CHAPTER 2

What Patients Want: Designing and Delivering Health Services that Respect Personhood

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A PERSON IS an embodied, intelligent being with the free will to act in fulfillment of his human needs (Ashley and O'Rourke 2002). A person is dynamic, changing, and inextricably linked to the human needs that possess all of us. The way in which we fulfill our human needs makes us who we are as people and constitutes our personhood.

As healthcare providers, you are not serving patients; you are serving people. You are designing and delivering services to meet the needs of normal people at the most difficult times in their lives. You are serving sick, lonely, suffering, scared, distressed, and worried people whose planned life journeys were irrevocably altered.

We often are asked, "What do patients or patients' families think?" as if patients and their relatives were somehow a different species with different thoughts or feelings than normal humans. We are asked this question because the traditional notion of a patient is someone to whom we do things; someone who needs to be fixed; someone expected to give up at least a portion of her free will to undergo the clinician's decided course of treatment; someone treated, manipulated, and in short dominated—at least in the traditional, perhaps unconscious, view.

In planning, designing, and delivering health services we often make the mistake of moving directly to patient, or even customer,

concepts instead of considering human beings in the context of their natural existence. Those who have designed and innovated the world's greatest products and services did not conceptualize an abstract customer, but rather were completely attuned to the reality of life and fundamental human needs.

Now that we have begun to align our thought with the concept of personhood, the questions healthcare leaders and managers should ask in designing and delivering a health service include

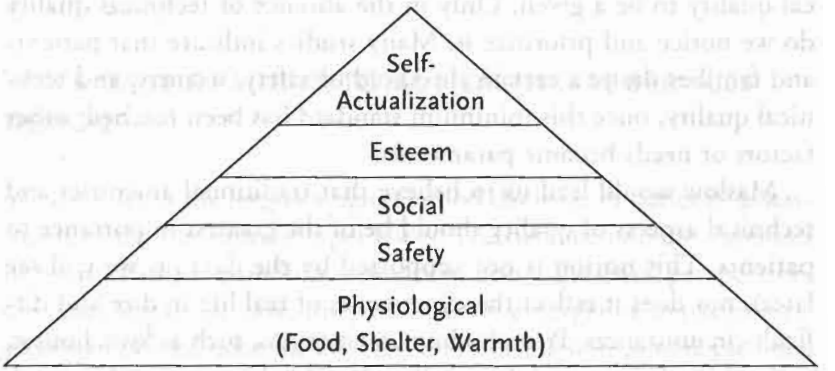
- What is it that people need?
- What is it that people want?
- What is it that people love?

MASLOW'S HIERARCHY: SAFETY AT ALL COSTS

Perhaps no one is more greatly associated with human needs than Abraham Maslow. Maslow (1987) grouped all human needs into a hierarchy: (1) physiological, (2) safety, (3) social, (4) esteem, and (5) self-actualization (see Figure 2.1). At each level a person must satisfy needs before striving to fulfill needs at the next level. A person must fulfill physiological needs before pursuing safety, social, esteem, and self-actualization needs. Physiological needs include food; water; clean air; and basic health services, such as life-saving interventions. Next, a person needs to feel and be safe through a secure environment, protection from harm, trust in those who surround him, and comfort or peace of mind in the knowledge that these needs will be fulfilled in the future. Social needs come next as we search for interaction, attention, and relationships, often categorized as psychosocial needs. Esteem represents what we derive from our actions and relationships: understanding, love, and emotional and spiritual support. Finally, self-actualization occurs when we operate at a fully charged, high level and experience the feeling of fulfilled purpose and meaning.

Maslow's popular hierarchy matches well with how health services have been designed and delivered in the past 50 years. The fore-

Figure 2.1: Maslow's Hierarchy of Needs



Source: Maslow, Abraham, MOTIVATION AND PERSONALITY, 1987. Reprinted by permission of Pearson Education Inc., Upper Saddle River, New Jersey.

most priority among healthcare professionals is to first, do no harm. Indeed, as laypersons undoubtedly agree, we do no want to be sick, and we definitely do not want to get sicker. We want to at least maintain our current bodily integrity; we do not want to be harmed. The Institute of Medicine's ([IOM] 2001) definition of quality reflects Maslow's hierarchy, declaring that healthcare must be

1. safe,
2. effective,
3. timely,
4. efficient,
5. equitable, and
6. patient centered.

Although IOM's finding that between 44,000 and 98,000 patients die annually in the United States as a result of preventable medical errors has heightened healthcare industry professionals' attention to safety and security, we have yet to see evidence that this has changed

the perceptions of patients or the public. The consensus explanation is that patients and family members consider adequate technical quality to be a given. Only in the absence of technical quality do we notice and prioritize it. Many studies indicate that patients and families desire a certain threshold of safety, security, and technical quality; once this minimum standard has been reached, other factors or needs become paramount.

Maslow would lead us to believe that traditional amenities and technical aspects of quality should be of the greatest importance to patients. This notion is not supported by the data (as we will see later), nor does it reflect the experiences of real life in dire and difficult circumstances. Powerful human emotions, such as love, humor, and spirituality, emerge forcefully when life becomes endangered. Many irrational decisions are made based on emotional needs (Hastie and Dawes 2001). Mathematician Blaise Pascal (1623–1662) observed, "The heart has its reasons which reason knows nothing of" (Pascal 1941). Humans today continue to risk security for love. We need humor when faced with difficulty. We seek to touch the divine when our lives look most bleak.

The reasons for this disconnect between the priorities suggested by Maslow's theory and healthcare consumers' actual behavior may lie in the fact that Maslow intended his hierarchy to explain human motivation. His findings were based on a series of case studies observing high-performing individuals. It is important to understand the context of the theory: these were psychological studies intended to answer the question of what motivates humans to achieve high levels of performance. As Maslow's hierarchy is a theory of motivation based on high-achieving, healthy individuals, it may be that the prioritization of human needs shifts and changes like a kaleidoscope when humans undergo difficult or life-threatening experiences.[1]

Although it possesses undeniable intuitive appeal, Maslow's hierarchy is inadequate in fulfilling patients' wants and needs. Nevertheless, the practice of healthcare management has strictly adhered to Maslow's hierarchy. Senior management often only concentrates entirely on safety, with patients' wants and needs only an afterthought. The result? Limited vision and lack of openness to innovation. In a recent conversation a healthcare CEO stated bluntly,

"I don't care if patients have a window; I want them to be safe." Why can't patients have both?

VOICE OF THE PATIENT: TOTAL HEALTHCARE SERVICES DESIGN

We drew from the largest single-method database of patients' assessments of their healthcare experiences. The data include the responses of more than nine million patients in 2004. Patients' perspectives on acute inpatient care, outpatient care, emergency departments, physician offices, home health care, and nursing homes were included using the approach of scientific reductionism—that is, reducing what people find most important in healthcare to its most elemental parts. In other words, across different healthcare service settings, medical specialties, organizational characteristics, and patient characteristics, what commonalities emerge that tell us people consider certain universal needs most important when receiving any health service? The answer to this question will isolate factors critical to patient loyalty and improving satisfaction. With these results, healthcare managers can take the next step in designing health services to truly foster personhood.

Table 2.1 lists the top five patient assessments with the strongest correlations to patient loyalty for acute inpatient care, outpatient care, emergency department, medical practice, and nursing home settings. The themes of staff response, demonstration of care and concern, clinicians' communication (information, explanation), and attention or sensitivity to special or personal needs are strong. Almost everything important to patients' loyalty occurs within the therapeutic encounter. What happens when patient and clinician meet is of paramount importance to whether the patient will recommend or return to that organization, facility, or provider.

Many of these assessments are worded slightly differently for the particular patient populations, but behind them are universal human needs. For example, "special or personal needs," "staff cared about you as a person," and "our sensitivity to your needs" all point to a

desire that clinicians personalize the encounter and attend to what makes us unique individuals.

It is also important to note the difference between actual physical comfort and staff concern for comfort or other assessments of physical needs. These key words indicate that people care more that providers demonstrate concern or caring behaviors than the actual physical sensations they experience. People do not blame the clinician or organization for being sick, even if, as in the case of medical errors, the illness is the organization's fault. People do blame others for not showing that they care.

Another important distinction is the provision of information. This gets to the how and what. What information are patients receiving? Do they understand this information? Do they want this information? Is this really what they want to know about, or is this what the institution wants to tell them? What does the patient want to know? An organization that respects personhood in providing information would ask the person what information they want to know instead of simply delivering the information it wants or needs to give them.

Table 2.2 lists what patients consider the biggest priorities for improving health services based on a balance of importance (correlation to overall satisfaction) and current national performance (mean score). This measure has been dubbed the Priority Index and represents the most effective way to understand how patients would prioritize any improvement efforts. The highest priorities are areas of low performance and high importance. Again, the same issues dominate: response; communication; care and concern; and patients' unique personal, emotional, and spiritual needs. Basically, patients are saying, "If you fix anything, please fix this. This matters more to me than anything else, and it needs to get better."

The emergence of these issues as patients' biggest priorities is significant. These surveys include many measures on technical quality, process quality, safety, amenities, and environment. While patients do rate other items (e.g., meals) lower, these technical aspects of care simply do not matter as much to patients. Only once does an issue explicitly regarding amenities or physical environment appear: cheerfulness of the practice (typically interpreted by respondents as a

Table 2.1: Strongest Correlations to Patients' Loyalty

	Care Setting				
Rank	*Acute Inpatient*	*Outpatient*	*Emergency Department*	*Medical Practice*	*Nursing Home*
1	Response to concerns/complaints	Staff worked together	Staff cared about you as a person	Confidence in the provider	Receptiveness to your ideas
2	Special/personal needs	Response to concerns/complaints	Information about delays	Cheerfulness	Treatment of visitors
3	Sensitivity to the inconvenience caused by health problems/ hospitalization	Sensitivity to your needs	Pain control	Our sensitivity to your needs	Treated with dignity
4	Nurses keep you informed	Concern for your questions and worries	Nurses keep you informed	Concern for your questions and worries	Responsiveness to your ideas
5	Inclusion in decision making	Staff concern for your comfort	Staff keep family informed	Explanation of problem and inclusion in decision making	Explanation of your care

Table 2.2: Patients' Greatest Priorities for Health Services

	Care Setting				
Rank	*Acute Inpatient*	*Outpatient*	*Emergency Department*	*Medical Practice*	*Nursing Home*
1	Response to concerns/complaints	Response to concerns/complaints	Informed about delays	Our sensitivity to your needs	Responsiveness
2	Sensitivity to the inconvenience caused by health problems/ hospitalization	Our sensitivity to your needs	Staff cared about you as a person	Cheerfulness	Receptive to your ideas
3	Emotional/spiritual needs	Staff worked together	Pain control	Comfort and pleasantness of the exam room	Keep you informed
4	Inclusion in decision making	Comfort of the waiting area	Nurses keep you informed	Wait time	Responsiveness to your ideas
5	Nurses keep you informed	Staff concern for your questions/ worries	Wait time	Convenience of office hours	Explanation of your care

global assessment of the collective attitude of all providers and staff at the clinic). Assessments of process only appear twice: wait time. Explicit evaluation of a safety, security, or technical quality issue only appears one time: pain control in the emergency department.

When we do ask patients specifically to evaluate the safety and security of health services and the healthcare environment, what drives their assessments? The strongest drivers of patients' perceptions in these areas are information provision, sensitivity to inconvenience caused by health problems and hospitalization, response to concerns or complaints, and emotional or spiritual needs. This tells us that what makes a health services environment safe and what makes people think and feel that a health services environment is safe are two completely different things. How we are treated by those delivering the health service drives our perception of safety and security in that environment. As Press Ganey researcher and psychologist Robert Wolosin, Ph.D., (2004) concluded, "Hospitals can maximize their patients' perceptions of safety and security by globally attending to the personhood of patients."

Every year, Press Ganey researchers conduct these analyses using the past year's data to understand, at a global level, what patients want. Since 2001, every year the results have been incredibly similar. Rigorous psychometric tests, such as confirmatory factor analyses, are conducted to verify that the results are not due to the survey, methodology, or some other factor. And every year the same results resurface, placing strong emphasis on respecting personhood. No matter how the data are sliced and diced, this theme continually emerges.

Taking into consideration the research presented here and the volumes of supporting data, we can posit that the following factors constitute universal human needs that should be taken into account in the design, delivery, and management of any health service:

- responding and being sensitive to patients' unique needs;
- responding to concerns and complaints;
- emotional and spiritual needs; and
- communication quality—informing, involving, and explaining to patients as well as displaying concern and caring.

PERSONHOOD, LOYALTY, AND BREAKTHROUGH PERFORMANCE

With this understanding, we can take healthcare to the next level, beyond the Maslowian safety-at-all-costs mentality and beyond the ethics-, law-, or regulation-driven checklist approach to patient autonomy. Healthcare can deliver services that are safe, effective, timely, efficient, equitable, and patient centered not only according to managers but also according to patients—the people on the receiving end. This patient-inspired approach raises healthcare organizations to the position they deserve—not just a business that meets customer needs but one that respects and enhances the personhood of its customers.

Good to Great (Collins 2001) highlighted the importance of the hedgehog concept—a single concept that, if followed extremely well and to the virtual exclusion of almost everything else, can help a business achieve its full potential. Safety is not the hedgehog; autonomous, consumerist medicine is not the hedgehog. Personhood can be healthcare's hedgehog:

> Breakthroughs require a simple, hedgehog-like understanding of three intersecting circles: what a company can be the best in the world at, how its economics work best, and what best ignites the passions of its people. Breakthroughs happen when you get the hedgehog concept and become systematic and consistent with it (Collins 2001).

Healthcare is delivered by human beings, for human beings, to serve our most basic human needs. The more healthcare becomes a real marketplace, the greater will be the emphasis on strengthening the connection between providers and patients.

Patients' Ratings and Loyalty

When patients evaluate their relationships with health services providers, they distinguish between contentment or marginally pos-

itive satisfaction and endearing loyalty and affection. Like customers in other service industries (Hart, Heskett, and Sasser 1990), patients can exhibit a false loyalty to their providers. Even if they respect clinicians' medical expertise and technical skill, many patients do not like the way providers communicate (Arora, Singer, and Arora 2004). During the encounter, patients will not tell clinicians their true opinion of the provider's behavior. True opinions will only emerge after the fact, on surveys and, if presented with a potentially better option, in loyalty behaviors.

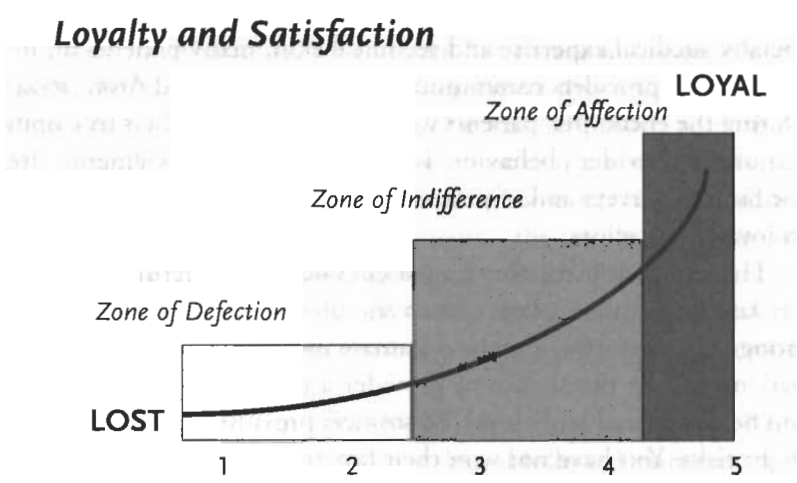
The strongest predictor of a patient's decision to return and bring her family members occurs when she provides the highest possible rating (e.g., Bertakis, Roter, and Putnam 1991; Press 2002). Only those patients giving the service or provider a five on a one-to-five scale can be considered truly loyal. Customers providing other ratings are flight risks. You have not won their hearts and minds; they are simply waiting for something better to come along (see Figure 2.2).

This top-box approach seeks to maximize the number of customers giving your organization a rating of five or "very good." In other words, the approach aims for consistently superlative service quality survey responses with the high rating or "top box" checked. Moving the "fair" and "good" satisfied patients into the zone of "wow" or "very good" will turn them into intensely loyal customers, leading to greater market share and achievement of financial objectives. According to Jones and Sasser (1995):

> Managers should be concerned rather than heartened if the majority of their customers fall into the satisfied (as opposed to completely satisfied) category. Most managers probably would be happy to learn that 82 percent of their customers fell into category four or five. The more appropriate reaction would be: "We have a problem. Only 48 percent of our customers are completely satisfied (scoring a five), and 52 percent are up for grabs."

The top-box approach to loyalty also drives comparative results. Table 2.3 illustrates additional consequences of the top box on percentile rank. Healthcare organizations in the top percentile ranks (91st and above) had 63 percent of patients rate them "very good,"

Figure 2.2: Patient Loyalty and Satisfaction



Source: Adapted from Jones and Sasser (1995).

more than twice as many as those rated simply "good." On the other hand, organizations in the bottom 10 percent had only 41 percent "very good" ratings. Healthcare organizations in the lowest decile had almost as many "good" ratings as "very good" ratings. Without benchmarking and the top-box approach, this could lead to the erroneous conclusion that patients are satisfied and loyal, when, in fact, their comparative performance is quite poor and their patients are at risk. Overall, the best performing healthcare organizations received 22 percent more "very good" responses than the worst performing organizations. This means that an additional 22 percent of their patient population are loyal to the healthcare organization and will be unlikely to defect. This kind of loyalty and positive word-of-mouth can mean a lot to the health service's financial security.

Figure 2.3, which precisely quantifies the model presented in Figure 2.2, demonstrates that a real, substantial difference exists between the healthcare services that patients evaluate poorly and those patients believe are top notch. This pattern holds true across all healthcare services as well as for patient and employee satisfaction. The mes-

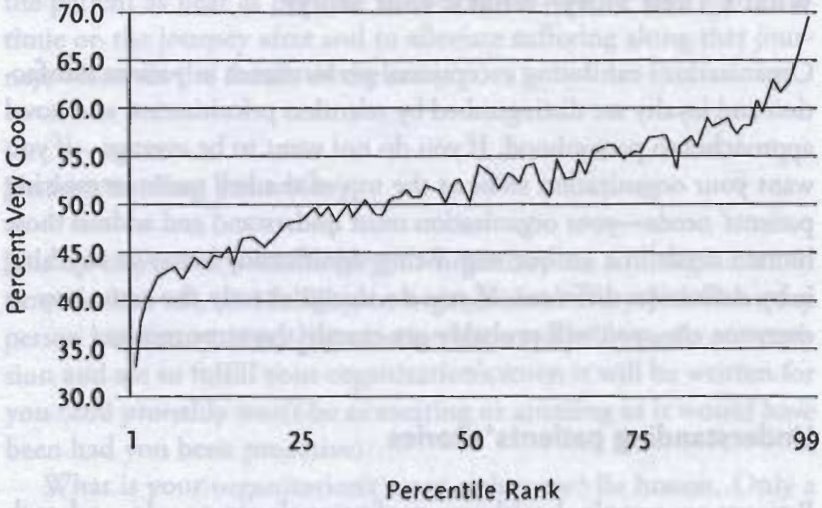
Table 2.3: Analysis of Patient Satisfaction Response Category % by Percentile Rank for Inpatient Acute Care, 2004

Response	*% Difference Between 90th Percentile and 10th Percentile*
Very poor	2%
Poor	3%
Fair	8%
Good	9%
Very good	22%

sage: there is a quantifiable difference between mediocre healthcare organizations and those that patients believe to be exceptional.

These comparative results are important for two reasons. First, percentile ranks serve as a gauge of differentiation in service excellence. Compared to all other organizations in the United States, have you

Figure 2.3: Average percent "Very Good" Ratings by Overall Percentile, Rank



The Data Represents the Experiences of 2,170,994 Patients at 1,506 Hospitals Nationwide Between January 1 and December 31, 2004.

effectively differentiated yourself? If you provide better service quality than 90 percent of all other organizations like yours, you have a distinct competitive advantage. Second, many studies have linked patient perceptions of quality and financial objectives, particularly profit margin. In a study of 82 hospitals, a 1 percent standard deviation change in the quality score resulted in a 2 percent increase in operating margin (Harkey and Vraciu 1992). Another study of 51 hospitals ascertained that up to 30 percent of the variance in hospital profitability can be attributed to patient perceptions of the quality of care (Nelson et al. 1992). Yet more research found that a 5 percent patient dissatisfaction rate can cost a private physician $150,000 in lost revenue (Drain and Kaldenberg 1994). A recent study at Rush University Medical Center examined every factor in the Press Ganey patient survey for its impact on loyalty to determine where the biggest financial return on investment for improvement would lie. Of all factors, if patient perceptions of how well clinicians provided information moved up from ratings of three or four to ratings of four or five, the resulting increase in admissions would produce $2.3 million in additional patient revenue, or an additional $82 for each current patient (Garman, Garcia, and Hargeaves 2004).

What's Their Story? What's Your Story?

Organizations exhibiting exceptional performance in patient satisfaction and loyalty are distinguished by relentless prioritization and novel approaches to personhood. If you do not want to be average—if you want your organization to be at the top of the bell curve in meeting patients' needs—your organization must understand and address those human needs in a unique way. Being significantly better at anything is by definition different. If you do things exactly the same way as everyone else, you will probably get exactly the same results.

Understanding patients' stories

Patients are people, healthcare professionals are people, and each person is on an individual life journey. Each person has his own nar-