE) → Safety + Communication

STAR Syndrome

Why do you have to know someone in healthcare to get good healthcare?

National CARE PFE
bring P + F to the table
hear their voice

- PF central core
- P Experience
- PFE

PFE → Verb (how to get)
PFCC - Noun (help score)

Patient Activation
1. **Point of Care**
   2. **Organizational**
      - PFAC
      - Governance
      - Committees
   - CMS - developed metrics

**PFAC**
- Staff
- Current Status: P + F
- Meet monthly
- Work on projects
- Make improvements
- Patient + Family advisors

**PFAC**
- Needs + Care
  - Usually start + champion
P + F

- 2 step interviewing process
  - need + ask for opinion
  - want to make a change

- how to redesign P + F
  - align
  - integrate
  - new, better metrics
  - need data to get mature to support

Define success
  - at least 1 exec sponsor attends
  - embed P + F advisors into maturity
  - improve HCAP
  - less errors

Issue:
  - How to involve patients and families more effectively in medical care

Problem:
  - Processes + Process
  - Culture
  - Organization
  - Discover new features + incrementally implement
- OPAC - share stories w/
  new nurses/interns
- Lunches + Dinners
- PTH - rounds on patients
  - 3 days/week
- No traction in the middle
  - operations, doctors + nurses
  - bedside staff
- clear process to join
  - creating a website

- governance
- ops
- point of care
- patient, staff?
- PFAC - backbone of hospital
- PFAC - what can they do
- 15 hospitals
- Need to get these running smooth
- PFAC - Goal setting
- This does not fit in between
- PFAC - Not representative of all population
- Operations driven - Market
- Start as Nurse driven
UH won't realize the benefits through the PFACs until they truly value the benefits. Although there are a lot of potential value that could come out of the PFACs but they do not value PFACs as a whole.

David Aaron - UH Hospital
Meeting with Chrissie

- Interviews

- New APAC

- Volunteer interview process
  - Need to capture passion
  - 2-3 year plans

"Bedwell A" - 2/29 - 6-7:30
  - Ad hoc meeting
  - 3/7 - Sendman - 6-8pm

- Blaine
  - Interview exec leaders
    - Joan Zaltanski
    - Dr. Annebel
  - CMO - Dr. Anderson

- Quality leaders
Staff
- Social Work
- Volunteer Services
- Physician
- Director of Nursing
- Quality Leader
- Patient Advocate
- Nurse Manager

60/40 or 20/30
- Patients to Family to Staff

- PRC Steering Committee
  - Dr. Lavan
  - VP of Nursing

- Should lead up to Operations
  - maybe?

- Actionable "Ideas"
  - Hit Wall
  - What is the Wall made up of
- Patient Exp
- Patient + Family engagement as a metric

- How does operations work?
- Seaham up ops
  - report to Kevin
  - Ron Dyaki - COO
  - Director of ops
  - Dr. Jeff Peters
  - COO - Mr. Enzi Rist
  - Legal dept is conservative
  - Staff liaison for each PTAC

- Google docs
  - test w/ Christie
Interviews with PFAC

Interviewee: Teresa (Med Surge)
Member since 2011

1. The main goal of the PFAC is to have the patient’s point of view shared with all management entities.
2. Was looking for a volunteering opportunity, has a story that happened with her son and husband, she is well experienced in healthcare specifically in ER, hence joined PFAC after referral by previous member.
3. Suggestions are heard and valued by Chrissie who seems to be championing it. Expect more from executors rather than Chrissie
4. She would like to have a part in implementing them, by observation, as long as it doesn’t take too much of her time
5. Staff members provide leadership. They are open-minded and value input
6. Meeting once a month is enough, else there would be a time issue
7. Would like to have an organizational chart that is clear in terms of communication and responsibilities in UH and specifically in the chain of command in a specific department
8. Minutes of meeting are taken during the meetings, no clear output “form” is present, just talk and notes that are later shared with management.
9. Many suggestions were implemented, like patient discharge procedure, miscommunication between nurse and patient, and Brochure distributed patients were not aware of. The feedback did not come from management, but from patients themselves after being tracked down and followed up by members like Teresa.
10. Yes she interacted with members from different PFACs, there are lots of information sharing and best practices, mainly through Chrissie’s initiative.

Interviewees: Paul and Mark both Seidman members

Q1:
- Paul: Considers the PFAC an Advisor Board where members get to have considerable input on project initiated by Seidman
- Example Project Contributions: Seidman does a good job of presenting the PFAC within projects and allowing its members to volunteer for the projects outside of the meetings
  - Paul
    - Electronic medical record IT project
    - Billing experience project
    - The Seidman Experience (no longer existing): Initiative where Mark was the PFAC representative chosen to speak with new hires during orientation
  - Mark
    - Chemo Class redesign
    - Clinical trial feedback
- Seidman encourages members to give honest feedback; even if it’s not what they always want to hear.
  - Paul: called their ability to provide honest feedback, “open season”.

Process Book
Infusing Design Thinking Into Problem Solving
Important element is the staff (i.e., Wendy Miana, CNO et al.) listens to concerns, and gives feedback

- PFAC feedback examples:
  - Paul: Online Health Management Tool for Patients: request to see more appointment documentation on the patient dedicated side (NOTE: I’m not sure if this is MyChart, but it would be a similar type of app)
  - Mark: Dietary Menu Feedback and Dietary Website
  - Mark: ~J-tube?? Literature review

- **SIDE NOTE:** The Director of Patient Experience education mentioned that all PFACs do not encourage honest feedback, but it’s important to the process of patient and family engagement. She said honest feedback in encouraged and works when—groups within the organization must seek PFACs input prior to getting too far into their projects. From the Paul and Mark’s perspective, it seems like Seidman does a good job of getting projects to their PFAC early.

**Q2:**
- Paul: Joined via nomination from clinical staff
  - Reason for remain a member is the cohesion between the group, where people have a common mindset in providing the best experience at Seidman

**Q3/Q4/Q9**
- Not initiators
  - Per Paul, the Seidman group does not initiate a lot of projects, but they feel valued
    - Initiating project isn’t important to them because the Seidman staff keeps them busy enough on projects that they provide feedback towards
  - Does not view themselves as an initiative or implementation group as much as suggestion group, feedback group; and group that delegates volunteers to special projects
- The members feel extremely valued
  - Example: Paul served on the Chemo Safety Governance committee

**Q5**
- Seidman staff is extremely motivated and organized
  - **Leadership presence - high level leader who can gain external traction on suggestions outside of the PFAC meetings**
    - Paul/Mark: Having the CNO as a regular participant and leader makes a big difference

**Q6**
- Meeting once per month is adequate
- Volunteers are volunteers, so too much time would be an issue

**Q7**
- Broader demographic
  - This would benefit the PFAC to gain other perspectives that match the demographics of the UH patient population
Q8
- PFAC meeting accomplishments are captured within a newsletter that goes to executive team, including the Seidman chairman
- Seidman members have also participated in the UH health fair, where they hang posters and hand out literature about the group to build awareness.

Q10
- Paul: They haven’t engaged much with other group outside of the meeting when all PFACs come together
- Patient connection to PFAC
  - Paul: Expressed that as both a member and frequent patient, he feels that he and others in the group like him are the bridge to the daily patient connection
  - He also mentioned that members of the PFAC go onto the hospital floor to get feedback. I didn’t get much information on this due to our time running short
Interviews with Executive Leaders:

**Basic Questions:**

1. **What do you think the goals of a PFAC are?**
   - A structured way to hear the voice of the customer. To receive feedback from the consumer to modify the delivery model.
   - Change the operations of the hospital to become more patient-centered. To ensure that what UH does, stems from the patient and not UH.

2. **What do you think patient and family engagement means?**
   - On a one-on-one interaction, we want the patients and family to be actively engaged in the patient’s care. To be equal participants in the care. To be knowledgeable and engaged in decision-making, and to feel like they are truly part of the team.
   - At a higher level, patients are partners in this journey, and part of UH.
   - Patients optimize their health through their influence with the system.

3. **What questions do you have about PFACs or what would you like to know more about them?**
   - Do PFACs feel they have enough of a voice up the chain, and in the higher levels of the organization?
   - How do PFACs think UH can improve communication?
   - There is disconnect between what the PFAC is, what the PFAC should be, and how the PFAC is perceived.
   - The PFAC should not be some type of catharsis for a patient who had a good or bad experience. The PFAC should be like a board. You don’t put people on a board based on their good or bad experience. You put people on a board because they have significant insight into how we can do our jobs better.
   - They should be chosen like board members. This should be the working format.
   - A lot of the initial PFAC initiatives were in response to an issue—so it was reactive rather than proactive. We need to become more proactive! Don’t wait for the consumer to have a problem, but rather work with the consumer to identify how to prevent the problem.

**Executive Leaders:**

1. **In what ways do you think the PFAC’s work can contribute to your job?**
   - Patient-centeredness is a team sport; from the time patients arrive at the hospital until they leave. To be truly patient-centered, every team member needs to know “I’m not just the valet. I’m not just the receptionist.” But rather, “I’m an important member of this team that contributes to making this a good experience.”
   - Each member of the team has a role in safety too. If you see something, say something. Do we have a culture of safety that can stop the line and ask questions?
   - Part of what’s powerful about patient experience, is the patient story. The patient story is very powerful and moving, but there should also be a directive at the end of it. There needs to be a take home point for the audience on what to improve upon or what to change.
2. How are patient and family engagement initiatives implemented and who drives them?
   o Chrissie serves as the liaison. There is no chain-of-command for PFACs. Chain-of-command implies a reporting relationship, and there is no reporting relationship for PFACs, because they are ad hoc and serve an advisory role. Leaders can choose how much or how little they want to leverage them.

3. How does Patient and Family engagement contribute in decision making within the organization?
   o We can only measure patient experience. Those numbers are all we do and who we are. It’s about safety and patient engagement. Those numbers are shared every month, and that drives the business every day. Safety, quality, and patient experience are paramount.
   o It contributes at the local level (every day at the bedside). It is not operationalized throughout UH.

**Ron Dziedzicki (COO) and Dr. William Annable (CQO):**

1. Are the Operations and Quality departments unique and separate?
   o From a hierarchy perspective they are separate, but from a subcultural perspective they are not.
   o Quality and operational effectiveness are integrated. They are so synergistic with each other. You can’t drive quality unless you leverage operational effectiveness techniques to drive quality.

2. Does any department at UH have a workflow or journey diagram of a patient? (From the time the patient arrives at the hospital till the time they leave?)
   o The Operational Effectiveness department has this. Talk to Ken Turner if you would like to get this.
Brainstorming sessions
Team Design Sessions and Meeting with Dr. Costa
Forming Solutions:

**Department Projects performed with Human-centered Design Thinking**

*Patient Point of View; mostly explained through PFAC members*
Proposed structure for PFAC work flow

Department Projects performed with Human-centered Design Thinking

Key points

- The different departments work on their projects while having an essential component of patient feedback.
- The Design & Innovation team supervises the meetings between departments and committees, so as to bring in the design thinking culture.
- The roles of the D&I team to create a sustainable patient-oriented thinking culture for all departments & UH system.

*Patient Point of View; mostly explained through PFAC members
General PFAC Meetings

This process will be repeated as needed by Chrissie for any topic.

1. Chrissie to determine topic for discussion
   - Topic for the meeting can range from anything related to the hospital but the meetings should stay focused on the single topic.
   - Potential topics can come from Chrissie, PFAC members, or hospital staff.

2. Chrissie to assemble team from PFAC membership
   - Based on the meeting topic, Chrissie will assemble a team of members with relevant background.
   - The PFAC attendees should have a diverse set of experiences in order to bring together as much perspective as possible.

3. Chrissie to hold meeting to discuss the issue and potential solutions
   - Chrissie will lead a meeting with the selected PFAC members to talk about the potential issue as well as potential solutions.
   - Chrissie will gather as much input as possible in order to provide a project team in the future.

4. If needed, Chrissie to find owner so project can begin
   - If it is determined during the meeting that the issue does not require an immediate solution, Chrissie will pass the information along to the correct group within UH (Ops, Quality, IT, etc.).
   - Go to Department Problem How do we make the implementation of a new solution?

How to infuse design thinking across UH

**CURRENT**

- Innovation
- Operations
- Quality
- HR
- IT
- Education

Currently the human centered design methodology/approach is centralized with the Innovation team at UH.

**PROPOSED**

- Innovation
- Ops/HR/IT/etc.
- PFAC

Our proposed approach will put our design thinkers in meetings with other teams throughout UH in order to demonstrate human centered design for all relevant projects.

**LONG TERM**

- Innovation
- Operations
- Quality
- HR
- IT
- Education

Over time, these interactions will help to infuse human centered design across the entire organization.

Process Book
Infusing Design Thinking Into Problem Solving
Final Solution

[Diagram with handwritten notes on a whiteboard.]

- Solution
  - Ideas
    - Role of Team
    - PFA 08 - Elements
  - Define Problem
    - Process Flow
    - Meeting O2 - Define - Role of Innovator
  - General PFAC meeting flow
    - Change to lead
    - Pick leader (ie. team)
- How to Infuse Design Thinking
  - Involve Team
    - Op/Quality/IT/Etc/
**Problem Statement**

**To Heal**

University Hospitals sees a lot of potential value that could come out of the PFACs; however, the PFAC’s current structure prohibits its full value from being realized.

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**Problem 1**

Majority of the ideas generated by the PFAC never make it to a department for implementation.

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**Problem 2**

Each department implements individual projects.

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**Problem 3**

Many projects are implemented by the departments without consulting the PFAC for their input in a possible solution.
STRENGTHEN THE PFAC STRUCTURE AND APPLICATION TO PLAY A KEY ROLE IN PROBLEM SOLVING AND IMPLEMENTATION ACROSS UNIVERSITY HOSPITALS, WHILE SERVING AS THE IMPETUS TO INFUSE HUMAN CENTERED DESIGN THROUGHOUT THE ORGANIZATION.

**DEPARTMENTS**

- IT
- OS
- OP
- RED
- NACOM

**IMPLEMENTATION**

- PROTOTYPE
- FEEDBACK
- STANDARDIZE
- SCALE

**NEW MEETING STRUCTURE**

The new meeting structure will bring the PFAC, Innovation Team, and a Department Team together to discuss the core details of the project and elicit PFAC input into the solution.

**INNOVATION**

- ONGOING
- DESIGN EDUCATION
- FACILITATE THE NEW MEETING
- INFUSE DESIGN THINKING

**PATIENT & FAMILY ADVISORY COUNCIL**

- FEEDBACK
- CONCERNS
- ASSEMBLE ADVISORY PFAC

CHRISSE AND TEAM WILL MAINTAIN THE PFAC DATABASE AND ASSEMBLE AN ADVISORY PFAC WHEN A DEPARTMENT CALLS FOR A MEETING.
SIGNIFICANCE

To Discover

Our proposed solution will provide benefits to University Hospitals in both the short and long term. Short term will focus on immediately improving patient experience with better thought out solutions while in the long term human centered design will be infused into the culture of UH through our proposed process change.

CURRENT

PROPOSED

LONG TERM

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CURRENT INNOVATION

IT QUALITY OPERATIONS

PROPOSED INNOVATION

ADVISORY TEAM

DEPARTMENT

IT QUALITY OPERATIONS

LONG TERM INNOVATION

IT QUALITY OPERATIONS