INFUSING DESIGN THINKING INTO PROBLEM SOLVING
AT UNIVERSITY HOSPITALS OF CLEVELAND

PROJECT REPORT – DESIGN IN MANAGEMENT: CONCEPTS AND PRACTICES
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IN PARTNERSHIP WITH

WEATHERHEAD SCHOOL OF MANAGEMENT
CASE WESTERN RESERVE UNIVERSITY

University Hospitals
SPECIAL THANKS TO THE FOLLOWING

All PFAC Patients, Family members and Staff

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EXECUTIVE SUMMARY

In the spring of 2016, a group of Weatherhead MBA’s from Case Western Reserve University set out to work on a Design project in conjunction with University Hospitals. The focus of the project was to look at the existing function of the Patient and Family Advisory Councils within the hospital and reimagine a way to more effectively use these individuals within the hospital with the focus being on improving patient experience across the hospital system.

The team set out to identify a core problem and propose a hypothesis based on the research and data gathered at University Hospitals and with the staff. The following report contains an in-depth look at the problem and our proposed solution for University Hospitals. This project report contains five main parts: introduction, problem statement, hypothesis, design process, and closing.

The core solution was broken up into three main parts: Problem, Idea and Significance. These are summarized below.

Problem

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

Idea

- 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.

Significance

- Short Term will result in better thought out solutions and problem solving across the hospital while long term these new interactions coupled with the positive outcomes associated with them will infuse human centered design throughout the organization.

In order to realize this vision, this plan will require alignment and ownership from the top of the organization at University Hospitals. The hospital leaders will need to be the champions for this solution to take hold in the hospital and gain the following it needs to get going with the hospital. If this happens, we feel the benefit to the overall organization will greatly improve the patient experience.
1 INTRODUCTION TO UNIVERSITY HOSPITALS

UNIVERSITY HOSPITALS OVERVIEW
University Hospitals of Cleveland (UH) is a not-for-profit medical institution. UH provides primary and community-based care. UH is one of the largest medical institutions in Ohio with an extensive network of over 150 locations that stretch throughout Northeast Ohio.

Functioning as an academic center, Case Medical Center and Case School of Medicine combine to form the largest biomedical research center in Ohio. Case Medical Center ranks in the top 15 centers in the United States with approximately $75 million in annual extramural research funding and a further $10 million in various other clinical trials.

UH is renowned for its children’s hospital, Rainbow Babies and Children’s Hospital that treats children with cancer, heart disease and a number of immunodeficiency disorders. RBCH serves a 12-county area in Northeast Ohio with a pediatric population of nearly one million.

UH is also known for its Accountable Care Organizations and the aggressive investments it has made in this space. UH is among the largest ACO’s in the country that includes 170,000 self-insured, commercially insured, Medicare and Medicaid members and beneficiaries. Other local players like the Cleveland Clinic have been slower to partake in the ACO movement and has created smaller versions of these ACO’s. UH launched its first ACO in 2010, the Employee ACO (UHACO) and has since added two more: Pediatric ACO and Medicare ACO. UH’s cutting-edge ACO’s have allowed it to become a leader in this space and to improve the overall quality of the care it provides while helping control the cost of care to its patients.

In the early 1990’s, University Hospitals created a new model for healthcare delivery along with a new strategy and vision. This new vision called for UH to better meet the healthcare needs of a large portion of northeast Ohio through physical expansion as well as an increase in their service offerings.

Through this new strategy, UH transformed from a traditional, single-site academic medical center into the network of hospitals we know today with the goal of meeting the following needs:

1. To complement our nationally prominent services in tertiary medicine, we added prevention, primary care and early screening.
2. To strengthen their clinical capabilities, they expanded their established areas of excellence and developed new areas at University Hospitals.
3. To improve access, they forged new hospital partnerships, developed the region’s largest primary care physician network, and increased the number and size of cost-effective outpatient centers.
4. To enhance care in the communities served by their new partners in University Hospitals, they opened satellites of some of their centers of excellence, initially for cancer care, cardiac care, pediatrics and women’s health.
5. To make quality care affordable, they redesigned the way they deliver much of their care, reducing inefficiencies and redundancies.
MISSION AND VISION

The mission statement of University Hospitals is simple and straightforward: To Heal. To Teach. To Discover. This mission served to help guide us throughout our design process. First and foremost this institution is a place where people go to get healed. That is something that always needs to be top of mind for University Hospitals and their staff. The second order of business is to teach. University Hospitals is a teaching hospital and medicine would not continue without institutions like University Hospitals that serve to teach the next generation of doctors, nurses and health professionals how to do a great job in a challenging environment. Lastly, UH serves to discover. As a leading medical institution, it should be the duty of UH to push forward medical research and discoveries. In addition this mandate helps the hospital to best fulfill the first two parts of the mission as well.

This mission is supported by a vision that drives University Hospitals health system: University Hospitals will be the premier integrated health system by providing access to the highest quality healthcare at a competitive price. This mission and vision have been a part of UH since the beginning, over 120 years ago. This mission drives the organization and is something that stayed top of mind for our team as we went through the design process.

COMPETITIVE LANDSCAPE

University hospitals, located in Cleveland has three main competitors in the area: The Cleveland Clinic, The MetroHealth System, and Lake Hospital system. With the ongoing acquisitions and consolidations of smaller hospitals, the healthcare “market” is narrowed down to the three mentioned hospitals. Competition in the field is very high, this lead to two main outcomes: Cheaper health care for patients that worked to the community’s advantage, triggered by the intense price competition, the downside however is the lack of personalized and/or customized health treatment for individuals as economies of scale in a healthcare system proved to be cheap and efficient, but misses special cases and special treatments. The market is looking now at more ways to optimize the treatments and increase the level of care.

Some of the strengths of UH that differentiates it from its competitors are many. A competitive spirit of fellowship in areas offering development, behavior and ADHD. The collaboration between clinical, educational and research categories in the development of the fellow is critical to his learning path. The fellows also undergo rotations at different hospitals to be exposed to different situations.

While Cleveland Clinic, one of the main competitors of UH focuses mostly on modernity and improvement and launching a new era of medicine through innovation, University Hospitals has a lot of experience through ages of practice, and backed by the Case Western Reserve University offering high academic achievements and breakthrough researches. It is also much easier for UH to recruit from the university and the alumni network has strong bonds with the school, hence the hospital, where more recognition is thus given. We see much more fellows and residents retention

We can also point out that the pediatrics practice at UH is one of the best in the country. Through the Children Rainbow Baby hospital, which stands alone yet affiliated with UH offers extensive care with high level of advanced methods of treatment.
The Rainbow Center for Public Policy offers opportunities and mentoring in important public policy initiatives, where after completing a three year fellowship program, graduates are eligible to join the Developmental-Behavioral Pediatrics subspecialty boards. This is also one of the greatest strengths of UH.

However, with the option of low cost affordable healthcare, UH is losing some of its patients to Cleveland Clinic and other hospitals. How can UH leverage its advanced research, academic expertise, and years of breakthrough researches to offer a cheaper, more accessible healthcare treatment for patients?

**Patient and Family Advisory Council (PFAC)**

According to the Agency for Healthcare Research and Quality a ‘Patient and Family Advisory Council’ is a formal group that meets regularly for active collaboration between clinicians, hospital staff, and patient and family advisors on policy and program decisions.

A Patient and Family Advisor is a former or current patient and family member of the hospital, who is emotionally, physically, and mentally ready to volunteer and partner with the organization to make improvements. This is typically a patient who is interested in being actively involved in their care of the care of a family member and has offered constructive feedback in the past.

PFAC groups at University Hospitals have existed for a few years now with the oldest one formed about 25 years ago. University hospital was in fact the second hospital nationally to establish a PFAC group (Rainbows babies and children’s hospital). In 2006 UH established the Patient and Family Council which governs the PFACs.

There are 23-25 PFAC groups at the hospital and about 7 of them are really engaged. The existing PFAC structure requires the groups to meet at least 10-12 times a year. A typical PFAC group comprises of 30-40% staff members and 60-70% PFAs. The patient and family advisory council toolkit lays out a guide to develop, structure and sustain PFAC’s.

The Patient and Family Council has been instrumental in achieving the following since its inception

- Revise the visitation policy to afford families more flexibility
- Enhance UH’s patient and family education materials
- Develop the UH Case Medical Center Patient Welcome Guide
- Provide comfort to patients’ family members with “Be Our Guest” dinners
- Update stroke, diabetes, heart attack and infection control teaching books

Chrissie Blackburn served as our key project sponsor for this semester long engagement. She heads up the PFACs at University Hospitals and brings a very unique and personal perspective to the table when it comes to patient and family engagement within a hospital system. She has been a family member through this hospital system for many years and a member of the Rainbow PFAC. She moved from a volunteer to an employee with UH in order to put her perspective and expertise into action across all of the hospital PFACs.
CURRENT SITUATION AT UNIVERSITY HOSPITALS

The department of strategic innovations was started early in 2015 and, along with Chrissie, this group will serve as our sponsor for the Design project during the Spring semester. The overarching goal of this group is to effectively embed human centered design across the entire organization of 27,000 employees. This is a tall task for any group and becomes even more of a difficult ask based on the small team size they currently operate with.

At the core, the organization is looking to infuse design thinking so that it can improve its HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores. The intent of the HCAHPS system is to provide the healthcare industry with a standardized survey instrument and data collection methodology that will help measure patients' perspectives on overall hospital care. Currently, University Hospitals is underperforming with their HCAHPS scores and that has a large and direct impact on the profitability of the hospital as a whole. There is a mandate from the top of the hospital on down to focus on improving the HCAHPS scores for the hospital system and improve the overall patient experience.

Looking at the most recently available annual report from 2014, you can see mentions of the Innovation Department and the PFAC extremely prominent throughout. University Hospitals is at a point where they realize the immense potential value that can come from both of these groups, but it is still struggling to actually figure out how to actually capitalize on it. An interesting focus of the annual report was around the following three directives.

As we look to provide a solution to the problem we identified, we believe we took into account these directives. Our team is partnering with this department of strategic innovations to work closely with them as they look to define their purpose within the University Hospitals System and extend their reach across the organization as a whole. Using the PFACs as a point of focus for our efforts, we decided to explore possibilities for how UH could more effectively use this great resource available to them.
2 THE PROBLEM

PROBLEM STATEMENT – TO HEAL
The Department Of Strategic Innovation is trying to infuse design thinking within University Hospitals 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.

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

Figure 1: Problem Statement
The problem statement is summarized in Figure 1 on the previous page. Overall we are looking to address two core issues with idea generation and problem solving at University Hospitals. The first issue has to do with the PFAC directly. Through the monthly PFAC meetings many ideas are generated through the discussions and interactions of the PFAC members, however a large percentage of those ideas never see the light of day. The level of success for which projects make it to the relevant department vs which will not make it out of the group will vary from PFAC to PFAC, but there is a struggle with concrete ownership when it comes to taking an idea from a PFAC and getting it to the relevant department to take it on and bring the solution to life.

The second issue has a more indirect relationship to the PFAC but it is still very significant. This issue is around all of the other ideas/projects that come out of the various hospital departments. This accounts for the majority of total ideas/projects in the hospital and the core issue here is that these projects never consult a PFAC when defining a solution or discussing the core issues they are looking to solve. These departments will, on occasion, work with a PFAC in a one off scenario to discuss an issue or work with them to solve a problem in the hospital but it is a rare exception and far from the rule of practice.
3 OUR HYPOTHESIS

THE IDEA – TO TEACH

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.

In order to solve the problems we identified, we propose to make the PFAC a key player in problem solving at University Hospitals through a collaborative effort with the Innovation department and other hospital departments as they work on projects. Currently the PFAC will only be involved with problem solving or project implementation on an exception basis. Using our proposed meeting structure during the ideation phase of project implementations we are looking to bring together the department who owns the project with the Innovation department and the PFAC to serve particular roles.
The Innovation department will provide representation in the meeting to help teach and progress the human centered design approach with the department that owns the project. Currently there is a lack of this expertise across the organization and these interactions with the Innovation department and other departments like Operations, Quality, HR, IT, etc will give the Innovation team a platform to teach their methods with practical application as these departments work through implementation of projects like they usually do. The role of the adhoc PFAC will be to provide a unique perspective and inputs into defining the true problem and helping to identify an ideal solution. Based on the particular project department and topic, the adhoc PFAC will be assembled based on their particular background and passions. A PFAC database will need to be maintained in order to track all possible PFAC volunteers along with details about each volunteer in order to query and pull the correct individuals based on the project requirements. This database would contain information about the volunteers including hospital affiliation, years of service, education, background, passions, interests, and a current list of volunteer activities/projects. We think it makes sense for this database to be managed by Chrissie and her team since she has a close connection to the PFACs and a strong understanding for the user base and application potential.
4 OUR DESIGN PROCESS

SOLUTION SIGNIFICANCE — TO DISCOVER
Before going into detail around our design process, we want to review the solution we developed in response to our problem statement and hypothesis above. The significance of this solution, we believe, is closely aligned with the strategic direction of University Hospitals. The solution components will help to convey the true issues and solution we see based on our research.

We see two outcomes of our proposed solution with respect to University Hospitals. First off, in the short term, we see the ability to improve project outcomes and implementations based on the approach that uses human centered design. By working with an adhoc PFAC and the Innovation department, the other hospital departments will be able to develop more robust and complete solutions that take into account direct feedback from your end users (as represented by the PFAC). These improved implementations will help lead to an improved patient experience and increased satisfaction. This benefit is core to the success of University Hospitals as they seek to put a key focus on improving patient experience across the organization.
In the long term, we see the solution helping to fulfill the primary goal of the Innovation Department. This proposed process will help to get Innovation team members and Design Thinkers working hand in hand with the PFAC and various other departments throughout the hospital. Overtime, we are confident the positive outcomes associated with projects that follow our proposed process will help to increase the adoption of human centered design across the organization. Instead of bringing this approach from the top down, we hope that the individual interactions and experiences of the staff will help to make the case for adoption and practice common sense.

**PROCESS PURPOSE**

Our solution proposes a new process for University Hospitals to abide by and not a physical product. At its most basic level, the purpose of this new process is to improve the patient experience at the hospital. UH is a community driven hospital and one way their success is measured is based on the perceptions of the community. University Hospitals has an amazing resource in the patient and family member volunteers that want to give their time to the hospital in order to make it a better place. This is a type of resource that most other companies would do anything to have access to and UH needs to recognize the value of these volunteers and treat them in an appropriate way. The insights they can provide in shedding light on the true user experience through the hospital has immense value to the organization as a whole.

In order to realize this purpose, alignment from the C level hospital leadership will be necessary. While the proposal is generally a small one, the change to the processes and current state organization of the hospital is a large one. The collaboration we are trying to bring along will not happen by itself and that is why it is critical that the hospital leadership be closely aligned to the solution in order to help ensure its adoption. We are confident that once it has a chance to embed itself into the everyday culture and processes of the hospital the results will speak for themselves.

**KEY FEATURES**

With our proposed new meeting structure, by bringing together the Innovation department, the PFAC members, and the hospital department in charge of execution in such a way that all entities that have an important input to lead to the decision making process for any kind of project that University Hospitals would want to work on will be presented. All sides will offer crucial information to explore in the creation of the new product or solution. We believe that by starting from the idea initiation phase created by the concerned department, and then walking through the brainstorming for optimization and suggestions, and last taking it to prototyping and back for feedback, we would have a process design revolving around patient feedback and patient input. The proposed idea of selecting PFAC members specifically tailored for the topic at hand ensures the best possible input for the project. The selection can also allow to choose PFAC members according to their tenure, their background, their area of interest, etc... Overall, the new meeting process will be towards human centered design thinking, putting the patient first.

By following the suggested process, there is a lot of benefit and convenience for the PFAC members and its leadership. Some of their primary concerns was the ambiguity in the communication path of their ideas and recommendations that they come up with in their meetings. Who takes the lead and champions that
idea? Where is it going? Who is the department in charge of implementation? The PFAC members will now have direct interaction with the concerned department during the new suggested meeting structure and will be able to propose changes and modifications as well as awareness of its status.

The departments themselves will now have a new point of view that is crucial for their product development: the input from a patient’s perspective via PFAC members. A lot of time and resources will be saved from actually developing an idea or a product that might not be completely accepted or useful for the patient.

The Innovation team will also be able to have direct presence in processes throughout University Hospitals, which will help them infuse design thinking at a faster rate, while helping different members of the meeting learn how to have human centered thinking, without actually leading the process as much as highlighting on key elements of design and innovation to consider.

So why is our new proposed meeting structure needed and desirable by University Hospitals? Some of the key outputs that will come out of the proposal is being able to relate the product and solution design to patient input and experience through PFAC members that will increase in turn the patient’s ratings, the HCAP scores. The patient’s point of view and experience is critical to UH’s scores which in turn will provide additional funding for further improvements. The Innovation team will be able to experience the education of design thinking throughout the hospital through the meetings, and will give them an opportunity for impact by showing the methodology’s impact. Also, PFAC members will feel as being stakeholders in the success of the hospital’s projects.

Our unified input process ensures the best brainstorming of ideas through diversity of players, a more patient-centered product development, and critical feedback for prototypes and solutions suggested by the hospital’s departments. We believe that the importance of patient experience and design thinking inclusion in University Hospital’s development processes will be realized and fully utilized with time, having direct correlation with the results of the different projects’ success as well as University Hospital’s overall performance and scores.

We expect that the application of our proposed meeting structure solution at UH’s main campus will quickly be adopted by the different locations of UH in North-East Ohio, and hence a unified structure will develop around it and will improve further through additional input from even more members of each of the participants: PFAC members, department representatives, and Innovation team.

**Concrete Embodiment of The Process**

The service in operation works to help strengthen the current PFAC structure and help enable there to be more meaningful feedback by patients and families while simultaneously infusing human centered design thinking into department meetings held by University Hospitals. Below is a detailed account of the steps involved in the proposed solution.

The PFAC sponsor will maintain a PFAC database to assemble ad hoc PFAC groups when a specific department calls for a meeting to discuss a particular issue. From this database, Chrissie will select a group of corresponding PFAC members who either have experience with the current issue or have a passion to
make an impact on a particular issue that the department has brought to the table. From here, there will be a new meeting structure where instead of it just being the members of a specific department, there will be members from the ad hoc PFAC group, a member for the Strategic Innovations team, and the members from the department. This allows for there to be both the infusion of human centered design thinking into the new meetings, along with gaining valuable feedback and insight from the PFAC. After this, the group members from that particular meeting will look to prototype, and eventually even standardize and scale the solution for implementation.

**Supporting Arguments**

**Business Case**

The cost of implementation will be additional resources (time, human capital, and potentially financial resources). The benefit greatly outweighs these costs as it will enable the hospital to improve overall patient experience while simultaneously infusing human centered design into the culture of UH. We believe this solution is financially feasible as the meeting structure we are proposing is not an additional meeting per se; but simply a change to the current structure of department meetings, which would include members of the PFAC and Department of Strategic Innovations. While there will certainly be additional costs, it is considerably less costly than the costs the organization would incur if UH were to construct our proposed solution as a completely separate additional meeting.

The short-term value of the solution is that project implementation will take into account direct user feedback with a focus on improving patient experience. This will lead to better outcomes and solutions for all parties involved. In the long-term, the interactions made in the proposed meeting structure will help infuse human centered design hospital-wide.

Issues management may face are associated mostly to time-related resource constraints. University Hospitals is constrained by its ability to allocate time and effort towards projects which have yet to show any tangible value as indicated in our interviews by the UH C-suite executives. Getting the “buy-in” of the C-suite will be critical to the implementation and execution of this solution; the limited amount of resources necessary to execute our proposed solution leaves us optimistic the C-suite will. As indicated above, there is potential for additional resources such as human capital and financial capital, but this should be relatively limited and increases the level of feasibility of this proposed solution.

**Our Work Process**

During the project, our team worked with three major groups.

1) **Project Sponsors**
   a. Chrissie Blackburn, Principal Advisor, Patient and Family Engagement
   b. David Sylvan, Director Strategic Innovation
   c. Kipum Lee, Director of Innovation
2) PFAC Groups
   a. Seidman
   b. MedSurge
3) Executive Group
   a. Dr. Michael Anderson, Chief Medical Officer
   b. Dr. William Annable, Chief Quality Officer
   c. Dr. Joan Zoltanski, Chief Experience Officer
   d. Dr. Ron Dziedzicki, Chief Operating Officer

The following timeline demonstrates the major path our team took during this research.

**RESEARCH TIMELINE**

Project Kick off Meetings

After our kick off meetings with the sponsors in December, we did the background research on University Hospitals and prepared the design brief. At this point, we were still waiting on a confirmation on the main problem area from our sponsors. We took a stab at formulating the Problem Statement with the limited knowledge we had.

**Project Kick off Meetings**

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Project Report
Infusing Design Thinking Into Problem Solving
Formulation of the Problem Statement

In January, we received more information and a concrete problem area to work on. During this time apart from meeting with the sponsors, we also met Dr. Marco Costa who is the chief innovation officer at University hospitals and heard his views on PFAC’s and larger picture.

After multiple meetings with the sponsors, we formulated the problem statement, which is as listed below.

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

Discovery Phase

With this problem statement and our research behind us, we started interviewing the PFAC groups and dig deeper to find what was inhibiting the PFAC from reaching its full potential. We observed PFAC meetings (Seidman and MedSurge). At a joint meeting of the Seidman and MedSurge group, we interviewed both staff and PFAC members and asked them some specific questions to arrive at a hypothesis (Interview questions, Appendix A). At the same time, we also recognized that just interviewing the PFAC members and sitting through the PFAC meetings is only going to give us one side of the story. To get the bigger picture and understand what the upper management thought about the PFAC’s and their value, we held executive meetings (Interview questions, Appendix B).

Some of the major feedback from the Executive meetings and PFAC meetings is as listed below.
Formulation of the Hypothesis

Between our meetings with the executives and the PFAC members, our team had multiple brainstorming sessions where we came up with our Hypothesis, structure of the PFAC and alternative solutions. Our final hypothesis, some excerpts from the brainstorming sessions and an alternative solution are as listed ahead.

Hypothesis

*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.*
Brainstorming sessions
Alternative Solution
Our alternative solution focused on the implementation piece of the equation. However, after speaking to Chrissie and understanding what happens to the ideas that come out of the PFAC we had to change our solution and take a different direction.

**Final Solution**

With our final hypothesis and alternative solution, we met Chrissie again to understand the implementation side of the PFAC workflow. This meeting gave us the insights we needed to carve out our final solution. Our team brainstormed for the last time and came up with the final solution which we then presented to David and Chrissie and sought their feedback.

After the review session, we updated our solution with the comments and completed our poster designs.

**Research methods used**

Our team used the following research methods

1. Observations: Involved attending various PFAC meetings
2. Interviews: Involved interviewing PFAC members, staff and executives
3. Brainstorming with stakeholders: Involved meetings with Chrissie, David and Kip. Running our solution through Chrissie, David and Kip and taking their constant feedback was key in reaching the final solution.
5 CLOSING THOUGHTS

University Hospitals is a great organization and a cornerstone in the Cleveland community as a whole. We have a very unique situation here in Cleveland with a number of very prominent hospital systems and each have their own strengths and focuses. University Hospitals needs to embrace the community and volunteer network it has built up in order to use that as a differentiating factor in this market. The potential value that can come out of applying human centered design throughout the organization is immense.

We hope that University Hospitals will be able to realize this potential and infuse design thinking principals throughout the hospital in order to provide the best patient experience possible.

Thank you.
APPENDIX A

PFAC Family and Patient Interview Questions

PFAC Meetings
1. Are you aware of the purpose of PFACs? What do you think the goals of the PFAC are?
2. What is your goal/reason for joining a PFAC?
3. Do you feel your suggestions/recommendations are heard/valued?
4. Do you just look forward to give suggestions/recommendations only or also help UH find a way to implement them?
5. Do you feel the staff members are as involved/motivated as the PFA’s in your group?
6. Do you think meeting once every month is adequate to achieve the PFAC goals?
7. If no, what according to you would be a better suggestion?
8. What other ways do think you could make an impact?

Implementation
1. Do you have any insights about what information is recorded on the PFAC meeting and what is it used for?
2. If yes, do you know how the results from the PFAC meetings are translated into actions within UH?
3. Have you seen any changes suggested by you or any PFAC members being implemented by UH in your term until now?
4. If yes, what was/were the change/changes?
5. If no, have you ever sought feedback on why things were not being implemented?
6. Have you ever interacted with anyone from a PFAC of a different hospital?
7. If yes what are the top two or three things that they do better than a PFACs at UH?

PFAC UH Staff Interview Questions

Personal
1. How many hours/week do you spend doing work related to this PFAC?
2. Do you think that is enough time to get the work accomplished?
3. Do you feel you are adequately compensated for your time spent doing work related to the PFAC?
4. What do you think is the main purpose of the PFAC?
   a. Do you think your PFAC is meeting that goal?
Co-workers

1. How much visibility do your co-workers have to the work you do within the PFAC?
2. How familiar are your co-workers with PFAC’s in general?
3. What is the perception on the floor of you working with a PFAC?
4. Do you think more people would be interested in working with the PFACs if there was better formal organization or compensation around the work?

Output

1. What is the most successful PFAC recommendation you have been a part of?
   a. Why do you think it was so successful?
2. Have there been potential projects that came out of the PFAC that failed?
   a. Why do you think they failed?
   b. Do you think a different approach might have helped that project to succeed?
3. How aware are your co-workers about projects that originate in the PFAC?
4. Does there seem to be “buy-in” on the floor for getting PFAC projects implemented successfully?

Input

1. Where do the input ideas come from for each meeting?
2. Who creates the agenda for each meeting? How detailed is that agenda?
3. Have you seen any coordination with groups outside of the PFAC to provide inputs for the PFAC?
   a. If yes, how did that process work?

APPENDIX B

Basic Questions

1. What do you think the goals of a PFAC are?
2. What do you think patient and family engagement means?
3. What questions do you have about PFACs or what would you like to know more about them?

Executive Leaders

1. In what ways do you think the PFAC’s work can contribute to your job?
2. How are patient and family engagement initiatives implemented and who drives them?
3. How does Patient and Family engagement contribute in decision making within the organization?
4. Are the Operations and Quality departments unique and separate?
5. Does any department at UH have a workflow or journey diagram of a patient? (From the time, the patient arrives at the hospital until the time they leave.)