Introduction

The premise underlying the need for improvement is the fact that the US healthcare system has waste, redundancy, and inefficiency. Those of us who work in healthcare know this is true. We witness this time and time again, and though efforts driven by Total Quality Management, Six Sigma, and Toyota Lean principles have led to significant improvements over the past several decades, much still needs to be done. Other industries have used technology, process improvement, and service excellence programs to redefine the customer experience and make it safer, but healthcare has not kept pace. People experience excellent, coordinated service every day in other lines of business, and consequently they wonder why their healthcare experiences remain cumbersome, fragmented, and lacking the necessary information exchange. People who consume healthcare services demand and deserve better.

Healthcare leaders and administrators aim to make greater strides in quality, safety, and efficiency. However, the current healthcare delivery system is so complex, with many specialized interrelated services and processes and various stakeholders, that improving the entire system to create a truly remarkable care experience is difficult. The healthcare experience should be safe, effective, patient centered, timely, efficient, and equitable, as noted in the Institute of Medicine's (2001) seminal publication *Crossing the Quality Chasm.* To achieve this ideal, leaders and administrators must examine healthcare from the perspective of the end user.

In some ways, healthcare today is not too dissimilar from the manufacturing industry, where the evolution of specialization began. Using a pin factory as an example, Adam Smith (1776), the father of economic theory, asserted in *The Wealth of Nations* that

greater productivity and efficiency could be achieved in manufacturing processes if each task were separately identified and performed by a specialist. Like manufacturing, medicine has evolved similarly. Contrasted with the rural doctor of the past who served as a generalist or family physician, modern medical practitioners have distinct areas of interest, requiring people in need of services or treatment to travel from one specialist to another. In this way, healthcare became organized around the convenience and productivity of the physician—the highest cost resource—and not the patient. Specialization offers several advantages, including greater medical and health discoveries, more groundbreaking research, and better understanding of disease and symptoms—all of which have led to improved clinical outcomes. At the same time, however, specialization has created processes that are so separate and distinct that moving from one service to another has become daunting even for the most educated healthcare consumer. In addition, many people do not understand the differences between the specialties—surgeons, internists, physician consultants, hospitalists, and proceduralists, to name just a few. This confusion is compounded by the roles of mid-level providers, residents, house officers, and students.

The fact that healthcare is typically paid for by a third party adds another level of complexity and creates more ambiguity in identifying who the "customer" is (i.e., is it the patient or the party who pays for the service?), especially when reimbursements for care do not cover the costs. If a healthcare organization wants to keep up with state-of-the-art technology, modern facilities, and competitive market-based salaries to hire the best talent, then expense management is a necessary reality. Cost savings tend to be garnered through process improvement, reduction of services (e.g., disease prevention, health education) that provide little to no reimbursement, or elimination of the elements of care that are deemed non-value added. In most organizations, cost reductions are defined by each department (silo) rather than across the system. This practice tends to shift rather than reduce costs and fosters the idea that each department will do more with less, which puts much stress on the

system and the staff who are expected to deliver. The end result is that the patient (and family) who moves from one unit to another across the system experiences the fragmentation firsthand and witnesses the frustration of each unit's physicians and staff who are forced to work with limited resources. Overwhelmed with the competing demands of regulations and accreditation, third-party payer reimbursement, value-based purchasing, and dwindling resources, institutions typically do not view patients as healthcare's ultimate consumer and thus pay little attention to the needs and convenience of the patient and family.

If healthcare institutions are to remain viable and ready to compete as accountable care organizations in the new world of the Affordable Care Act, then patient-centered care, quality and safety, and the opinions of patients must become a priority to maximize safety, clinical outcomes, and margins. This will require healthcare organizations to hold frank and open dialogue to better understand the fundamental needs of their patients and families. As healthcare leaders, we are educated to manage by data, define the metrics of success, analyze, evaluate, and assess. What we have not been formally trained to do is to view the care experience from the patient's perspective. Although we use tools that recommend identifying value-added work as defined by the customer, we tend *not* to ask the customer. Instead, we base our strategies on what we believe our patients want and need. The patient and family member must be included in the conversation, and we must be open to listening and hearing what they have to say.

The truth in healthcare is that people's stories drive more immediate action than do pure data. As author Rachel Naomi Remen (1997, xl) says in her book *Kitchen Table Wisdom,* "Facts bring us to knowledge, but stories lead to wisdom." When we learn about a negative personal experience, we gain a human connection and are affected on a visceral level, which then compels us to react and improve the offending situation. Though data are important, they can lead to generalizations and depersonalization that cause us to detach from the real impact of our actions on individuals. For

example, consider what happens when a VIP (e.g., celebrity, donor, or board trustee) experiences the healthcare system and then questions why certain aspects are not organized around the patient. The leaders' attention immediately turns to resolving the problem and introducing better processes. So why aren't these issues examined regularly and given the same priority as other pressing matters? The answer is that the influential individual's story was shared at the highest level of the organization, which has the capability to quickly remove barriers to improvement and where the story made an immediate impact.

These stories are created and told every day in every area of the healthcare system. We need only to draw them out and listen to the lessons therein. Institutional leaders must engage patients and families, especially those dealing with chronic illnesses as they experience the system on many levels. These people witness the organization's strengths and vulnerabilities and likely know more about its operations than we do. We need only ask for their input.

REFERENCES

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