LEVERAGED ACTIONS & CATALYTIC TRIGGERS: THE ART AND SCIENCE OF EXPERIENCE DESIGN METHODOLOGIES

TED BALL

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Don Drummond says that he thinks that the health sector is "ready to change". Clearly, there is some validity to his assessment. More and more healthcare leaders are now acknowledging that we do in fact need a fundamental transformation of the way we organize and deliver healthcare services in Ontario.

So we are through the "*denial*" and "*resistance*" phases of the change process, and have now entered the "*exploration*" phase – where we seek to discover where we should go from here.

Many of us believe that the fundamental paradigm-shifting transformation required by the realities outlined the ***Drummond Report*** is: a **patient/ client revolution**. What could this mean to you, and to your organization?

In their commentary on "***Why The Nation Needs A Policy Push on Patient-Centred Care***", Epstein, et al, say that "patient-centred care ultimately derives from the healing relationships between clinicians and patients, and -- by extension -- patients and family members." They say that "a patient-centred approach fosters interactions in which clinicians and patients' values and preferences guide the relationship; help patients and their families make clinical decisions; facilitate access to appropriate care; and, enable patients to follow through with often difficult behavioural changes needed to maintain and improve health."

The authors' team says that "truly patient-centred care requires knowing the patient as a person -- and engaging them as an active participant in his or her own care." So, what would that "*be like*"? What would it "*feel like*" -- if we actually designed systems, structures and processes with the patient at the centre?

Boards and senior managers of healthcare service provider organizations need to think through how they would measure their progress on improving patient/ clienteted-centeredness. Currently *NRC Picker* (the company that tracks patient experiences) suggests the following seven components of *patient-centered care*:

1. ***Respect for Patient's Values, Preferences and Expressed Needs***. This dimension is best expressed through the phrase, "***Through the Patient's Eyes***" and the book of the same title. It leads to shared responsibility and shared decision-making.

2. ***Coordination and Integration of Care***. This dimension addresses team medicine and giving patients support as they move through different care settings for prevention as well as treatment.

3. ***Information, Communication and Education***. This includes advances in information and social technologies that support patients and providers -- as well as the cultural shifts needed for healthy relationships.

4. ***Physical Comfort***. This dimension addresses individual, institutional and system design (i.e. pain management, hospital design, and type and accessibility of services).

5. ***Emotional Support***. Empathy and emotional well-being are as important as evidence-based medicine in a holistic approach.

6. ***Involvement of Family and Friends***. Care giving includes more than patients and health professionals so that the larger community of caregivers are considered.

7. ***Transition and Continuity***. Delivery systems provide for caring hand-offs between different providers and phases of care.

But does *NRC Picker's* questions go deep enough? Are our existing legislation and regulatory frameworks clear enough?

Some tell-tale signs of patient-centred care, according to Steve Wilkins in ***Mind the Gap***, include:

- Patients are treated as the most important member of their healthcare team and taught how they can best contribute to the team's success;

- Patients opinions are actively sought, listened to, and, honored where possible;

- Patients tell you that their doctors and other healthcare team members really listened to what they had to say;

- Patients and providers know each others' names;

- Providers feel that their patients are actively involved in their own care; and,

- You can see significant improvement in patient health status, adherence, engagement, level of utilization and patient provider experience.

Another popular patient-centred framework called, the "***Senses Framework***", is based on the critically important concept of *relationship-centred care*. This framework focuses on the experiences of both the patients and the staffs in the context of a "caring relationship".

The *Senses Framework* is based on the belief that in order for good care to be achieved for the client/ patient/ resident, all people involved in providing care for the person need to experience the six "senses" that are listed below:

A sense of security:

- To feel "safe" and to receive, or deliver, competent and sensitive care;

A sense of continuity:

- Recognition of biography, using the past to make sense of the present and helping to plan the future; working with a consistent team using an agreed philosophy-of-care;

A sense of belonging:

- Having opportunities to form meaningful relationships, and to feel part of the community;

A sense of purpose:

- To have opportunities to engage in purposeful activity, or to have a clear set of goals to aim for;

A sense of fulfillment:

- To achieve meaningful or valued goals and to feel satisfied within one's efforts;

A sense of significance:

- To feel that you, and what you do, actually matter, and that you are "valued" as a person of worth.

While these may be some typical outcomes sought, how do you actually design the systems, structures, processes that result in patients experiencing these six "senses"?

Leading *experience design* expert, Art Frohwerk of *Clearpath*, teaches organizations how to re-design themselves utilizing his world-leading *Experience Design Storyboard* & *Master Process*. This tool, developed originally for the Disney Corporation to design the "customer experience" for a visitor to a Disney Theme Park, has been refined by Art and

his team over the past 15 years to focus on the patient/ client/ resident experience in healthcare settings. While Art's basic design approach has been copied in the U.K. (called "*Experienced-Based Design*") each off-shoot has generated their own insights and lessons learned.

After 25 years supporting healthcare leaders as they test new and innovative tools that help them develop and execute effective strategic change, I have been quite frankly stunned to discover such a simple and effective methodology for mobilizing the collective intelligence of front-line healthcare workers to redesign their hospital, our homecare services and, very importantly, our primary care services.

Given the importance that Health Minister Deb Matthews has placed on ***The Excellent Care for All Act***, the "patient experience" will increasingly become an issue that healthcare leaders need to learn about, and help promote. On my personal learning journey about the patient/client experience over the past three years, the best tool that I have discovered to improve the patient experience is called, the "*Storyboard*".

The **Experience Design Storyboard** is based on leading-edge sciences of visualization, storytelling, process workflow, experience design and behavioural psychology. Having been a member of systems thinking tool development design teams in the '90s, I can see how Art's stuff really fits together as an integrated system.

I recently had an opportunity to experience the *Storyboard Methodology* with a cross-functional team of senior/middle managers and front-line home care service providers -- who engaged in 8 hours of patient engagement data-gathering, and another 25 hours of dialogue about "designing the patient experience". Experience design process inventor Art Frohwerk explains that the idea of the "story" helps us anticipate the set of things needed to deliver an effective service with an intentional experience.

I have seen how "*storyboarding*" helps people visualize what an entire service experience will "look like", "feel like" and "be like" as Art Frohwerk unfolds the wrap-around-the-room set of panels depicting each chapter, scene and stage that the group created through their storytelling dialogues together.

While the initial stages of this redesign process enables people to "slow down", at some point, it is "time to speed up". In the top-down world of strategy execution, these are called "*leveraged actions*". In the bottom-up world of experience design, they are called "*catalytic triggers*": the proven key leverage points that accelerate change in complex adaptive human systems. We need both *leveraged actions* and *catalytic triggers* to succeed. Otherwise, you are left with a set of good intentions, going nowhere.

Successful transformation depends on an organization's ability to identify the most *leveraged actions* that would create "maximum impact, for minimum effort", "biggest bang for the buck"; etc.

Systems thinking guru, Peter Senge, describes "*leveraged actions*" as small, well-focused actions that can produce significant enduring improvements if they are in the right place. For example, the "trim tab", or small "rudder on the rudder" of a ship would be a good metaphor for leverage. This tiny trim tab is what makes it easier to turn the rudder, which in turn makes it easier to turn the ship.

The most *leveraged actions* (i.e. "biggest bang for the buck"), for creating a "patient-centred care" revolution in Ontario would include:

- The provincial government aligns the economic incentives and rewards to achieve the goals and objectives of the ***Excellent Care for All Act***;

- The Minister/ Deputy/ ADMs/ Board members/ CEO's/ senior managers invest significant effort to celebrate breakthroughs on performance measures for patient-centred care;

- Governance Boards that are prepared to re-invent and transform themselves to become focused on quality, safety and the patient experience. Such boards will model for staff that they can transform too;

- CEO's who demonstrate commitment to becoming true Learning Organizations and engage the collective intelligence of their organizations to develop and execute the necessary strategic changes;

- Facilitative managers who drive fear out of their organizations. They emphasize learning, continuous improvement and personal growth;

- Organizations, and networks of organizations along the continuum of care, need a *common language* and set of *frameworks* for talking about, planning for, and implementing complex change; and,

- At the organizational level, managers need to develop or adapt measurement/ learning systems for "testing" the various theories of change, and discovering how to continuously improve on their performance.

But to succeed, the revolution must be a <u>bottom-up</u> revolution, as well as <u>top-down</u>.

Boards will discover that they will have tapped into a groundswell of support when they transform themselves to become much more focused on "the patient experience". While staff and physician satisfaction rates skyrocket in such circumstances, the goal is always to achieve the "patient-centred care" objectives of the organization.

Numerous studies have demonstrated the link between patient satisfaction and clinical outcomes. Research shows that less stressed patients who trust and engage their caregivers have fewer complications, are more compliant with prescribed treatments, and

are less likely to experience a preventable medical error. While these are compelling reasons to become “patient-centred”, what could you actually “do differently”?

Next week, my blog will be an essay I wrote for *Cancer Advocacy* entitled, “***Patient Anxiety Emotional Intelligence Unleashing The Power To Care Within A Culture Of Empathy***”