SPECTRUM

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Using the Power of Story to Transform the Patient Experience

How storytelling pulls back the curtain to reveal experiential truths

Although patient surveys reveal broad attitudes, such as the unwillingness of patients to recommend a specific hospital, surveys do a poor job of illuminating *why* patients feel that way. In working with large and small hospitals, clinics, and private practices, we have documented and analyzed more than 900 personal stories from patients and family members, as well as clinical and nonclinical staff. From this qualitative research, we have discovered that stories are not only powerful communication, teaching, and enculturation tools; they also can reveal valuable insights in ways that typical quantitative measures cannot.

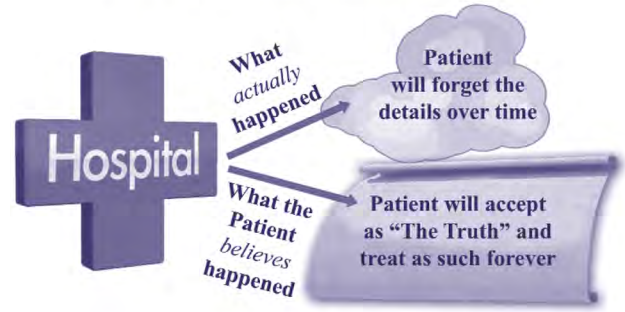
Within patients' stories and recollections reside their true needs and wants, as well as the key drivers that affect how they determine their satisfaction. A survey question, no matter how well designed, elicits answers from the patient only within the boundaries of that question. Stories, on the other hand, can lead anywhere and are universal in communicating experience, emotion, and opinion. When patients share the *story* of their healthcare experience, all the rich nuance that underlies their attitudes comes to the fore. You see the experience through *their* eyes.

Story: The Essential Tool for Understanding the Patient Experience

For the past 20 years, i.d.e.a.s has been engaged in creating purpose-built experiences in the film, entertainment, learning, hospitality, and theme park industries. Over the past three years, we have applied our "guestology" practice to help healthcare facilities rethink and intentionally redesign their patient experience. With the advent of the HCAHPS patient experience survey, creating a better patient experience is no longer an option for hospitals; it is an imperative.

Using a process we call StoryAnalytics, we comb through patient stories and observations seeking patterns and disconnects, and then create visual models for what drives patient experience. This gives us a clear picture of both the "actuals" of the patient's stay and the "perceptions" patients have about their experience. Over time, what patients *believe* happened becomes truth to them, regardless of what the patient's chart may indicate or hospital staff recalls **(Figure 1)**. It is this *perceived* truth that becomes the basis for the patient's word of mouth, intent to return, and willingness to recommend.

Figure 1. Actual vs. Perceived Truth



Two Separate Worlds

First and foremost, we have discovered that patients and clinicians live in decidedly different worlds. Their perspectives and language are not only foreign to one another; frequently they are in conflict. Clinicians and leadership view the patient experience as a medical one, focusing on quality, efficiency, and outcomes. In contrast, to patients their experience is emotional, relational, and informational.

To illustrate, in **Figure 2** we see the reality of a patient and his medical condition (shaded area)—say, a gallbladder problem—not life threatening, but serious enough for the patient to be hospitalized. **Figure 3** graphically illustrates how

Figures 2-4. Three Views of a Medical Condition:

Reality *(Figure 2)*

The Clinician's View *(Figure 3)*

The Patient's View *(Figure 4)*

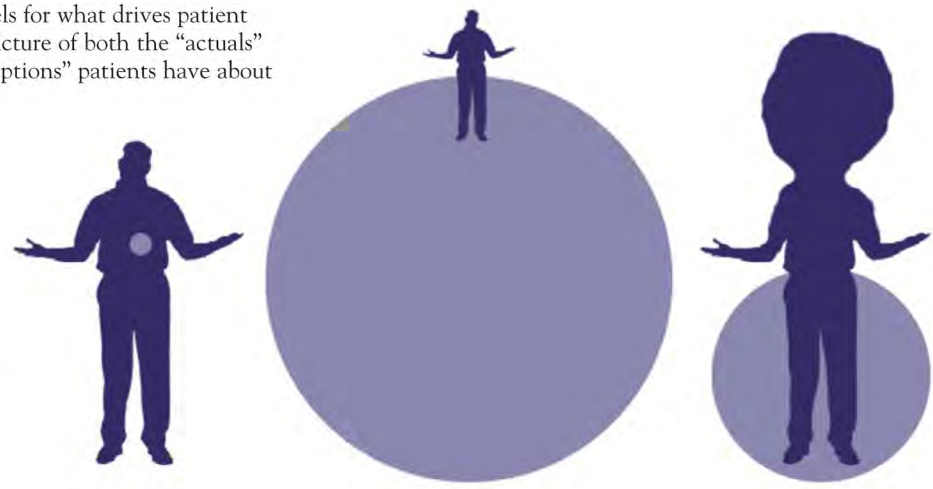


Fig. 2 *Fig. 3* *Fig. 4*

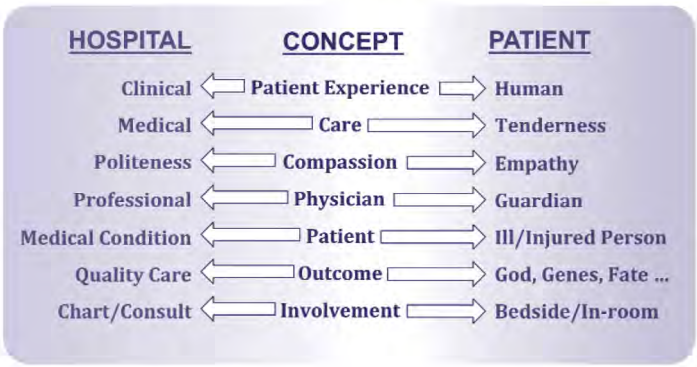
clinical staff often views such a patient's condition. The focus is on the medical issues—the chart, tests, and treatment plans. At times, the clinicians must speak with the patient who is "attached" to this condition to gather or transmit information, but their focus is primarily on the medical condition.

In **Figure 4** we see the medical condition through the patient's eyes. The condition is magnified because it is *his* condition, *his* uncertainty about the future, and *his* pain. The enlarged head indicates the very personal and emotional nature of the situation. The infantilized appearance is no accident, because patients often regress in these situations. It is the psychological impact of the experience that affects how the patient feels and sees everything, including hospital staff and the way they deliver services. What drives the patient's reality is his perception, intermingled with fear.

Neither the clinician's nor the patient's perspective is wrong, but they are in conflict with one another while inhabiting the same experiential space. This foundational disconnect is often at the core of many other problems that can lead to negative patient satisfaction scores. It must be intentionally bridged throughout the patient's journey.

This dichotomy in perspective is clearest when you consider the different meanings patients and clinicians ascribe to the same concepts. We soon discovered that although these two audiences were telling us similar tales using similar language,

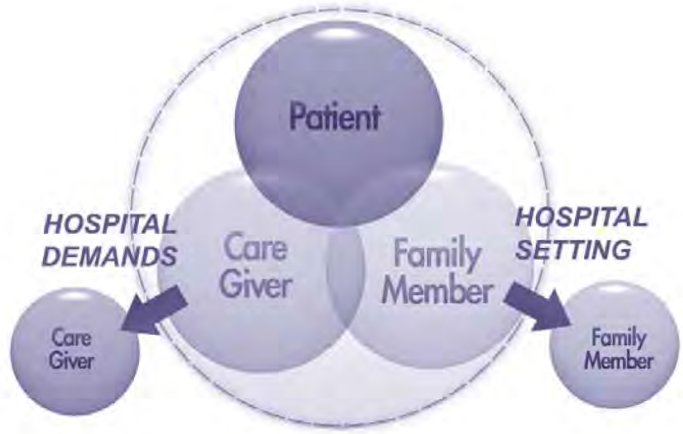
Figure 5. Perceived Meanings of Common Concepts to the Clinician and the Patient



when we asked what they meant, the stories led down two very different paths. When we compared the perceived meanings of some common terms associated with a hospital stay **(Figure 5)**, we found widely divergent interpretations between how hospital staff members were using the terms and how patients and family members were understanding their meaning.

For example, a physician we observed told a mother that the physician would be starting her toddler on a "stronger" medication. What the physician meant was a *better, more efficacious* medication. But what the mother heard was a *more dangerous* medication. Here we have two completely different interpretations of the same common, everyday term. Imagine what kinds of confusion and emotional stress can occur when more complicated clinical terms are used and the challenges of accurate comprehension compound the situation.

Figure 6. The Caregiver Circle



Entering the Caregiver Circle™

In an ideal world, the patient, family member, and caregiver reside in what we term the "caregiver circle" **(Figure 6)**. When this relationship union is undisturbed and intact, patients report a higher level of satisfaction in the stories they tell about their hospital experience.

Unfortunately, hospital and administrative demands are increasingly pulling the caregiver—usually the nurse—away from this relationship circle. And, more often than not, hospital settings are not conducive to keeping family members and patients connected. This separation of patient from family—whether by policy or lack of proximity—disrupts the patient's primary social, emotional, and psychological bonds, creating additional stresses beyond those warranted by the patient's medical condition and hospitalization.

The result is that patients often have to face much of their healing journey alone in an alien environment. This unintentional abandonment can lead over time to issues with patient attitude, confrontation, and even compliance. Conversely, efforts to bridge the gap can lead to positive changes in the patient's attitude.

One patient who shared her story with us was facing a long-term stay in the maternity high-risk unit and was very dissatisfied with her accommodations and care. At the time, she was seriously considering leaving the hospital and going to a different one. But when a nurse took the time to pluck dead petals and leaves off the flowers in her room rather than throwing the arrangement out, the patient had a change of heart.

As the patient described it, the nurse's actions showed that she recognized the emotional nourishment the flowers gave the patient, implicitly acknowledging her humanity and needs. This helped to bridge other factors the patient had perceived were lacking in her care. When the nurse acknowledged and cared for the only other living thing in the room, the patient formed a firm belief that she and her unborn twins would be safe in that hospital. That nurse entered the caregiver circle when she reached out to care for the patient's flowers.

Another example was that of a surgical nurse who mistakenly gave a patient and her family the wrong time to arrive at the hospital for a fairly serious medical procedure. Realizing her

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SHSMD Datebook

August 14–September 12
Online election of 2009 Board members and president

September 17–20
Connections 2008: The SHSMD Annual Educational Conference and Exhibits, San Francisco Marriott, San Francisco

October 2
Webcast: "Using Communications to Manage Customer Loyalty"

October 20–November 2
Online course: "Orientation to Healthcare"

October 27–November 9
Online course: "Service Line Marketing"

December 3
Webcast: "Building Healthcare Relationships with Web 2.0 Tools"

April 27–28, 2009
"The Essentials of Healthcare Strategic Planning," Embassy Suites Chicago–Downtown/Lakefront

April 27–28
"The Essentials of Healthcare Communications and Public Relations," Embassy Suites Chicago–Downtown/Lakefront

April 27–29
"The Essentials of Healthcare Marketing," Embassy Suites Chicago–Downtown/Lakefront

April 29–May 1
"Raising the Bar in Healthcare Marketing Performance," Embassy Suites Chicago–Downtown/Lakefront

April 29–May 1
"Raising the Bar in Healthcare Strategic Planning Performance," Embassy Suites Chicago–Downtown/Lakefront

April 29–May 1
"Raising the Bar in Healthcare Communications and Public Relations Performance," Embassy Suites Chicago–Downtown/Lakefront

September 30–October 3
Connections 2009: The SHSMD Annual Educational Conference and Exhibits, Orlando, FL

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error, the nurse called extremely early the day of the surgery, waking up the family to let them know that the patient needed to be at the hospital in an hour. The family rushed to get the patient there on time, but two of the daughters got caught in morning traffic and arrived late. They hurried to pre-op, only to find the same nurse holding their mother's gurney and refusing to let her go to the OR until all the family members had a chance to say "I love you" to their mother.

The nurse's compassion in recognizing the family's need to connect emotionally with the patient before she underwent a risky procedure completely mitigated the scheduling error. Even though this was the same nurse who had told the family the wrong time, creating a massive inconvenience and aggravating their already high level of stress, the family immediately embraced her as one of their own. The family even went so far as to recognize the nurse's actions by expressing their great appreciation to the unit manager. This nurse entered the caregiver circle the moment she empathized with the family and responded to their emotional needs.

The fundamental question every hospital in America must ask is, how can we build human systems that bring out the best in all of our staff—systems that empower staff members, whether they are in a clinical or nonclinical role, to step out of that role and offer the magic of connection and authentic relationship to patients and families who are suffering and in distress? Although the examples above are representative of our findings, the real finding is that a quick-fix or "relationship program" won't move the needle. Designing and implementing a program to truly change patient experience is a culturally determined and exacting effort.

With the advent of HCAHPS and the competition for healthcare dollars and patient loyalty, quality healthcare can no longer mean simply good medicine. Quality healthcare must now include the goodness of the human heart in a new and sustainable model for care delivery.

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