Artemis:

A Stellar Service Experience

Jacqueline A. Schuman

Vanderbilt University

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Dedication and Acknowledgements

I am thankful for the many people, experiences, successes, and challenges that both led me to pursue this degree and provided me with the focus, drive, and resilience to see it through to completion.

A special thank you to Artemis for allowing me to partner with them to explore this important topic for their organization.

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To those who have ever doubted their ability to achieve their goals and dreams after setbacks: Keep going. You are enough.

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Executive Summary

This capstone looked at how a women's healthcare organization can maintain their service levels, with service being defined by the CEO as stellar service, which is compared to a resort feel from first to last point of contact and includes patient and clinical care, while scaling their practice to a new model and with the intent of expanding this new model to additional locations across the country in the future. The goal was to do a comparative analysis to understand if a difference exists between the service levels in the original, standard care of practice, and the new model practices by examining the patient experience through the lens of a luxury patient experience since the luxury service experience focuses on the highest level of customer service along every touchpoint of delivery throughout the customer journey. The organization being studied is Artemis (name has been changed to protect the identity of the organization), a full-service women's healthcare organization that has expanded its practice to a new model in an effort to meet the needs of women in a market that lacks supply of providers while focusing on providing the greatest level of care for these women (stellar service) that solves their problems and helps them live a healthier and more empowered lifestyle. In turn, this organization meets an important need and gap in the healthcare industry.

To learn about how the organization can best maintain stellar service levels for patient and clinical care as it scales to this new model practice, this study addressed

the following questions to understand more about the patient experience (note, patients are referred to as clients in these questions):

1. To what extent do client experiences, as perceived by staff members, differ between the original, standard care of practices and the expanded, new model sites?
2. To what extent do client experiences differ between the original, standard care of practices and the expanded, new model sites?
3. What factors may be contributing to those differences?
4. How do the client experiences impact the client behaviors?

Two conceptual frameworks emerged from the literature to address the problem of practice, with Klaus' (2017) luxury patient experience (LPX) being the primary framework and the servicescape for hospital healthcare framework developed by Suess and Mody (2017) serving as the secondary framework . Klaus (2017) introduced the luxury patient experience as one that exists on a continuum where the patient (customer) journeys through touchpoints in the healthcare practice, the organization designs this journey through their definition of the LPX, measures the defined LPX, builds a strategy to enhance it, implements and evaluates the strategy, and then the patient continues along the journey that the organization continues to refine. This framework combines what is known about research from the

best in customer experience (CX), patient experience (PX), and luxury service to create a combined LPX that delivers a best-in practice, personalized, and high-end patient experience. The servicescape framework shows how the stimuli in the healthcare environment, including atmospherics, service delivery, physical design, and wayfinding impact patient satisfaction which in turn, impacts their loyalty intentions/behavior, and their willingness to pay out-of-pocket expenses to a practice (Suess & Mody, 2017). The patient journey is significant to both of the frameworks and so it becomes an important focal point of this study to further understand the LPX at Artemis.

A qualitative comparative analysis (QCA), multi-case study approach with a quantitative survey was used to conduct this study with the original practice serving as one "unit of analysis" or "case", the new model practices serving as another "unit of analysis" or "case", and a comparison between these two cases taking place to understand the differences between these two models and how those differences may be influencing stellar service in each case (Yin, 2018). Data collection included site interviews with key site leaders at the original practice and three new model sites adapted from Gurruraj and Pascal's (2020) interview guide on the customer experience, patient journey mapping (Trebble et al., 2010) at the same four sites which included walking the patient journey, multidisciplinary interviews with front-facing staff members and providers, and observational evidence (Yin, 2018)

gathering, and administration of the adapted servicescape survey for hospital healthcare (Suess & Mody, 2017). The following are the findings and recommendations that came out of this study:

Research Question 1:

Finding 1: The years of experience working at an Artemis practice combined with some aspects of the format of the model of the practice (the model being original versus new) appears to impact client experience at the new practice in a way that can leave patients feeling frustrated, less accommodated for, and possibly less satisfied than in the original model.

Research Question 2:

Finding 2: Client experiences may be influenced by their expectations for the different practice models, based on the branded model at each practice.

Research Question 3:

Finding 3: Significant factors that contribute to the difference between the two practices include (1) established leaders in the original practice versus new leaders in the other; (2) a requirement for an appointment in the original practice versus no requirement in the other; (3) and the establishment of a new model in this sector of the gynecology market.

Research Question 4:

Finding 4: Client experiences influence client's satisfaction, their desire to return to the practice, the likelihood that they share this practice with friends and family as a practice of choice, and their willingness to pay out-of-pocket expenses.

The findings of this study led to six recommendations:

Recommendation 1: Artemis should develop a plan to utilize a team approach to do their own patient journey mapping exercise at each site, including walking the patient journey and conducting qualitative interviews with patients that help them understand where "moments of care" (Kreuzer, Cado, & Raïes, 2020) take place along the LPX journey.

Recommendation 2: Artemis should create Patient Journey Champions who can be present for each touchpoint along the patient journey.

Recommendation 3: Artemis should build a training and development program that accounts for the nuanced differences that exist for the new model practice, includes what has been learned from the success of the original practice, and includes an intentional mentorship program.

Recommendation 4: Artemis should utilize trend data from patient visits at the new sites to build a predictability model around the daily patient flow that helps support this flow with staffing and appropriate expectations for adaptability and service.

Recommendation 5: Artemis should develop a measurable strategy for factors, implementation, evaluation, and organization-wide celebration of a 10/10 rating for stellar service.

Recommendation 6: Artemis should develop strategies that acknowledge and address customer's desire for convenience within the new practice while maintaining stellar service and accessibility for all.

While this study focuses on how Artemis can provide consistent stellar service while scaling a women's healthcare practice, it can apply to how healthcare providers broadly are able to better the experience for patients along their journey to provide them with the best of care regardless of the type of healthcare practice. These findings and recommendations look at these enhancements through a lens that incorporates customer experience, patient experience, and luxury service and it can be adapted broadly to healthcare organizations to deliver the best-in-class service and care for their patients.

Introduction

Artemis (name has been changed to protect the identity of the organization), a multi-location women's health organization, has both adapted and expanded its practice to meet the growing needs of their specialized medical population as a gap currently exists in the balance between the demand of patients and provider availability (Ibis World, n.d.). This gap could mean the difference between patients getting the care they need to prevent issues that could have lifelong health effects. The organization's expansion includes a move from its original practice to a newer model with multiple facilities. Since embarking on this organizational growth, they have seen a drop in service levels in the new locations as compared with the original practice, with service being defined as patient experience and clinical care. The Owner/Founder of Artemis, Dr. Chip (name has been changed to protect identity) desires an organization with "stellar service" which she has defined as service that is consistently at 8 or above on a scale of 1 through 10. Unfortunately, the owner is seeing service at about a 5 level in her new locations.

When further defining "stellar service", Dr. Chip says the experience should feel like a resort from the entry point to care to exit. She also says that patients ' problems should be resolved. In an area of healthcare that is noted by Dr. Chip as an emotional experience for most women, she believes that the cross between this resort feel and holistic care should have a positive influence on the overall patient

experience that leads to satisfaction, a return to the practice, and a healthier lifestyle. Herein, we begin the journey towards a plan to understand more about the patient service and experience in each practice location as Artemis desires a consistent and sustainable culture of “stellar service” as the organization scales in size and scope.

Identified Problem of Practice

As a medical organization scales business from an original, standard care practice to a new model of practice with multiple sites, how do they ascertain whether the level of service in the new model sites is comparable to the level of service in the original, standard care practice, with the service desire level being that of stellar service?

Organizational Context

Artemis is a full-service women’s healthcare organization that provides holistic care to women. Full-service care can be defined as encompassing comprehensive women's health care from wellness, preventative care to problem-oriented care that requires a gynecologist's supervision. The practice focuses on the delivery of this care with compassion for the patient. The organization serves women, on average, typically beginning at puberty, the onset of sexual activity, or any age if they seek care in relation to gynecological issues. They also serve the transgender population. Each practice includes doctors, mid-level providers (physician’s assistants [PA’s], advanced

nurse practitioners), medical assistants (MA's), ultrasound technicians (sonotechs), and front desk workers. At each location, a PA serves as a site leader. The overall practice also includes a management company with a human resources manager, a phone operator team, and a surgical coordinator. The key stakeholders for this project directly include the chief executive officer (CEO)/founder of the practice, the doctors, PA's, MA's, and front desk workers at each site. These people will be involved in a presentation of the project, findings, and recommendations to learn from this study. The entire organization's actors, including the management company, also serve as stakeholders as these findings are likely to influence other areas of the practice, such as the scheduling operators, depending on the ultimate recommendations. The decisions from this project may inform the way that the patient journey is delivered by providers in the practice, the protocols and procedures that are followed by each actor in the practice, the way that Dr. Chip designs the stimuli (atmospherics, service delivery, physical design, wayfinding) within each practice that has an influence on the patient's experience and satisfaction, and the onboarding, training, and education that staff members receive within the practice.

Problem of Practice

As a medical organization scales business from an original, standard care practice to a new model of practice with multiple sites, how do they ascertain whether the level of service in the new model sites is comparable to the level of service in the original, standard care practice, with the service desire level being that of stellar service? The CEO desires a 10 of 10 for service levels. This 10/10 is her judgement call from a service standpoint and it is unclear whether she has defined the 10/10 service for all of her staff members beyond explaining her philosophy and the components that go into serving patients around clinical and patient care. She notes that she believes the original, standard practice level is an 8 out of 10 while the new model sites are at about a 5 out of 10. She also believes that her presence on-site is one of the reasons why the service at the original practice, where she works, is better than at the new sites as she believes that during the weeks that she is on-site at the new model sites that the service levels improve, but then that they drop again upon her departure. She says that she is able to address problems right away at the practice that she works at, but at other practices, she may not find out about those problems until they are much further along, and so it takes time to resolve the problems. Some of the challenges that she references in the organization have to do with the level of commitment from staff members. Specifically of note, the MA's positions are repetitive with a lack of upward mobility. In turn, the CEO does not

always see the accountability she would like to see from them to reach stellar service levels.

There are several strategies that have been put in place to try to understand this problem although no real measurement has been done to date to understand if there are differences in service levels between these practices from a patient experience perspective as it relates to the CEO's definition of these service levels via stellar service. In September of 2020, a management company was created to manage non-clinical tasks such as phone calls and emails with the goal of creating clear rules and metrics for overall performance. An end-of-day reporting data report was created in June 2020 to track visits, no-shows, walk-ins, walk-outs, new versus established patients, and services such as sonograms and procedures. This report tracks this data for new sites against established quarterly goals. In September, this tracking document was edited to include data about the new phone operating team to understand how many of their messages were distributed to each location and the number of messages that are action-oriented. A root cause analysis system was also put in place to help identify the cause of problems that do arise within the service to patients. Standardized protocols, policies, and procedures have been implemented and continue to be refined at all practices to help keep service quality levels consistent.

This issue is important to the organization if they are going to deliver patient care that is consistent with the values of the organization for comprehensive, holistic care with compassion. It is also important as the CEO plans to continue to scale the organization and wants to understand how to grow larger with consistency in the delivery of care. As the organization grows, the CEO will have less time to check into each site. Therefore, it will be more difficult to manage consistency in service delivery if the problem has not been addressed and there has not been identification and understanding of the processes and practices that need to be followed to deliver that consistency of stellar service. As a result, new practices may have lower service levels and the organization will start to move further away from meeting its values.

Additionally, patient satisfaction could decrease, and patients may not return to the practice or recommend that others come to the practice. The drops in these service levels may also contribute to less success with the business model since it is an innovative model that is focused on changing the existing paradigm of women's health care. Ultimately, this new model practice, which is meeting an important need within the women's healthcare field, could fail. If it fails, women will continue to have difficulty getting their healthcare needs to be met in a timely manner which contributes to diseases and unhealthy lifestyles/practices, and from a business standpoint, it can impact the business' bottom line and ability to successfully scale further. Given the goals of this practice to meet the gap in the need for this

population and its current success in doing so, this failure could impact an important market in our healthcare system.

Literature Review

Overview

A review of literature on patient experience (PX), customer experience (CX), and luxury service was foundational to the understanding of this problem of practice. This review provided a deeper understanding of the concept of the PX and how PX can influence perceptions of service in a healthcare practice. Since stellar service is the desired model for Artemis, an understanding of how to create the best possible PX should give insight into the important components involved in delivering on a stellar service PX. The review also helps with the development of an understanding of the CX as it is designed and experienced through service and retail organizations which focus on producing the highest level of experience for customers in order to influence their purchasing behaviors. Since patients are the customers of healthcare organizations, an understanding of the CX can help shape ways to design a PX that influences patient satisfaction and loyalty. As stellar service is the highest level of service desired within Artemis and it is being compared to a resort-style experience, a look at the luxury experience in the service industry focuses on how to deliver the highest quality of service available.

Patient Experience (PX) as a Customer Experience (CX)

In recent years, PX has been highlighted as critical to the success of healthcare providers (Suess & Mody, 2017). Healthcare has learned from years of research from the hospitality industry that both design and service are critical to the customer experience (Suess & Mody, 2017). Even with that knowledge, hospitals and healthcare provider sites have continued to lag behind the hospitality industry in terms of design and feel, even though these factors could offer the comfort that enhances the patient experience as patients are the customers of healthcare. Additionally, consumerism has increased amongst patients with changes in healthcare coverage, additional competition for doctors, and access to information via technology (Suess & Mody, 2017). Requirements now exist for mandated reporting of patient experiences and medical reimbursements and funding are tied to this reporting, further increasing the focus on the patient as a customer and his/her satisfaction (Suess & Mody, 2017).

As the competitive landscape in healthcare increases, the relationships between care providers and patients are important and can influence the industry's views of that provider which ultimately increases the patient's overall satisfaction (Ibis world, n.d.). Since service has become increasingly important to influence a patient's behavior, it has also influenced their decision to utilize and stay loyal to a healthcare provider (Suess & Mody, 2017). In turn, the healthcare industry has started looking at

ways in which they can provide service that includes learning and modeling from the hospitality industry and a take on healthcare PX through a CX lens as is viewed in hospitality industries that focus on delivering great service (Klaus, 2017). Still, within this service industry, there are different levels of service with luxury service being the highest level and demanding a focus on the highest quality of interactions and touchpoints throughout the customer's journey (Gurruraj & Pascal, 2020). Hence, a combined look at the luxury service industry, patient experience, and customer experience provides a comprehensive view on how to look at stellar service for a satisfying patient experience that is enhanced beyond the norm in the healthcare industry.

The PX is an important place to start when gaining knowledge of how to provide great healthcare service. Each patient is unique with specific needs. Therefore, there is value in understanding these unique needs and experiences throughout the patient journey to design ways to enhance experiences that include direct touchpoints and interactions (Lee, 2019). A co-creation between the patient's experience and the provider's design of those experiences can enhance the perception of value for both patients and the organization as designed practices meet the stated needs coming directly from the patient's feedback (Lee, 2019).

The CX is important to success in the hospitality and service industries. Organizations who understand the details and complexities of the CX and how to tap

into creating the best of that experience can lead the service industry as innovators (Gurruraj & Pascal, 2020). At the same time, in today's society, customers have easy access to information through technology and can more easily personalize their experiences as a result of that access (Piccoli & Grün, 2017). This access creates a greater need for organizations to hone in on the personalization of these experiences as competition is great. The entirety of this customer experience has evolved over time and is complex, including aspects such as buying behavior, satisfaction and loyalty, service quality, relationship management, customer centricity and focus, and customer engagement (Gurruraj & Pascal, 2020). To fully understand and realize an excellent customer experience, Gurruraj and Pascal (2020) propose an integrated conceptual CX Model to help organizations with the design, delivery, and management of CX. They also recommend the use of a customer journey map to understand important touchpoints and interactions and pose a mind-map model to help with the identification of factors and barriers along the CX journey (Gurruraj & Pascal, 2020).

Patient Experience (PX) through a Luxury Service Lens

The luxury service experience is a uniquely personalized one that meets the physical and emotional needs of customers along a journey that includes the pre-service, service, and post-service components of that journey (Gurruraj & Pascal, 2020). Actors along the journey work as a team to create value for consumers based

on the specific needs expressed and learned from those consumers throughout the process of engaging them in the luxury experience (Gurruraj & Pascal, 2020). The actors and organizations work to design and deliver an experience that ultimately creates the highest level of service, catering to the unique needs of their customers, and developing an emotional and memorable experience for them (Gurruraj & Pascal, 2020). This design can include everything from the inclusion of the use of technology, to the way that actors on the journey greet customers in a customized way that shows that they know the customers' interests upon their arrival on-site, to the personalized follow-up notes that they send to thank customers for choosing the organization for their travel or hospitality needs (Gurruraj & Pascal, 2020). These luxury experiences provide an emotional gratification that leaves customers satisfied due to the individualized experience that they received and in turn, this satisfaction builds their loyalty to the brand so that they return to it and tell others stories about it (Gurruraj & Pascal, 2020).

People are willing to pay for a luxury brand based on what that brand means to them (Gurruraj & Pascal, 2020, as cited in EHL, 2020). In turn, a luxury service model should be designed to serve people in a way that delivers on the highest quality of value of the brand the service represents on every kind of level possible (Gurruraj & Pascal, 2020, as cited in EHL, 2020). Given that the service of the healthcare industry is an emotional one where emotions arise from the variety of situations the patient

faces, a focus on the details of service like those provided by luxury experiences can help refine that service in a way that caters to those emotions, creating an enhanced experience that ultimately can lead to patient satisfaction and loyalty to healthcare providers (Klaus, 2017; Suess & Mody, 2017). Further, in the healthcare industry, in particular, the luxury experience that goes beyond the material definition of luxury and delivers on heartfelt moments and connections between patients and providers during such an experience where emotions are high is the one that can deliver true luxury to its patients (Kreuzer & Raïes, 2020).

By looking at PX through a CX lens, one sees that the journey of the patient, similar to that of a customer, is inclusive of pre-service, actual service, and post-service (Klaus, 2017). Critical touchpoints, interfaces, and behaviors along this journey influence the view of a positive service experience. Klaus (2017) brings the two concepts together and defines a PX through an integrated view, noting the complexity of these experiences, the importance of designing them in a way that meets the needs of that complexity and ultimately impacts the overall well-being and lifestyle of that patient. With this integrated model of looking at the PX through a CX lens, one can use customer journey mapping models, like those outlined by Gurruraj and Pascal (2020), to better understand the patient experience and identify factors that impact and detract from that experience. Trebble et al. (2010) provide a process for how to map the PX in a healthcare practice through a patient journey exploration.

Further integration includes bringing these two models together by looking at the PX with a luxury hospitality lens to create the best in-service experience for all patients (Klaus, 2017). The luxury patient experience (LPX) brings the PX, CX, and luxury service into one view that centers the patient as a consumer, follows the patient along a continuum of interactions designed with the LPX definition of the organization in mind, meets the emotional needs of the patient through these interactions, and leaves the patient with a feeling of enhanced well-being and standing in society because of the quality of this experience (Klaus, 2017).

Summary

This literature review shows the importance of incorporating the components of the PX, CX, and luxury service research into the design of this study as each of these concepts address components that Dr. Chip notes are important for the delivery of stellar service at Artemis. The LPX model is a model that addresses how organizations deliver, evaluate, and adjust a strategy that centers the patient through a carefully designed experience intended to meet their needs for the highest level of service and care. A deeper dive into how the patient journey can be mapped in the data collection process provides an even greater understanding of how to measure the LPX across the Artemis practice locations and compare the journeys between the original, standard care practice, and the new practices.

Conceptual Framework

Luxury Patient Experience

The important factor of this integrated model for the greatest patient experience is that it meets the needs of the customer as a patient while creating positive emotions which leads to a healthier and better life. This concept leads to the first conceptual framework on which this study is based, listed in Figure 1 as the LPX continuum (Klaus, 2017). The PX exists on a continuum because of the importance of the customer journey through all phases including pre-service, service, and post-service, the interactions along that journey, and the impact that each step of that journey has on the customer's satisfaction and behavior (Klaus, 2017).

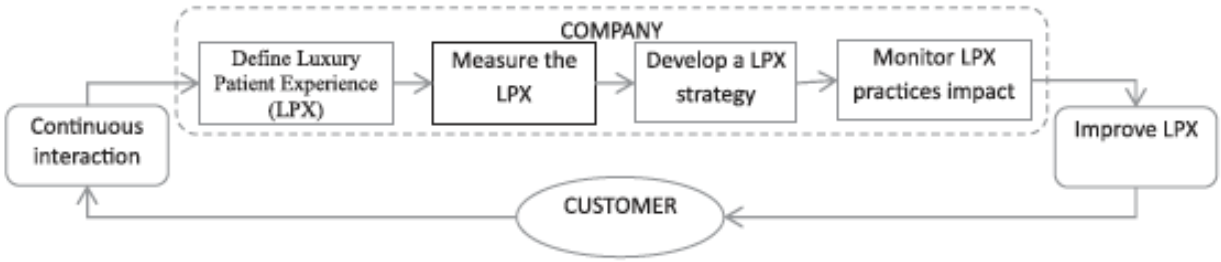

Figure 1: Conceptual framework: luxury patient experience LPX continuum (Klaus, 2017, p. 91)

Servicescape for hospital healthcare

Along with understanding the patient experience, it is important to understand how that experience ultimately impacts the customer's behavior. This understanding helps the organization know how the factors that influence the patient's experience contribute to the successes and challenges of the organization. The customer's

behavior can be reviewed through the second conceptual framework, the servicescape framework for hospitable healthcare, outlined in Figure 2 (Suess & Mody, 2017). This framework identifies how the elements of atmospherics, service delivery, physical design, and wayfinding within a healthcare environment impact the patient's overall satisfaction and in turn, their behavior towards the healthcare provider (Suess & Mody, 2017).

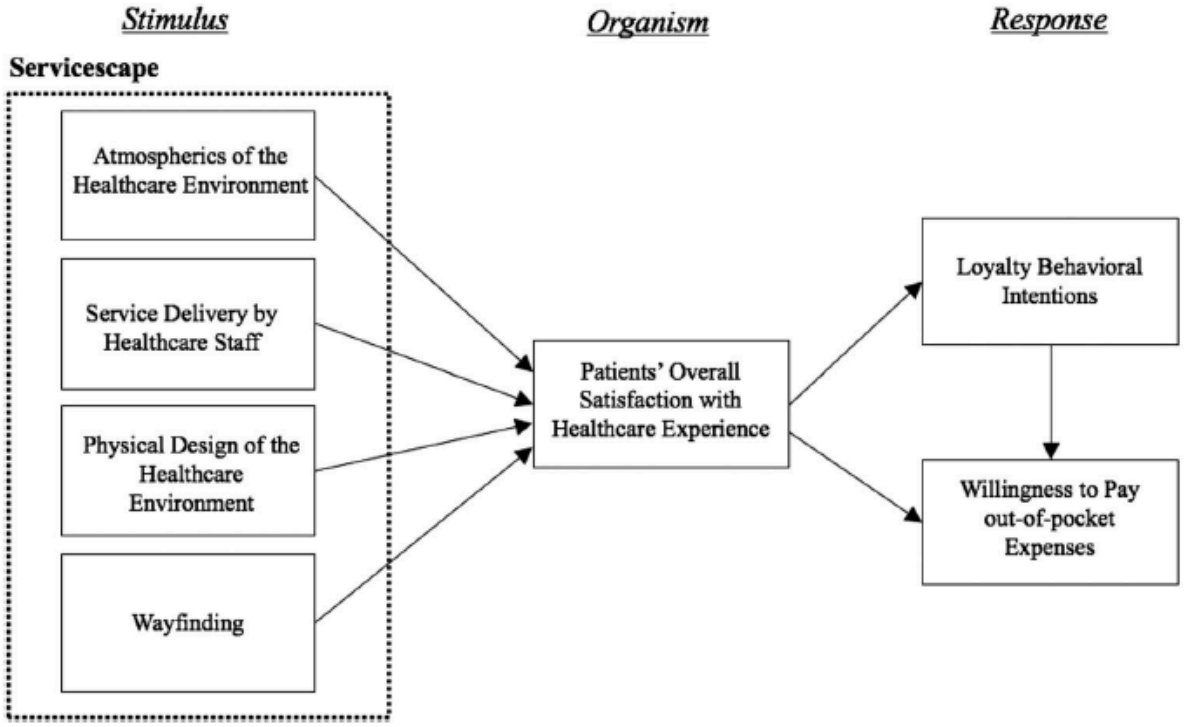

Figure 2: Servicescape framework for hospitable healthcare
(Suess & Mody, 2017, p. 133)

Patient Journey

While not a conceptual framework, the patient journey is key to both of these frameworks. Trebble et al. (2010) provide the process for mapping this journey and the ability to do so from different and/or multiple perspectives including the

staff/provider and patient perspectives. This patient journey serves as an important bridge between these two conceptual frameworks and is pertinent to the understanding of the LPX and the designated problem of practice.

Research Questions

To assist Artemis in understanding the identified problem of practice, the following research questions guided this work:

1. To what extent do client experiences, as perceived by staff members, differ between the original, standard care of practices and the expanded, new model sites?
2. To what extent do client experiences differ between the original, standard care of practices and the expanded, new model sites?
3. What factors may be contributing to those differences?
4. How do the client experiences impact the client behaviors?

Project Design

Data Collection

The capstone project used a qualitative comparative analysis case study approach, including a survey, for data gathering and analysis. Since case studies are helpful exploratory methods, specifically when asking how questions and employing various or a mix of data collection methods such as interviews, direct observations,

and review of materials and documents to understand the dynamics of a single case experience, this method was chosen as the most applicable for this study (Yin, 2018). The design was conducted to assess the complexity of the LPX by looking at the patient journey within the healthcare organization sites and understanding the factors and barriers that impact the LPX. The purpose of this capstone project is to understand the LPX in a women's healthcare practice. Given that the stated problem of practice asks for a comparison between the care experiences at the original, standard practice versus the new model practices, a multi-case study approach was decided upon to conduct this research, with the two practice models each serving as "units of analysis" or a "case" within this study. To summarize this case study model, the original practice site serves as one case, while the new practice model serves as another. In addition, since this study compares the differences between two cases, the original and new model practice sites, a qualitative comparative analysis was done as a part of this multi-case study approach (Goodrick, 2014). Comparative analysis case studies, in particular, are good at examining the causality of an intervention, which for Artemis includes a comparison of one type of practice versus a changed practice, often include both qualitative and quantitative data, similar to the data analysis necessary in this study, and take into account how the context of an environment influences the success of the intervention that has taken place within that environment, which for this study allows one to see the comparison of two

different environments between the original and new model of practice (Goodrick, 2014).

The data collection took on an integrated perspective including information at the organization, patient, and co-creation (patient input plus staff member/provider input) levels with the following methods for data gathering and analysis:

1. Interviews with key persons within the organization. Interviews were the primary way to gather data and they explore research questions one, three, and four. These interviews took place in a semi-structured format with key persons within the organization who are decision-makers. These people included the owner, a PA/site leader for each site, and several MA's. Interview questions and the semi-structured approach to interviews were adapted from Gurruraj and Pascal (2020) and are featured in Appendix A. Gurruraj and Pascal (2020) used these interviews to understand the experiences of customers in luxury service organizations from multiple organizational decision-makers' perspectives. Interviews at Artemis were held across four different practices. At the original, standard care practice, a PA/Site Leader and a MA were interviewed, with the PA/Site Leader being interviewed and video recorded via zoom and the MA being interviewed in person. At new model practice 1, a PA/Site Leader and Head MA were both interviewed and video recorded via zoom. At both the new model practice 2 and the new

model practice 3, a PA/Site Leader was interviewed, and video recorded via zoom. The CEO was interviewed via telephone on speakerphone and recorded via zoom. All video recordings were transcribed via Otter.

a. Recruitment and Sampling Methods:

All participants were recruited via an email from the CEO inviting them to take part in the interview process. Three staff members from the original practice and six staff members from the new model sites were included in this recruitment. Six total staff members and the CEO ultimately took part in the interviews, with two from the original practice and four from the new model practices. Each participant was provided a letter explaining the study, the confidentiality of the interviews, and the voluntary nature of the interviews.

2. Patient Journey Mapping. Patient Journey mapping was conducted at each site to help gather information about pre-service, service, and post-service experiences for patients. This journey mapping exercise helps answer research questions one to four. Appendix B explains different methods for mapping the patient journey that were considered to take on this process, such as a multi-disciplinary meeting, walking the journey, direct observation of the patient journey, and the patient's self-reported experience. Based upon consultation with Dr. Chip, I walked the patient journey at each of the four practices and additionally, held multidisciplinary meetings with the front-line

team including MA's, PA's, and site leaders. I also gathered field notes and took pictures at each site to round out the patient journey mapping exercise. Appendix C is the patient journey map ontology that was used to understand the elements of the patient journey. This understanding included patient persona, medical timeline, and medical pathway. Appendix D includes the Base Patient Journey Map Template that was integrated to specifically understand ways to map the journey. I also utilized Appendix E from the Patient Journey Mapping Process to document the patient journey touchpoints at each location. Table 1 details the patient journey mapping plan that I followed to collect this data.

a. Recruitment and Sampling Methods:

Patients were randomly selected to take part in the journey mapping exercise from the waiting room while waiting to be seen by providers. The patient was alerted either by the front desk worker, a MA, or a provider about the option of having me accompany them along all or some part of the patient journey when I was on-site at each practice in November. Patients were given a letter explaining the study, the confidentiality of the visit, and the voluntary nature of the journey mapping exercise.

Table 1: Patient Journey Mapping Plan

Multidisciplinary Meetings with Front Line Team (i.e., MA, PA, Site Leaders, Dr.'s).	Walk the Journey. Observe from staff and patient's perspectives.	Enter details into a table
Draft Map to understand current patient journey at each site. Identifying each step: •See Appendix E: Patient Journey Map Data of Steps, Written	Interview staff	Refined with Follow-up from Multidisciplinary Meeting Group as Applicable: •See Appendix E: Patient Journey Map Data of Written Steps
	Allow for direct patient observation: •Observe process. Sit in on booking process. Sit in on procedure. •Identify sequence of steps. Assess for duration (Min and Max times) and factors that influence duration. (digital watch/notepad to check and record times). Identify time for total patient journey. •Note staff-patient, staff-staff, interactions and functions •Recording and movement of relevant information	Draw Journey with Input from Multidisciplinary Meeting Group: •See Appendix F: Patient Journey Map Visual (*Note: may use the one from luxury service industry)

	Identify: •Start (admission to unit). •Completion (discharge) points •Locations throughout to be involved in patient journey	Add relevant feedback to coding map

3. Patient survey to understand factors that influence patient behaviors. The survey (see Appendix G) looks at the way that stimuli in the healthcare environment, including atmospherics, service delivery, physical design, and wayfinding, influence the patient satisfaction and experience and ultimately, the ensuing response that they have to the healthcare practice as a result of their interaction with those stimuli. The survey addresses questions two through four. This survey was given to patients at all four practices and adapted from Suess and Mody's (2017) servicescape for hospital healthcare survey, with only changes to the demographics component of the survey around gender, to include non-binary options under gender, and the deletion of healthcare practice type given all organizations are similarly women's healthcare organizations.

    a. Recruitment and Sampling Methods:

Patients were randomly selected to take the survey from the waiting room while waiting to be seen by providers. The survey was given at several

different time points. Once, when I was on-site at each practice in November. The second time, at site 2 within a few days of the initial survey date to gather additional survey numbers. The second time at sites 1 and 3, at a later date in March to gather additional surveys, as the initial survey numbers were low. All surveys were accompanied by a letter explaining the study, the confidentiality of the survey, and the voluntary nature of the survey.

Table 2 shows how these data collection methods align with each research question.

Table 2: Data Collection Methods by Research Question

Research Question	Interviews	Patient Journey Mapping	Survey
RQ1	X	X	
RQ2		X	X
RQ3	X	X	X
RQ4	X	X	X

The majority of data was collected simultaneously due to travel restrictions and quarantine rules with COVID-19, I was limited to the time frame that I could come on-site at each practice. I selected a time frame during a late November 2020 weekend. During that time frame, I conducted patient journey mapping at each site, interviewed staff members about the journey on-site, distributed surveys to patients,

and took field notes. I also held zoom meetings with site leaders either during that time frame or shortly after since I interacted with most of them while at the practice and was able to build a relationship and then schedule an interview with everyone other than one of the original practice site leaders, which made it easier for scheduling purposes. I conducted an interview with Dr. Chip about a month after my visits so I was able to update her on the interview efforts and then interview her as well that day, limiting the number of meetings we would need to schedule as a result of this method.

Dr. Chip requested that surveys be distributed via paper while patients were waiting in the waiting room as to not give them an additional item to have to do after their visit. I took advantage of my time on-site and presence to administer surveys. Since we ultimately needed additional surveys as our initial sample size was low at each site, I asked one of the site leaders to distribute more surveys and then scan and send them back to me after my visit. Dr. Chip also asked the other site leaders to redistribute additional surveys and she returned them at a later date.

Conceptual Framework & Data Collection

Figure 3 shows the data collection process, with the primary source for data collection coming from interviews with key site leaders and the secondary sources coming from patient journey mapping and the servicescape survey.

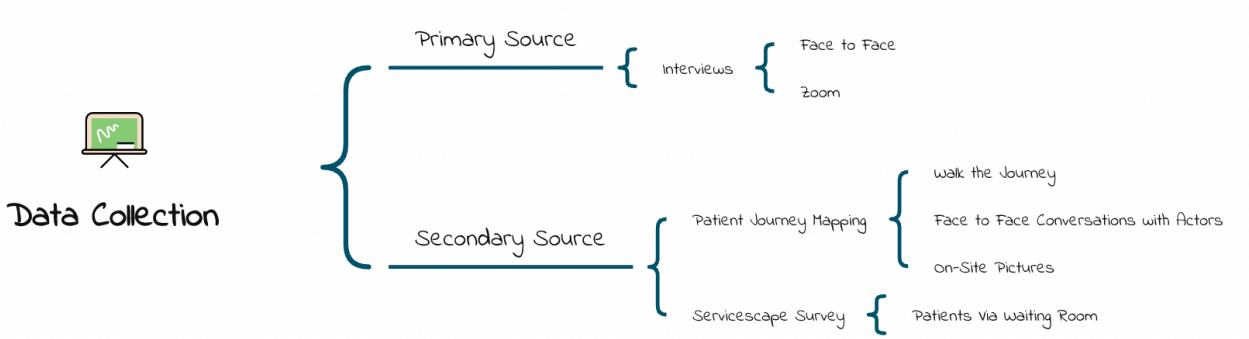

Figure 3: Data Collection Process

The conceptual frameworks of luxury patient experience and servicescape directly inform the chosen data collection tools. As seen in Figure 1, the LPX exists along a continuum that the customer, who in the LPX model is the patient, moves through each step of the way. The customer starts with continuous interactions which include every person and part of the patient journey. The interviews with key persons, patient journey mapping exercises, and patient surveys help one understand more about the details of those interactions and the intended and actual experiences through those interactions. The LPX continuum then shows that the company, in this case, Artemis, defines the LPX. The interview with the CEO gives insight into how the LPX is defined at Artemis as she sets this standard and the interviews with key persons in the organization illustrate their understanding of that definition as providers and staff members. The measurement of the LPX then comes next on the continuum. In this study, the LPX is measured through interviews, patient journey mapping, and the servicescape survey.

The servicescape model, which is the second conceptual framework and outlined in Figure 2, is one that shows how factors in service impact patient (customer) satisfaction which ultimately influences a response that shows their level of loyalty and willingness to pay out of pocket expenses. This survey was chosen as another way to measure the LPX at Artemis since it directly asks for the patient's experience, giving Artemis important information regarding how stimuli and interactions within the environment influence the patient's experience and behavior. These are important items along the LPX continuum, and the survey is a validated measure of how healthcare stimuli influence patient experience and behavior. The rest of the LPX continuum shows how the understanding of these interactions, the defined LPX by Artemis, and the data collected for measurement becomes useful to inform a LPX strategy that can be monitored and improved. The findings and recommendations from this study, data collection, and data analysis will inform recommendations that can be utilized to help Artemis move through this continuum with this improved strategy.

Figure 4 provides a visual of how these data collection tools are informed by the two conceptual frameworks. The different colored stars (blue and purple) in the conceptual frameworks and data collection tools map show the direct connection points between those data collection tools and the frameworks. The blue stars show that the data collection methods of interviews with key site leaders, patient journey mapping, and the servicescape survey are all ways to measure the company's LPX, as noted in the LPX framework and continuum. While the survey instrument study from the servicescape framework is a way to measure all components within that framework, the blue stars show that when triangulating

data, the interviews with key site leaders and patient journey mapping exercises also give insight into the patient's overall satisfaction with the healthcare practice. The patient's response to those stimuli, which is also denoted by blue stars for similar reasons, is demonstrated by loyalty intentions and/or willingness to pay out-of-pocket expenses, even though this source of data analysis is from the staff perspective versus the patient perspective. The purple stars show that there is a direct connection between the data collection methods of walking the patient journey, face to face conversations, on-site pictures, and patient surveys via the waiting room to the customer's continuous interaction points along the LPX continuum and that these specific methods also measure the stimuli in the servicescape framework of atmospherics, service delivery, physical design, and wayfinding.

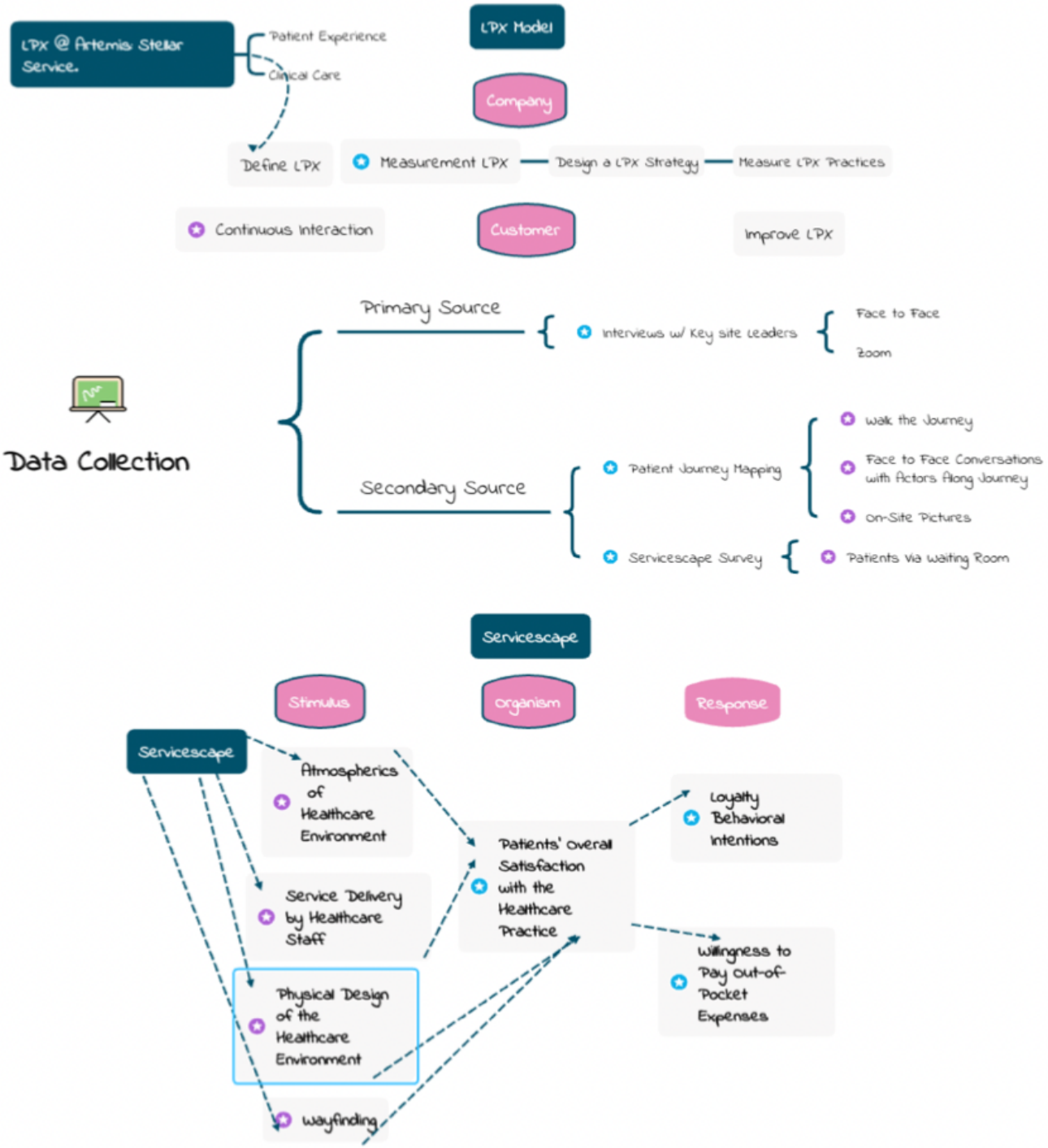

Figure 4: Data Collection Tools and Conceptual Framework

Data Analysis

Qualitative Data: Interviews with Key Site Leaders

To analyze the interviews with key site leaders, I went through an inductive coding process that was guided mainly by the primary conceptual framework of the LPX and secondarily by the servicescape framework. Figure 5 shows how research questions 1, 3, and 4 tie to the qualitative interview questions and how these questions are connected to both conceptual frameworks.

Figure 5: Qualitative Survey Questions Tie to Research Questions and Conceptual Frameworks

The present study is grounded in the LPX and servicescape frameworks, providing the theoretical foundation for study research questions and subsequently for site leader interview data codes. Coding included the following steps:

1. Interviews recorded on zoom were transcribed through Otter.

2. Each transcribed interview was entered into a Word Doc.

3. One interview was captured via hand-written notes and subsequently typed into a Word Doc.

4. All Word transcriptions were exported into Dedoose.

5. The open coding process was initiated using Dedoose to highlight original quotes, words, and phrases from each of the seven individual interviews.

6. Topics were created to categorize quotes, words, and phrases into themes. These core themes united the topics into axial codes.

7. These axial codes were then added to a mind map through XMind. Quotes and phrases that best illustrated the axial codes were added to the mind map and separated by original and new practice to organize and compare both cases by axial code.

8. The axial codes were then reviewed, and further categorization was created to build aggregate themes, combining axial codes into three overarching themes.

This coding process was modeled after Carton's (2018) illustration of coding. The process to determine these axial codes and aggregate themes included a review of interview transcripts, the research literature on patient experience, customer experience, and luxury service, and the details of the LPX and servicescape conceptual frameworks. Table 3 details the axial codes and aggregate themes that emerged from this coding process. See Appendix H for the code mind map.

Table 3: Key Site Leaders Coding Schemes

Axial Code	Aggregate Construct
The practice	Patient Journey: Designing delivery on the promise of the brand
Design	
Stellar Care	
Touchpoints	
Personalization of an emotional journey	
Axial Code	Aggregate Construct
Team approach	Patient Experience: Factors of influence on the patient experience
Provider/employee characteristics	
Solving problems	
Co-creation	
Axial Code	Aggregate Construct
Competition	Patient Response: Understanding the patient response
Loyalty/satisfaction	
Barriers	

Through the coding process, three aggregate themes emerged: (1) patient journey: designing delivery on the promise of the brand; (2) patient experience: factors of influence on the patient experience, and (3) patient response: understanding the patient response. The first theme on designing delivery on the promise of the brand derives from both literature on a luxury experience that details the importance of delivering on the brand (Gurruraj & Pascal, 2020, as cited in EHL, 2020) and research on the management aim of the LPX, the main conceptual framework of this study, which is stated as design, execution, and evaluation (Klaus, 2017). As explained in the literature review on the patient experience as a luxury experience, for the patient experience to be one that reflects a luxury one, the design of that experience at every point along the patient journey should be one that meets the unique, emotional needs of that patient (Gurruraj & Pascal, 2020). That experience should reflect the luxury brand that the patient expects that he or she is paying for and so the organization, in this case, Artemis, must design that experience in such a way that this reflection is possible (Gurruraj & Pascal, 2020, as cited in EHL, 2020; Klaus, 2017). A comparison between the delivery on the promise of the brand in the original practice versus the new practices, the two cases being reviewed in this study, will give important insight into research question 1, which asks about the client experience through the lens of the staff at each site. This insight will further illustrate

the influence of the design of the continuous interactions during the LPX journey in each case and will create an understanding of if the LPX matches Dr. Chip's definition of a stellar service experience. The second theme of factors that influence the patient experience also ties to the research around the management aim of the LPX and starts to answer research questions around the client experiences and factors of influence on that experience. Klaus (2017) names execution as the second management aim of the LPX for an organization. He says that how the actors on the patient journey execute the design of that LPX influences the lived experiences of the patient throughout their time interacting with the practice and those lived experiences influence their perception of the practice (Klaus, 2017). The statements and phrases from the interviews help to provide a comparison of actions that may or may not be taken in the original versus new practice that become factors that create a positive or negative experience. The third theme of understanding the patient response addresses the LPX management aim of evaluation. It also addresses the servicescape conceptual framework's trajectory of how patient responses ultimately influence their behaviors to remain loyal to a practice and/or pay out-of-pocket expenses (Suess & Mody, 2017) and starts to answer research question 4 regarding how client experiences influence their behaviors. Klaus (2017) says that the third management aim of the LPX is evaluation and that the patient's response of both if and why they recommend or do not recommend a practice to someone gives insight

into if the practice is meeting their LPX strategy through design and execution since the evaluation of the response tells the true story of the patient experience. The understanding of these responses at the different Artemis practices is important to influence an LPX strategy that works for both practices.

Qualitative Data: Patient Journey Mapping

Patient journey mapping took place at three new practices and the original practice between November 27th and December 2, 2020. Table 4 illustrates the details of walking the patient journey, including the number of patients seen per site and patient journey touchpoints observed for each patient. Overall, I observed at least some part of 16 patient journeys with 11 observations at the new, model sites and five observations at the original site. In addition to patient journey mapping, I was able to talk to front desk workers, MA's, PA's, and ultrasound technicians at every location and the surgical coordinator and a phone operator from the management company to learn more about the patient journey. I also took pictures at each practice to add context to my understanding of the patient journey.

Table 4: Walking the Patient Journey Overview

Location	Patient #	Patient Journey Touchpoint	Date

New Practice, #1	1	Triage Patient Room Triage Check Out *Post Interview	11.27.20
	2	Triage Patient room Check out	11.27.20
	3	Exam Room *Post Interview	11.27.20
New Practice, #2	1	Patient Room	12.1.20
	2	Waiting Room Patient Room. *Vitals & Provider Visit.	
	3	Patient Room Sono/Ultrasound	
	4	Patient Room	

New Practice, #3	1	Waiting Room Triage Waiting Patient Room Sono Waiting Room Blood Work Triage Checkout	12.1.20
	2	Final Triage	
	3	Check-in Waiting Triage	
	4	Check-in Wait Triage Waiting Patient Room Waiting Room Ultra/Sono	
Original Practice	1	Triage Patient Room Check-out	12.2.20

	2	Triage Check-out	
	3	Triage Patient Room Waiting Sonotech (provider in with) Checkout Wait Lab/triage	
	4	Triage	
	5	Triage Patient Room	

To analyze the data from patient journey mapping, I created a number of documents: (1) written patient journey maps for each location, and (2) a composite map of patient visit stages, patient activities, channels, and touchpoints. I added relevant feedback from interviews to the coding map from the key site leaders to provide more context to the understanding of the PX. I then examined important aspects of the process maps and information gathered by utilizing the guide on how to analyze a patient journey process map from Trebble et al. (2010) which can be found in Appendix I and includes important questions to analyze this data.

Quantitative Data: Servicescape Survey

To analyze the servicescape survey, as some surveys were individually handwritten and others were emailed to me post-visit and sent as PDF files, all individually handwritten surveys were scanned as PDF files so that a database of all surveys was electronically created. The results of each individual survey were manually inputted into an Excel spreadsheet by the individual survey. All data were inputted into R.

Demographic survey responses were inputted as factors in R, with 0 denoting no answer to the question, the level of each response beyond 0 starting at 1 and going up to the number of possible responses for that particular question. Since demographic data was not used in the statistical analysis itself, no observations were removed from the analysis where there was missing demographic data.

For the survey question responses, questions were divided into groups by section (one for each of the four client experience sections, one for the overall satisfaction, one for loyalty, and one for willingness to pay out-of-pocket expenses). The questions in each section were marked with a letter indicating the group they were in followed by a number. This number indicated the position where the questions appeared on the survey within the letter group. For example, A represented a new model practice site so, A13 represented the 13th question in this first group. The responses were entered numerically from 1 to 5, with N/A marks denoting questions that were skipped. For the analysis itself, any survey question

rows with N/A values were removed as aggregates from each category were taken for the analysis and it was necessary for these aggregates to be unaffected by the zeroes in those N/A responses. R was utilized in the following way to analyze the data and answer research questions 2, 3, and 4:

1. Research Question 2: To analyze the surveys to understand research question 2, to what extent do the client experiences differ between the original, standard care of practices and the expanded, new model sites, t-tests were used to compare the groups. A t-test was run to analyze the survey data from the original, standard care of practice (n=18). A t-test was also run to analyze the expanded, new model site practices all as one data set (n=49). To correct for the multiple comparisons, a Bonferroni test was completed. This test is the most typical one to run, but also the most conservative.
2. Research Question 3: To analyze the surveys to understand research question 3, what factors may be contributing to those differences, multiple linear regression was used to determine which factors detailed within the survey, atmospherics, service delivery, physical design, and wayfinding contributed to differences between the patient experiences at the original site versus at the new sites.

3. Research Question 4: To analyze the surveys to understand research question 4, how do the client experiences impact the client behaviors, linear regression was completed.

Servicescape Results: Profile of Respondents

The demographic characteristics of respondents can be found in Appendix J and are listed by total respondents and by original and new sites.

For both site formats, the majority of respondents were female (original, 94.7%; new, 100%). At the original site, 5.3% of the survey respondents identified as genderqueer. At both the original site, the majority of respondents were between ages 18-29 (original, 47.4%; new, 65.3%), with patients between 30-44 being the next highest age group for respondents (original, 31.6%: new, 28.6%), and the third-highest age group at the original site being 45-59 (15.8%) and at the new site being 60-75 (4.1%). Most patients spent less than an hour waiting at Artemis in both the original and new sites (original, 63.2%; new, 55.1%) while some patients waited between 1-3 hours (original, 26.3%; new, 38.8%). For both types of practices, the vast majority of respondents visited them a few times a year (original, 78.9%; new, 73.5%) and some patients visited them only once a year (original, 21.2%; new, 12.2%).

At the original practice, the majority of patients were employed part-time (31.6%) while at the new practice, the majority of patients were employed full-time (49%). Income levels varied at each practice with original practice respondents

reporting 26.3% made $30,000-less than $45,000, 21.1% made $15,000-less than $30,000, and 15.8% making $45,000 to less than $60,000 and $90,000 or more. At the new practice, 22.4% of respondents reported income levels at $15,000-less than $30,000, 20.4% reported making less than $15,000 and 12.2% reported making $30,000-less than $45,000 and $45,000 to less than $60,000. The highest level of education at both practices was graduate school (original, 21.2%; new, 14.3%) with the majority of respondents having a college degree at both practices (original, 42.1%; new, 44.9%). White/Caucasian was the ethnicity reported from the majority of respondents at the original practice (47.4%) with none of these listed ethnic categories fitting patients' ethnic backgrounds reported as the next highest from the respondents (26.3%), and Asian/Pacific Islander reported as the third highest identified group. The majority of respondents at the new practice reported their ethnicity as Black/African-American (40.8%) with the next highest reported ethnicity as White/Caucasian (18.4%) and the third-highest reported ethnicity as none of these categories (14.3%).

A summary of the means has been reported in Table 5.

Table 5: Means and Standard Deviations for Survey Measures

Question		Mean	SD
Atmospherics of the healthcare environment			

	The ambient lighting creates a comfortable atmosphere	4.26	0.92
	The music is pleasing	4.31	0.82
	The ambient temperature is comfortable	4.46	0.66
	Walls, floors, and ceiling color schemes are nice	4.34	0.73
	The scents in the air are pleasant	4.34	0.7
	The overall decoration is attractive	4.22	0.79
	There are enough plants and flowers	3.91	1.03
	The paintings and pictures are appealing	4.19	0.82
	There is enough quietness	4.37	0.79
	Overall appearance of staff is nice	4.53	0.63
	There is enough artwork and decoration	4.28	0.77
	Furnishings are comfortable	4.34	0.7
	Equipment is visually appealing	4.34	0.68
Service delivery by healthcare staff			
	People receive a nice welcome from the staff	4.62	0.57

	There is a good cooperative atmosphere among staff	4.63	0.57
	It is easy for patients to identify the name, surname, and function of the staff	4.43	0.68
	Staff are informative	4.6	0.58
	Service from staff is prompt	4.6	0.58
	Staff are willing to help patient	4.62	0.55
	Staff are polite	4.62	0.57
	Staff are sympathetic and reassuring	4.6	0.58
	Staff are organized	4.63	0.54
Physical design of the healthcare environment			
	The furnishings are in good condition	4.47	0.61
	The quality of the furnishings is good	4.41	0.65
	The walls, floors, and ceilings are well kept	4.49	0.63
	The patient areas are kept clean	4.59	0.58
	The number of seats (chairs and sofas) is appropriate	4.44	0.74
	Patient waiting areas are well-equipped (chairs, sofas, tables, TVs, newspapers, magazines)	4.28	0.79

	The restrooms are well kept	4.49	0.59
	The equipment is in good condition	4.51	0.59
Wayfinding			
	It is easy to recognize the entrance of this healthcare unit	4.35	0.81
	In this healthcare unit, there are enough signposts to help you find your way around	4.37	0.73
	In this care unit it is easy to find your way around	4.44	0.66
	In this care unit, you can easily find information points	4.43	0.65
	Waiting areas are clearly defined	4.63	0.54
Overall satisfaction with healthcare experience			
	I am satisfied with the quality of services, in general	4.66	0.51
	I am satisfied with the logistics of service delivery	4.57	0.63
	I am satisfied with employees' attitudes	4.66	0.54
	I am satisfied with the general atmosphere of the facility	4.65	0.51
Loyalty intentions			
	I am willing to recommend healthcare unit to others (friends, colleagues, and family members), who seek my advice)	4.69	0.5

	If I need medical service in the future, I would consider this healthcare unit as my first choice	4.66	0.51
	I would visit other healthcare units run by the same parent group	4.53	0.59
Willingness to pay out-of-pocket expenses			
	If the healthcare unit raised out-of-pocket expenses relative to other hospitals, I would consider this healthcare unit as my first choice	4.06	0.88

Servicescape Results: Statistical Analysis by Research Question

The following information explains the results of the statistical analysis by the research question:

1. Research Question 1: T-tests were run for each of the five survey categories for the original and the new practice models. In all five of them, the p-value is not significant at any reasonable level of alpha (in this case, 0.01 was used as alpha for a Bonferroni correction of 1/5 for the 5 t-tests and an original alpha of 0.05). Therefore, there was no evidence of a statistically significant difference between the original and new practices for any categories of the patient experience ($p>.01$). Of note is that in none of these categories does the data really fit the normality assumption for a t-test. In part due to the numeric constraints of a 1-5 Likert scale survey like this and because the data for all five of these categories are heavily skewed left and does not fit a normal distribution.

2. Research Question 3: Multiple linear regression showed that service delivery and physical design are two factors that could be contributing to differences in the satisfaction of the patient experience at the original versus new sites as a linear relationship was seen between these two categories and overall satisfaction. This test resulted in a very small p-value (R shows this as 2.2E-16) and high R-squared of 0.69. The concern here is that due to the bounded Likert scale that is used, the residuals are not normally distributed. Additionally, the RVF plot looks a bit unconventional due to the discrete nature of the dependent variable. These concerns show the limitations of using multiple linear regression as the test for measuring these relationships and explains why the confirmatory factor analysis (CFA) and structural equation modeling (SEM) used in the original study serves as a model that better suits the measurement of this relationship.
3. Research Question 4: Linear regression was used to understand how client experience impacts client behavior. Since willingness to pay out-of-pocket expenses only had one subcategory of questions, the decision was made to combine these two variables together as an aggregate of patient behavior. Therefore, in this model, overall patient satisfaction served as the predictor or explanatory variable and an aggregate of the loyalty and willingness to pay out-of-pocket expenses served as the dependent variable. Statistically significant evidence of a linear relationship was seen between patient satisfaction and loyalty

behaviors and willingness to pay out-of-pocket expenses ($p < .05$). Concerns still exist here around the limitations of using linear regression as the test for measuring these relationships since there is a lack of normalcy among the residuals as can be seen by looking at a QQ plot which shows tails jutting off to both sides indicating very low kurtosis and an indication of skewness, which we were already aware of as noted above, due to the bounded Likert scale and the majority of 5's for answers.

Of important note for all of the statistical analysis is that there was one outlier in this data set that did impact this data analysis slightly although taking it out would not change the statistical significance for any of the tests.

Triangulation of Data

Yin (2018) shares that the triangulation of data from multiple data sources helps strengthen the construct validity of a case study. Modeled after Figure 4.2 in Yin's work (p. 191), Figure 6 shows the way that the data collection tools in this study come together as a convergence of evidence. An important note about this data is that this data exists for both the original site and the new model practices, so this triangulation was done for both case studies. With regard to the integration of patient journey mapping with qualitative interview coding, refer to Appendix H to see how this integration took place as "pjm" stands for any phrases or comments that came from the patient journey mapping exercises.

Figure 6: Triangulation of Data

Concerns About Analysis

1. Patient Journey Mapping

Concerns for the patient journey mapping exercise center around limitations as one person mapping the patient journey. Yin (2018) notes that direct observation without a team of people is a weakness as it limits the ability to gain broad knowledge about that which is being observed. In addition, Trebble et al. (2017) recommend a team of people to partake in the patient journey mapping exercise including an administrator who understands lean management principles and healthcare practitioners. While I fulfilled the administrator role, I did not have any additional members to map the journey with from the healthcare side which could have helped with observations, an understanding of how to navigate the mapping

exercise in terms of jumping into the queue with patients along the journey and undertaking additional tasks such as documenting time at each point of the patient journey. To account for this concern, I also had conversations with front line staff members to gain their perspective on the patient journey, utilized observational evidence found during my time there to inform notes, took breaks to document feedback and write out patient journey maps, created drawings of the patient journey while on-site and took pictures for further observational evidence to have visuals to reflect on after these visits (Yin, 2018). I also took notes immediately after each visit. These provisions helped me gather a greater depth of data to help give more information for the analysis. Even with these provisions, performing this exercise as one person limited the breadth of data that I could gather from these observations (i.e., I was not able to document time for each touchpoint along the patient journey). The triangulation of data from multiple data sources helps to address these concerns from a data analysis standpoint as I am able to look at multiple data points for a more in-depth analysis than I would have been able to have had I only relied on the patient journey mapping exercise as a single observer.

2. Servicescape Survey

Concerns about the analysis for the surveying of information from patients center around how and when the patients took these surveys. The surveys were distributed while the patients were sitting in the waiting room. There are some

patients who handed them in at the end of their visit, but many who filled them out while in the waiting room and handed them in before their visit started. If I was the person to hand the surveys to the patients, I encouraged newcomers to fill the survey out after the visit so that their survey would reflect their impressions throughout and immediately after the visit. At the same time, I did not have a way to control for if they followed this process. Therefore, it is possible a newcomer would be commenting on an experience that they had not fully engaged in yet at the time of the survey completion. For returning patients, if I was the person to hand them the survey, I told them that they could either hand the survey in at the end of the visit or if they preferred, fill it out while waiting and based on the past experience. There are still limits to survey responses from returners who handed the survey in at the beginning of the practice, as they would be speaking to their experience based on memory which could be inaccurate or depending on the time of their previous visit, may not reflect the current state of the patient experience at the practice.

Furthermore, there were times when I was not the person handing the survey to patients. Although I similarly directed the front desk workers about how patients could fill out the surveys as noted above, I could not control for their messaging to patients. An additional concern is that there were surveys that were given out after my visit to each practice. Given those situations, I similarly could not control the messaging to patients who filled out the surveys. These circumstances mean that the

data analysis around surveys may not accurately reflect the patient experience, making the interviews and patient journey mapping an even more important piece to the true context of the patient experience. Therefore, as I triangulated data, I took this information into account and put more weight on the analysis from interviews and the patient journey mapping exercise for findings and recommendations.

Findings

Research Question 1

The first research question asks how staff members describe the client experiences at each of the practices.

Conceptual Framework

The juggling act of working in a practice such as Artemis, whether at the original or new model site, is a great one. Providers and staff members have to balance between patient care, maintaining the flow of the practice, documenting their notes and patients' labs, and following up in a way that meets the needs of patients and solves their problems. A colleague at the new practice shared that providers and employees " need to be extremely organized, level-headed, warm and compassionate" in order to do their jobs well. Given all that is needed to find success as a provider and/or staff member at Artemis, the staff has great influence over the client experience as they are both touchpoints for patients along their journey and

the people who guide and impact that journey depending on how they manage that flow on a daily basis. The first part of the LPX continuum includes those touchpoints for the patients and the staff members are the people who deliver the LPX design which is defined by the CEO. Their insight into what the patient or client experience is like in the practice is important as their perception and understanding of this experience can guide how they continue or adjust their strategy for delivering on that experience.

Table 6 shows a comparison between the way that staff members, through both key site interviews and patient journey mapping conversations, describe the client experiences in the original versus the new sites. From the table, one can see that there are both similarities and some differences in the way that clients experience this journey, according to the perspectives of the staff members at each site.

Table 6: Comparison, Staff Descriptions of Client Experiences at Original Versus New Practice

Original Practice	New Practice
Cared For	Personalized
Comfortable	Accommodated
Responsive to Needs	Connected (as if close to them or family)
Informed or Educated	Upset if tell a story too many times
Feelings are validated	Varies by type of appointment (scheduled versus unscheduled)

Original Practice	New Practice
Safe	Impacted by the ability to use technology at check-in
Helped	Long waits

Finding 1

The years of experience working at an Artemis practice combined with some aspects of the format of the model of the practice (the model being original versus new) appears to impact client experience at the new practice in a way that can leave patients feeling frustrated, less accommodated for, and possibly less satisfied than in the original model.

Original Model Practice

There is clarity from staff members around the way to address the patient experience that exists at the original practice. The site leaders that I talked with in the practice had six-plus years of experience in the practice and were clear on the importance of the flow of the practice, ways to solve problems, and their roles on how to best educate and co-create on an experience that meets the patients' needs. One site leader shared the importance of patient education as a way to solve problems for patients even when the patient's requested need (i.e., a medication they think they need or a problem they think they have) is in conflict with what the provider knows is best for them or what is truly going on with the patient: "So then it becomes a patient

education of, why did you get it again? What can you do to not get it again? It's the patient education and just taking that extra two minutes to explain what's going on."

As patients often begin to tell their story/issue to MA's as they are the first point of contact along the clinical care portion of the journey, at this site, MA's were clear with these patients at the onset of this story sharing that they need to share this information with providers as they will be the ones to address these problems during the patient room visit. This clarity helps guide the patient experience so that they understand the need to tell this story to the provider regardless of whether they begin to tell it to the MA, possibly eliminating any duplicate storytelling or frustration that could come from telling a sensitive story multiple times. MA's also proactively would take off two pounds when weighing patients which I interpreted as a way to co-create their experience and contribute to one that makes them feel good, should a lower weight number help with that. Additionally, the flow was noted as critical to success and the patient experience. Separating the waiting room from the check-in desk, for example, was one way that appeared to help with the feel of flow in the practice at times when it was busy.

New Model Practice

At the new model practice, while site leaders and staff members could define Artemis' definition of the LPX well, at times, they seemed to have less clarity on the delivery of that experience. The shorter length of time in site leader or leadership

roles at Artemis may be contributing to some of that lack of clarity as all of the site leaders had two or fewer years of experience with the practice and often noted that they were learning as they were going. The team format created for site leaders has been valuable for this learning. At the same time, three of four leaders that I talked with noted this challenge, as seen in Table 7.

Table 7: Quotes from Site Leaders at the New Practices Around one of their Biggest Challenges

Leader #1	Leader #2	Leader #3
"My biggest personal challenge right now is balancing my role as an administrator, with my role as a provider."	"…just getting used to, more skills in my role that are, or more tasks that I'm, you know, being assigned to and just kind of learning how to do them. Which is like an everyday thing."	"This is the first time I've been…head of anything so I'm learning as I go, like, you know…nobody teaches you how to do it so it comes as I go."

A site leader shared that MA's are not always clear with patients that they cannot solve their problems when patients tell them their issues during their time with them. In turn, after a patient has told the MA their issue, the patient gets frustrated with the provider for asking them to repeat the story again. This example shows a possible negative impact on the patient experience. Additionally, while MA's accommodated for the patient experience around weight at the new site, this accommodation came after disappointing comments about weight were made from patients illustrating a reactive versus a proactive approach to addressing the possible issue. An example of

this reactive accommodation was after a patient noted that the weight on the scale was wrong, the MA said, "we will take off a few pounds". While this response is a positive way to co-create with the patient to add value to their experience, a proactive approach to something like this could create an even better experience for them.

Due to a patient's ability to see a provider without an appointment and the effect that this dynamic has on managing the daily flow, including the wait times, lack of predictability of flow, and longer wait times were noted as challenges for many staff members at the new sites. At one site, I observed this play out as a patient walked up to the check-in desk complaining that her appointment was at 2:30 PM, but it was now 3:05 PM and she had yet to be seen. At the same time, the format of the new sites is that the check-in desks are in the same area as the waiting room. While this makes the check-in staff members accessible to the patients, it can make any backlog very visible to them as well and I did not see a lot of awareness around proactively addressing patients who had been waiting for a long time, despite clear visibility to those patients in the space. A staff member said that she thinks "the patient journey is going to be a little bit different for someone that makes an appointment versus [someone who does not]" further illustrating the impact of this lack of predictability, how it effects flow, and ultimately, how it effects the patient experience. Additionally, while technology at the new sites can be a plus in terms of managing the flow, it was mentioned that this piece can be challenging for patients

who may not be as savvy with technology, further creating some inconsistencies in the patient experience.

CEO's Perspective

The CEO has noted that one of her biggest barriers is staffing and training. She also explains that with her new model, she "created this concept of patients being able to [come without an appointment] and get whatever they want, so it has also created an expectation for those patients". If they do not have a good experience with this new concept, she explains how they then perceive it by saying, "then they're like, well, I, I [came in] and they didn't do very well at all". Per the research on the importance of the brand in the luxury service experience, the negative perception that could be created as a result of a patient's experience not meeting the expectation for the brand could be detrimental to the new brand that she has created (Gurruraj & Pascal, 2020, as cited in EHL, 2020). This expectation for patients around their experience increases her need to find the right staff who can "continue to provide [her with] the same care" as in her original practice. At the same time, some of the challenges for her in this new model are ones that are inherent to the model and staffing with a new practice.

Conclusion

Dr. Chip has created a new practice that is meeting a critical need for women's healthcare in an area of healthcare where the supply does not meet the demand (Ibis

World, n.d.). At the same time, the complicated nature of a full women's healthcare organization and delivering on what she has set up as a vision for the LPX, the format for delivery of the model, and the lack of experience of providers and staff members, with experience being defined as length of time working at the practice and in this particular model of practice, who need to carry out this model, may be contributing to some patient dissatisfaction and frustration with the new sites.

Research Question 2

The second research question asks how client experiences differ between the original, standard care of practices and the expanded, new model sites.

Conceptual Framework

This research question focuses on the delivery of the LPX at the original and new model sites. It also speaks to how different stimuli in each of the two environments, in this case, mainly the service delivery, may or may not be impacting that patient satisfaction, as detailed in the servicescape framework. Table 8 and Table 9 map out the journeys at both site models including the patient activities, channels, touchpoints, emotional status, and insights along each stage of their journey. In Table 9, items that are unique to the new practice are written in purple. Note, for the purpose of the maps in these two tables, all other items are similar along the patient journey.

Table 8: Original Practice, Map of Patient Visit Stages, Patient Activities, Channels, Touchpoints, Emotional Journey and Insights

	Pre-Visit			Visit	Post-Visit
Stages >>>>>>>	Awareness & Research	Planning & Booking	Pre-Visit	Visit	Post-Visit
Patient Activities/Tasks	X Google gynecologist X Talk with a friend X Get referral from Dr or City MD	X Call for appointment X Book appointment through website	X Gather insurance and/or any preparation documents for visit X Print or pull up Location information and contact information X Access/respond to appointment reminder	X Approach Office X Check-in for appointment X Input information on tablet X Enroll on patient portal X Wait for appointment X Walk through office space X Provide information about problem X Provide feedback if expectations are not met	X Provide feedback and testimonials X Complete follow-up survey X Access patient portal X Pick-up any medication at pharmacy X Schedule surgical procedure X Talk to friends and family about visit X Access reminder for next visit

Channels (Encounters)	X Website X Social Media, PR X Intermediaries for Referral	X Phone operators X Website X Intermediaries for Referral	X Intermediaries X Website X Phone operators	X Front Desk X MA's X PA's/Providers X Sonotech X Intermediaries (i.e., tablet) X Website	X Intermediaries X Social media, PR X Surgical coordinator X Phone operators
Touchpoints (Device & Physical)	X Website landing page X Word of Mouth X Social Media blogs X Building location X Emails, printed materials X Phone Calls X Intermediaries Face-to-Face (i.e., Dr's office, City MD)	X Operations team X Website landing page X Intermediaries booking method	X Intermediaries of information (i.e., google location, maps) X Website landing page X Operations team's phone calls, emails, or text messages	X Check-in & Check-out X Tablet X QR Code Access through Personal phone/Website/Intermediaries for information X Bathroom X Waiting Room X Triage X Patient Room X Ultrasound Room	X Social Media X Intermediaries face-to-face interactions (i.e., pharmacy) X Email asking for feedback X Website landing page to provide feedback & access patient portal X Word of mouth X Operations team's phone calls, emails, or text messages X Office visit (surgery/repeat visit touchpoints)
Emotional Journey	😊	😊	😊	😕	😐
				😐	😊

Insights	*important to help with the design of each touchpoint and influence and design on each channel within the patient experience. *Can more personalizatio n take place before the patient reaches the practice?			*Observational Evidence (Yin, 2018, p. 182), Old practice: Appointments help manage the flow; at the same time, there is separation between the waiting room and the front desk which eliminates any chaos felt during bottlenecks.	

Table 9: New Practice, Map of Patient Visit Stages, Patient Activities, Channels, Touchpoints, Emotional Journey and Insights

	Pre-Visit			Visit	Post-Visit
Stages >>>>>>>	Awarenes s & Research	Planning & Booking	Pre-Visit	Visit	Post-Visit

Patient Activities/Tasks	X Google gynecologist X Talk with a friend X Walk by practice X Get referral from Dr or City MD	X Call for appointment X Book appointment through website X Walk into the office	X Gather insurance and/or any preparation documents for visit X Print or pull up Location information and contact information X Access/respond to appointment reminder X Wait for appointment	X Approach Office X Check-in for appointment X Input information on tablet X Enroll on patient portal X Wait for appointment X Walk through office space X Provide information about problem X Provide feedback if expectations are not met	X Provide feedback and testimonials X Complete follow-up survey X Access patient portal X Pick-up any medication at pharmacy X Schedule surgical procedure X Talk to friends and family about visit X Access reminder for next visit
Channels (Encounters)	X Website X Social Media, PR X Building facade & signage X Intermediaries for Referral	X Phone operators X Website X Intermediaries for Referral X Front Desk	X Intermediaries X Website X Phone operators X Front Desk	X Front Desk X MA's X PA's/Providers X Sonotech X Intermediaries (i.e., tablet) X Website	X Intermediaries X Social media, PR X Surgical coordinator X Phone operators

Touchpoints (Device & Physical)	X Website landing page X Word of Mouth X Social Media blogs X Building location X Emails, printed materials X Phone Calls X Intermediaries Face-to-Face (i.e., Dr's office, City MD)	X Operations team X Website landing page X Intermediaries booking method X Check-in X Waiting Room	X Intermediaries of information (i.e., google location, maps) X Website landing page X Operations team's phone calls, emails, or text messages X Waiting Room	X Check-in & Check-out X Tablet X QR Code Access through Personal phone/Website/ Intermediaries for information X Bathroom X Waiting Room X Triage X Patient Room X Ultrasound Room	X Social Media X Intermediaries face-to-face interactions (i.e., pharmacy) X Email asking for feedback X Website landing page to provide feedback & access patient portal X Word of mouth X Operations team's phone calls, emails, or text messages X Office visit (surgery/repeat visit touchpoints)
Emotional Status					
					

Insights	*important to help with design of each touchpoint and influence and design on each channel within the patient experience. *Can more personalization take place before the patient reaches the practice?			*Observational Evidence (Yin, 2018, p. 182), New practice: When busy, mix between waiting area and reception desk can be "felt". Can create a feeling of chaos.	

Finding 2

Client experiences may be influenced by their expectations for the different practice models, based on the branded model at each practice.

Original Model Practice

As seen in Tables 8 and 9, the patient journey starting points can be very different for the original practice from the new practice because their planning/booking phase includes some form of making an appointment, whether by

them or through a referral from another practice. So, the way they come to the practice can be in different ways, whether word of mouth, through a referral, or through a google find, but they will always have to go through some sort of booking process. The ease of that booking process influences their initial impression and experience before they walk in the door, regardless of the way they came to book the appointment.

New Model Practice

As seen in Tables 8 and 9, at the new model site, patients have two options in their planning/booking phase: (1) book an appointment in a similar form to one of the ways described in the original practice, (2) enter the office without an appointment. When observing the check-in process of the patient journey at one of the new model sites, a comment from a representative at the site noted that this second option, which is part of the branding of this practice, makes it seem as if patients will be in and out. She also noted that since patients can come in without an appointment, they feel the visit should be fast.

CEO's perspective

When talking with the CEO, her comment about expectations of the new environment corroborated the findings at the new site around the influence of the brand on the client's expectations. The CEO lamented that "now they have an expectation where they're like, okay, I'm gonna walk in and get whatever; but I can't

and we cannot get an IUD on your first visit because we have to do a full evaluation...patients' expectations have gone too high (CEO)". While her comment refers to their expectations around what service they will receive when being seen during the visit and the comments from the new model sites speak to a sense of urgency from those who come in without an appointment, all of the comments show that there is a client expectation tied to the branding of the new site that seems to be influencing their experience.

Conclusion:

These comments from the patient journey mapping and interviews show how the client experiences may be influenced by the expectations that they have for each site which may be based on the branding of the different models. In turn, clients at the new site who come to the practice without an appointment and expect to be seen quickly, but ultimately have to wait or do not get exactly what they want in that one visit may have a different level of satisfaction about their LPX based on an expectation set from the brand of that practice. This expectation does not match the CEO's definition of the LPX as one of her main priorities is that clinical care in the LPX at Artemis includes solving problems which, to the point of her previous quote, is not necessarily something that can be done quickly and/or in one visit. At the same time, research shows that delivery on the promise of a brand is one of the most important components of fulfilling a luxury service experience (Gurruraj & Pascal, 2020, as cited

in EHL, 2020). This mismatch between the expectations created through the branding of the new model site and the actual experience must be solved to maintain a LPX at Artemis.

Research Question 3

The third research question asks what factors may be contributing to those differences.

Conceptual Framework

The LPX continuum shows the importance of evaluating the success of the implementation of the LPX strategy. Additionally, the servicescape framework shows that there are important stimuli that serve as factors that influence the patient experience. From the surveys taken at both the original and new model sites, it is clear that service delivery and physical design, two components of servicescape stimuli, are factors that contribute to differences in the patient experiences at Artemis. Qualitative interview feedback and patient journey mapping provide additional context to the details of how these factors contribute to the differences between these practices along the LPX continuum.

Finding 3

Significant factors that contribute to the difference between the two practices include (1) established leaders in the original practice versus new leaders in the other; (2) a requirement for an appointment in the original practice versus no requirement in the other; (3) and the establishment of a new model in this sector of the gynecology market.

Original Model Practice

As noted earlier, the service delivery in the original practice includes a clear mindset about what service means and how to influence the patient experience through service. It was noted by a provider that "the practice is your job". This understanding of everyone's role to do whatever it takes to solve problems is clear and much of that clarity is based on established leaders motivating people through and with that mindset and carrying out their daily work in a way that models that behavior. Experience does matter here. Belief in a model that asks providers to give full attention to patients with care and compassion is inherent in this mindset and with the leaders at this practice. Additionally, as noted previously, the predictability of the flow of the practice, given a more standard model that has existed in this industry for a long time and the information that providers and staff members have access to, based on the model of scheduling appointments as seen in Table 8, helps them focus on service delivery and how to hone that craft.

New Model Practice

Leaders at the new sites believe in the model and mission of Artemis and the care and compassion that comes along with serving patients. They talk about taking the extra steps to contribute to the patient experience. One provider details the way that she does this by personalizing the experience: "we try to keep up with them, even just outside of, like, medical visits I guess just like they're personalized; just

always trying to ask them, like how they're doing or how their holidays were or if there's anything new in their lives". They also have awareness of the importance of the way the office feels through the physical design: "We want a welcoming sign; we want it to look inviting, you know, not like a cold, normal doctor's office, we want the patients to feel comfortable". At the same time, as noted above, they have less experience with Artemis which at times effects their ability to problem solve and meet the needs of the patients and organization in the same way. As also noted above and seen in Table 9, the need to take both patients with and without appointments creates a different model that is less predictable and often a disruption to the flow that is needed to create the best possible patient experience. A staff member said that this experience "can get overwhelming" at times.

The CEO's perspective and the Research

Dr. Chip shared that many of her biggest barriers center around staffing, training, and standardization processes. She says that the staff in the practices are "working long hours and [offering]…really complicated services….it is pretty intense. So, getting the staff, all up to speed and continuing to provide me the same care is one of the biggest challenges." Dr. Chip also explains how while this standardization of protocols is important, it can be difficult for her to keep doctors at the new practice because it is hard to tell another doctor what to do. She also explains that patient

expectations have gone really high at the new practice and that since they do not have to book appointments, they expect to have their needs met quickly.

Taap et al. (2011) performed a comparative analysis that lends insight into the experiences that Dr. Chip notes she is having with challenges around staffing, training, standardization, and patient expectations. In their research, they compared the service quality in two bank models of practice which included conventional and Islamic banks (Taap et al., 2011). Their comparison of the two bank models was done using the SERVQUAL model for measuring service quality to customers across five dimensions (tangibility, reliability, competence, convenience, expectations, and perceptions) with the addition and inclusion of convenience as an additional measure given the increase in the use of technology and its impact on the customer experience (Taap et al., 2011). Their findings showed that at both banks the customers' expectations around service convenience were higher than the service they received. Additionally, their study showed that customers showed a greater expectation for competence at the Islamic banks over the conventional banks given the new model, but the Islamic banks actually had more challenges with hiring and training staff since their model requires additional understanding of their systems and practices and less personnel who are available with that understanding. Ultimately, Taap et al. (2011) found that there is an opportunity for the Islamic banks to learn from the conventional practice to take what works well and adapt those things to this

Islamic bank model that is both newer and necessary in the market to help with their gaps in service competence and meet their gaps in expectations. At the same time, Taap et al. (2011) explain the challenges that are inherent in hiring, staffing, and training for Islamic banks because of their newness to the market. They note a shortage of hiring people who are experienced in this market, which may be similar to what Dr. Chip experiences when she shares challenges of a similar shortage in hiring, staffing, and training for her new model practices. These factors are important to understanding the contributions of what may be different about patient satisfaction in the new versus the original practice as Dr. Chip is similarly managing high expectations of customers that do not match their experiences at the new practices and inexperienced staff and/or challenges hiring and training staff to perform based on her necessary standards for stellar service and her needs for operations in her new model practice.

Conclusion

The development of an understanding of the factors that contribute to the difference between the original and new practices is important to refine a LPX strategy that can deliver the consistency of the stellar service that Dr. Chip aspires to see at all of her practices. It is important to utilize the knowledge and experience of what makes the original practice successful to help the new practices as the original practice is delivering on the service levels that Dr. Chip desires to see, often due to

their additional experience working in this practice and sector of the market. At the same time, the differences that exist that are inherent in the new model, such as the ability to see providers without making an appointment and the new design of the model itself are contributing factors towards why service delivery is being impacted at the new sites. This understanding can help Dr. Chip build strategies for patient and clinical care that leverage the experience of the original model to develop staff and providers in the new model while learning how to understand and meet the unique needs that exist to provide the best care in the new models.

Research Question 4

The fourth research question asks how client experiences impact the client behaviors.

Conceptual Framework

The conceptual frameworks show the importance of client satisfaction on building, refining, and evaluating the LPX strategy as the clients' experiences influence their behaviors which in turn influences the success of the LPX strategy and healthcare organization. The servicescape model shows that patient satisfaction leads to loyalty intentions to return to the practice and the willingness to pay out-of-pocket expenses. The data from the patient survey distributed at Artemis confirms these findings and specifically shows that patient satisfaction is aligned with their

behaviors at these practices. Data from interviews and patient journey mapping confirm these findings as well.

Finding 4

Client experiences influence clients' satisfaction, their desire to return to the practice, the likelihood that they share this practice with friends and family as a practice of choice, and their willingness to pay out-of-pocket expenses.

Original Model Practice

When asked about how staff and providers know patients have had a good experience and what they do to show that, the main answer centered around the patient's return to the practice: "If they come back, that shows their loyalty." At the same time, according to the interviews with staff members and providers, there was no clear way that this satisfaction was measured. Rather, their comments spoke to actions taken during the visit that led patients to return or to share the practice through word of mouth with friends and family members. One provider said, "If you have somebody that comes in and you help them figure out the problem, or help prevent it from coming back, you've solved a huge problem and they are going to be grateful. They're going to come back and they're going to tell their friends." The providers also know that it is their role to deliver the type of care that influences the patients to return and that these experiences matter for patients to find the best overall satisfaction that fits them. This understanding is evidenced by a comment from one of the providers around care and satisfaction: "I tell patients all of the time. If

you're not comfortable with me, if you're not comfortable with the other person, if you're not comfortable with your practice, find someone, because we're not here for us we're here for you. And if you can't communicate freely with your provider for whatever reason, then you're not getting the care that you need." The actions of the patients at this practice and their willingness to return, request a specific provider, and tell others about the practice speak to how their experiences impact their behaviors. This understanding of the importance of how the patient feels aligns with what was noted earlier about what Klaus (2017) says about the importance of the evaluation of the LPX experience as not only being about the patients' actual behaviors of returning to the practice or sharing the practice with others through word of mouth but also about why they share the practice with others. While this practice has not been intentional about their measurement of how they make the patient feel as a part of the evaluation of their experience, staff members do show through their comments that they understand that it matters.

New Model Practice

When walking into one of the new model practices, a whiteboard is posted on the wall with goals for the day. One of the goals says "schedule follow-up appointments for all patients" illustrating the importance of the follow-up for patients. Follow-up continues to be the main way that providers and staff members at the new model practice sites measure patient satisfaction, including follow-up with specific

requests to see a certain provider: "I take that as like the almost…the highest compliment that you can ask me like they're coming back, they want to see, you're helping them," said one provider. Even while comments like this explain that returning patients are satisfied, some lack of clarity still exists around how to influence, understand or measure if patients are satisfied as one site leader stated that she is "not directly involved in that" and "there's no real way to measure it". At the same time, one site leader speaks to the way this satisfaction is measured: "at every monthly meeting we do stats from each office. So, we see how many patients are new, how many patients are established, and how many patients. I guess are [non-appointment], or appointment-based, so that is a way of quantifying it."

There is consistency among staff members and providers around their understanding of the power of a referral and word of mouth for the practice and how it has influenced both the return of patients and their influence on bringing family and friends to the practice. One site leader noted that referral or word of mouth was the second most common way, behind returning to the practice, to understand if a patient was satisfied. She illustrated this satisfaction with a brief story of the power of word of mouth and how it influenced a family to come to the practice: "Last week I had a mother, grandmother and mother, and a daughter; so, three generations that came into the office together which I thought was really cool." Given this data, there seems to be importance around clarifying everyone's role in delivering on and being

able to understand how to measure patient satisfaction as there is great importance around how it leads to returning and new customers for the practice.

CEO's Perspective

When asked how she measures patient satisfaction, the CEO said, "this is what I'm lacking; I haven't actually measured." At the same time, she speaks about many different ways that she learns about their satisfaction, including, negative patient feedback through surveys or online channels, expressed dissatisfaction with bills or the results from the visit, and recurring patients who return to the practice. She says, "being that we have grown so quickly, and we have a lot of recurring patients, I think they are satisfied; about 95% of them are pretty satisfied." She even comments on how the design of the practice influences satisfaction when she comments on the physical elements and music that is playing in each waiting room and the patients' responses to this music: "A warm clean inviting meeting room is very, very, very important. The music...finally I have our radio in every office, and patients have actually complimented us many times." While she does not feel she has specifically measured patient satisfaction and how the client experiences influence their behaviors, her feedback on the behavior exhibited by satisfied clients is consistent with what is stated from staff and providers at both the original and new sites and what the patients say satisfaction means and the behaviors that those patients exhibit when satisfied through the results of the patient servicescape surveys.

Conclusion

Through the multiple ways of gathering data about the patient experience at both the original and new sites at Artemis, it is clear that satisfied patients return to the practice, tell others about it, and will be willing to pay out-of-pocket expenses. Therefore, for the success of the practices and the new model sites, it will remain important for all staff members and providers to understand their roles in influencing that patient experience and further understanding of the components that lead to patient satisfaction as that satisfaction ultimately leads to their willingness to return, bring others to the practice, and pay for services that they may need that are not covered by insurance. Additionally, Klaus (2017) notes that a management aim of the LPX is evaluation so that providers learn the why behind a patient's return to the practice or spreading of the word about the practice to family and/or friends as this why will help healthcare practices continue to refine their design in the delivery of a successful LPX strategy.

Recommendations

Recommendation 1

Artemis should develop a plan to utilize a team approach to do their own patient journey mapping exercise at each site, including walking the patient journey and conducting qualitative interviews with patients that help them understand where "moments of care" (Kreuzer, Cado, & Raïes, 2020) take place along the LPX journey.

As noted in the concerns section about the patient journey mapping exercises, Trebble et al. (2017) recommend that journey mapping is conducted with a team to ensure a thorough process for understanding the patient journey and also see the team approach to journey mapping as an opportunity to perform a team-building exercise. While a good amount of data came from the patient journey mapping exercise in this study and Artemis does a number of professional development workshops where they perform mock patient journeys, if Artemis takes the current work done to build a base understanding of the journey from the patient's perspective and builds a team to refine this work, they will have a greater perspective about the patient experience and how to influence it from the users themselves. Their team, which is an important part of their success and approach to patient and clinical care at each site as learned throughout this study, will also be strengthened through the team-building exercise.

As recommended by, Trebble et al. (2017), Artemis should build a team of three or more people to map this journey at each site. Given what is now known about the impacts of the nuanced differences with the new model site, a focus should be on understanding how some of the differences within the new model translate into differences in that patient experience. The exercise can further enhance value and eliminate waste along the patient journey by filling in gaps that I was unable to assess as additional people will help divvy up responsibilities so one person can time the

journey points, another can ask questions along the way, and another can observe and record insights and outcomes (Trebble et al., 2017). Additionally, research done by Kreuzer, Cado, and Raïes (2020) shows how short, interpersonal interactions influence emotional moments that define true luxury during the patient experience. Dr. Chip should review this research and utilize its findings to add a qualitative interview component to the patient journey mapping exercise to learn more about if and where these "moments of care" exist at Artemis within the experience or how they can be integrated into the experience. This refined and more in-depth insight can help further refine the LPX strategy around stellar service as "moments of care" have been defined as ways to influence a luxury patient experience while additional information about journey channels and touchpoints can increase co-creation and value for patients along the patient journey and LPX continuum.

Recommendation 2

Artemis should create Patient Journey Champions who can be present for each touchpoint along the patient journey.

Berry and Davis (2015) discuss ways to meet the emotional needs of patients during their journey through cancer. One of their recommendations is to give them access to control at a time when emotions are high, and much is out of their control. They recommend providing patients with a patient coach to provide that control so that patients are never without someone to lean on throughout their time navigating

their illness (Berry & Davis, 2015). Patient Journey Champions at Artemis can fill a similar need. They present an opportunity for Artemis to have one person who is present for a touchpoint at every point on the patient journey. These champions will enhance the comfort of the patient through an emotional experience, they will allow for further personalization of the patient experience, help build out Kreuzer, Cado, and Raïes' (2020) "moments of care" through short, but poignant interpersonal connections, and further the staff's capacity to proactively notice and resolve problems.

When I walked the full patient journey at each practice site, I noticed that I was the only person with whom the patient interacted through every step of the visit. This consistency of my presence throughout the journey gave patients the opportunity to develop a relationship with me which I saw brought a sense of ease to a number of nervous and scary moments for those patients. At times, because of my consistent presence, patients would ask me about how to approach the provider they would see next. I assumed that patients saw me as the person who had already heard the issues that they were dealing with along the way and saw the provider as someone who was new to their issues during that visit. At times, patients also voiced their frustration about having to repeat their concerns multiple times throughout the visit. The consistency of presence was another way to alleviate the emotional stress that can result from telling one's story multiple times. For example, at the end of one visit with

a patient who had been nervous throughout her time there, the patient was asked by the provider if she would return given that she did not return after her previous visit/issue. Then, at the check-out point, when asked about booking her next appointment, in response, the patient turned to me and asked, "will you be here when I come back?".

Without knowing it, the times when this patient turned to me throughout her journey to ask questions provided the "moments of care" (Kreuzer, Cado, & Raïes, 2020) that built comfort and confidence for this patient. A Patient Journey Champion can provide this same consistency to Artemis patients and further their desire to provide, as the CEO stated, "compassionate, and holistic care to all women, and…put all the dots together and try to figure out what exactly is wrong with the woman rather than just fixing the problem". This strategy can ultimately deliver the CEO's level of stellar service in a way that provides a true luxury experience of meeting the unique needs of women along an emotional patient journey (Berry & Davis, 2015; Kreuzer, Cado, & Raïes, 2020).

Recommendation 3

Artemis should build a training and development program that accounts for the nuanced differences that exist for the new model practice, includes what has been learned from the success of the original practice, and includes an intentional mentorship program.

Through research comparing conventional banks to Islamic banks, one learns the importance of acknowledging and building on what is important in a new model of business, learning from models that have worked in the past, and utilizing training and development to prepare employees for success in new market environments (Taap et al., 2011). Artemis can build a training and development program for its practices with this research in mind. There is much to be learned from the original sites and the CEO should continue to build off of that success in training programs that bring staff members at the new sites, who have less experience with the practice, to learn how to provide the highest level of care. However, research in this study shows that there are clear nuanced differences that exist for the new model practice. As noted in other recommendations, building a clear understanding of how these nuanced differences impact the patient experience can help refine service delivery and training and development programs for new practices should acknowledge and reflect those differences.

Additionally, intentional mentorship programs should be built as a way to utilize more seasoned leaders to provide guidance, advice, and problem-solving opportunities on a consistent and planned basis. Berry and Davis (2015) talk both about the peer-to-peer learning that Dr. Chip does provide for her site leaders and team members and the importance of using middle managers as teachers to develop other staff members. Dr. Chip can build on this idea to develop mentors as teachers

and in turn, develop a mentorship program as a part of the professional development for staff members at the new practice sites.

Recommendation 4

Artemis should utilize trend data from patient visits at the new sites to build a predictability model around daily patient flow that helps support this flow with staffing and appropriate expectations for adaptability and service.

It was noted at every single new practice site that the unpredictability of flow at the new site, based on the variation of patient numbers daily because of a mix between patients with appointments and without appointments, becomes a frustration for patients and a challenge for site leaders, staff members, and providers to manage. As Artemis implemented a tracking system (the end-of-day reporting system) last fall to understand more about patient data at each practice, they should utilize this data to understand daily trends at each practice and develop a predictability model for new practices to aid with the flow and staffing coverage. This data can help fill the gap that exists in this model on understanding how many patients will attend daily. While it may not be as accurate as having a clear sense of appointments for the day, the trends can influence how to better anticipate, plan for, and manage the flow.

Recommendation 5

Artemis should develop a measurable strategy for factors, implementation, evaluation, and organization-wide celebration of a 10/10 rating for stellar service.

The CEO is clear that she wants a 10/10 level of stellar service in clinical and patient care at all of her practices with drops that go no lower than 8/10. It would be helpful for her to develop measurable factors for her staff members that define a 10/10 level of service, a clear strategy for how to implement those factors for the 10/10 level of service at all practices, a way to measure if 10/10 service has been met on an intentional, timely, and consistent basis, and a way to acknowledge and celebrate the implementation of a 10/10 level of service throughout the entire organization.

Earlier in this study, it is noted that the CEO believes solving problems quickly is important. Berry and Davis (2015) also address the importance of solving problems quickly in a healthcare practice to help manage the emotions of the patient. Dr. Chip could create a scorecard of some kind that adds "problem-solving" as a factor of a 10/10 stellar service level since it relates to her philosophy on the highest levels of service. If she then implements a way to measure service levels, talks through successes and opportunities to improve as a team, and celebrates 10/10 stellar service staff/providers on a consistent basis (quarterly or monthly) through acknowledgment and sharing of stories, this process can further develop an understanding of the type of service she wants to be modeled in each practice. Since commitment levels from staff members at new sites have also been noted as challenges, the celebration can be tied to some form of award system to help with

motivation and commitment as the acknowledgment of stellar service will be rewarded within the organization. As she currently honors employees of the month at each practice, she similarly could honor and name the "stellar service employee" who then becomes a model for the service she wants to implement at each practice.

Recommendation 6: Artemis should develop strategies that acknowledge and address customer's desire for convenience within the new practice while maintaining stellar service and accessibility for all.

Both the original and new model practices understand the importance of co-creation and creating value for the patient through that co-creation. An important way that Artemis can co-create with the patient is to meet their desire for the convenience that is both inherent in today's society (Taap et al., 2011) and built into the branding of the new model practice. A site leader at the new practice said that she "[thinks] co-creation has a big influence on [their] practice and [they're] always changing based off of patient suggestions because if one patient's feeling that way, there [are] probably other patients...that are also feeling, you know, possibly similar." She continued on to say, "I think [co-creation is] important in a practice." Another site leader noted how customers have the choice of which provider to go to at their fingertips and the convenience of quick access through information from the internet creates an influence on that choice and gives everyone the ability to quickly find information about a practice. She said that it's important "that you're comparable

online to other doctor's offices and what they're doing and what they're offering because it's at people's fingertips to find a new clinic or somewhere that looks more appealing online. So, I think the whole like social media, and being online and keeping up with the times is one of the biggest challenges that everyone's facing in healthcare." This level of accessibility contributes to the convenience that patients are looking for.

In Taap et al.'s (2011) article comparing Islamic banks to conventional banks, the researchers evaluate service at each model and add the convenience dimension to this surveying of customers as they see how the customer's desire for convenience has increased with the changes in access to technology. Their strategies around meeting the desired service of customers include the importance of accounting for the convenience that customers are looking for within their banks (Taap et al., 2011). At the same time, they also clarify the importance of serving the needs of their entire population which includes addressing those needs of their elderly customers with counters and care specifically for them (Taap et al., 2011). Dr. Chip and Artemis can benefit greatly from taking the same strategic approach towards how they employ strategies for convenience and accessibility.

Evidence from this study shows that convenience has become an important factor for patient satisfaction in the new practice based on comments from patients about waiting and provider, staff, and the CEO's feedback that patients' expectations

are to be seen and have their problems resolved quickly and immediately. Customers very well may be more demanding in this sector of Artemis than in the original practice given the model that has been created that allows for them to see a provider without an appointment. At the same time, Taap et al.'s (2011) study shows that customer's desire for convenience has gone up in society as well based on technological advances. While Artemis has done a lot to meet those needs for convenience with their use of technology, they still are seeing a need to meet the expectations set for convenience from their customers in other ways.

Evidence in this study also shows that while they are increasing how they meet those needs through technology for some people, they are missing the needs of others, such as populations who may be less tech-savvy. The following quote from a site leader explains this challenge when explaining the check-in process at the new site, how much time is spent at this point on the journey, and how this part of the journey influences the patient experience. She notes that time is influence by "how fast you can fill out the tablet and so, you know someone who's younger and maybe a little more electronically savvy may fill out the tablet faster than someone who is in their fifties or sixties and isn't great with an iPhone or a tablet. So that can definitely change I think the experience for a patient a little bit depending on what age you are."

Artemis' success with the LPX strategy of stellar service will benefit from both the inclusion of service that addresses and meets the needs that customers have for convenience and allows for accessibility to all ages within that strategy. Doing both of these things will more broadly enhance the patient experience at the practice especially given what is known about the influence of that experience on customer loyalty intentions to return and their influence on others through word of mouth. If those who want more convenience built into the strategy and those who need additional help with some of the items that create that convenience both have a stellar experience, the CEO's desire to continue to fill the gap in the industry for women will be furthered as this new model will reach women of all ages and backgrounds.

Discussion

This study was conducted to ascertain if differences existed in the service levels at a women's healthcare organization as the model was scaled to a new model with multiple sites and with the desire for a service level being that of stellar service. There is importance to this research as both this new model and the scaling of that model to additional sites help fill a gap that exists in women's healthcare between supply and demand with the demand outweighing the supply of providers in this market. The practice is also shifting the paradigm of service delivery to women in a way that can help meet their needs so that they can live healthier lifestyles with more

confidence and control over their bodies and wellness. The success of this model is important for the healthcare industry to serve women and the transgender population who is also served by this practice. Since patient experience is critical to the success of healthcare providers, the CEO's ability to understand how to uphold service levels while scaling her practice can dictate the future success of her model in this industry.

The study findings showed that while there were some differences in the patient experiences at these different models, most of those differences had to do with the development of a new model practice that inherently influences factors that change that experience. These factors are what need to be addressed to maintain stellar service levels in the new model sites. Some of these factors are that building a new practice model that is shifting the paradigm in gynecology leads to hiring staff members with less experience in this type of practice, there are different components of the new model that influence the flow of the practice, and the brand of the new model itself creates expectations from patients for fast service that may lead to lack of satisfaction from patients when the model does not deliver on that expectation. These findings are significant to help the CEO, Dr. Chip, adjust her stellar service/LPX strategy to enhance patient experiences at her new model sites before she scales to additional sites.

Limitations

Limitations for this study included challenges around the study's design and implementation in a number of ways. The patient journey mapping exercise was only conducted by one person even though Trebble et al. (2017), the model from which this process was adapted, recommends that a team of people conduct the exercise to help with depth, breadth, and accuracy in the documentation of the experience. The servicescape survey was implemented through the patient waiting room, at two different times in each practice, and by different administrators with different directions. Ideally, this survey would be taken along the visit and handed in at the end or taken at the end of the visit for the most accurate details of the full patient experience through the practice. Given the administration of the survey, many surveys were handed in before the visit took place so there was no way to know if there was a true understanding of the full experience and based on the responses that included a distribution that was not normalized, it seems as if it wasn't taken very seriously. Additionally, statistical tests of multiple linear regression and linear regression that were run were not the best statistical methods for looking at relationships between stimuli and responses based on the Likert scale design for the survey. In the Likert scale design, values are bounded on the left and right sides of the distribution curve and therefore, do not fulfill all assumptions for normality around residuals. Therefore, the original design for the servicescape survey which

utilized CFA and SEM to analyze this data would provide a more accurate way of running statistical analyses to understand the significance of these factors on patient satisfaction and behaviors.

Potential avenues for continued inquiry would be to further the patient journey mapping, as recommended in this study, with the inclusion of a qualitative study that measures for the "moments of care" as found by Kreuzer, Cado, and Raïes' (2020) study to truly understand how to create a luxury patient experience. From the research reviewed in PX, CX, and luxury service, Dr. Chip would be doing a groundbreaking study to combine these two efforts and would, in turn, have an opportunity to gain a more in-depth understanding of what defines an LPX along all touchpoints of the patient journey in her new model practices that would include connections during the experience that can further set her practice apart in the care that patients receive. The rest of the industry can learn from this study because of the depth that it provides in looking at multiple angles of the patient experience through a patient, customer, and luxury lens and how it incorporates a breadth of a study that truly showcases the importance of the details of the design of every part of the patient journey for satisfaction and loyalty to a healthcare practice. Ultimately, it can help providers and organizations understand what motivates a patient to return back to a healthcare appointment that evokes such an emotional experience and there is

great importance to this understanding as this return provides patients with the care that influences the health and wellness of people.

Finally, I expect that Artemis will adopt many of the recommendations from this study, even if adopted in an adapted manner. As first orders of business, I think they will perform the patient journey mapping exercise as a team-building one as Dr. Chip is a believer in professional development and building her team to deliver the best care possible. I think they will develop a mentorship program as a part of their training and development model. I also think that they will utilize patient champions at each practice.

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Appendices

Appendix A: Interview Guide

(Adapted from Gurruraj & Pascal, 2020)

Duration: Approx. 50 to 60 mins

Introduction Questions:

1) Personal background:

a. Name:

b. Age:

c. Professional experience:

d. Current role:

2) As the owner or leader of a healthcare practice, we understand that you provide a set of services and experiences to your patients. Can you please elaborate on how this journey began?

a. The challenges you had to go through during the initial days

b. What steps you took to overcome those challenges?

3) What factors play an important role for a company such as yours to operate in a stellar-service healthcare practice (i.e., As either leader of the original practice or new, model site)? What are the differentiating factors?

a. What capabilities should a healthcare provider have in order to succeed in this segment of the market?

b. Is there a competition for you in this segment?

c. What is the entry barrier for a new entrant into this segment?

4) What are the different channels (e.g., online, offline etc.…) that you use to reach your target customer? And how?

a. What percentage of target customer come from which channel? And do you as a healthcare operator in this field have any preferences on the channels?

b. How do you ensure that your customers receive a seamless experience across all the channels? And how are all the channels integrated?

5) Can you please elaborate on the patient journey process along with different touchpoints where the patients are contacted?

a. Who are the actors involved within this journey and what processes are followed?

b. What according to you are the critical touchpoints within the journey?

c. Do you provide a personalized experience throughout the patient journey? If yes, please elaborate on the personalized experience at different phases.

6) What do you think your patients value the most in the service(s) that you provide?
a. How do you currently measure your patients' behavior (, i.e., satisfaction, loyalty, etc.…)?
b. What steps or actions would you take to ensure patient retention and loyalty is maintained?
7) In your view does co-creation have any influence on patient experience.
a. Provide example(s) of co-creation that has resulted in either positive or negative patient experience.
8) What are the driving factors and barriers for providing patient experience within this segment and delivery style of healthcare?
a. How has technology changed the way you provide experience to your patient?
b. What kind of digital experience have you adopted to make this experience a memorable one?
9) What according to you are the current and future challenges of this segment of the healthcare industry?
a. Are there any challenges that you are facing? And how do you plan to tackle these challenges?

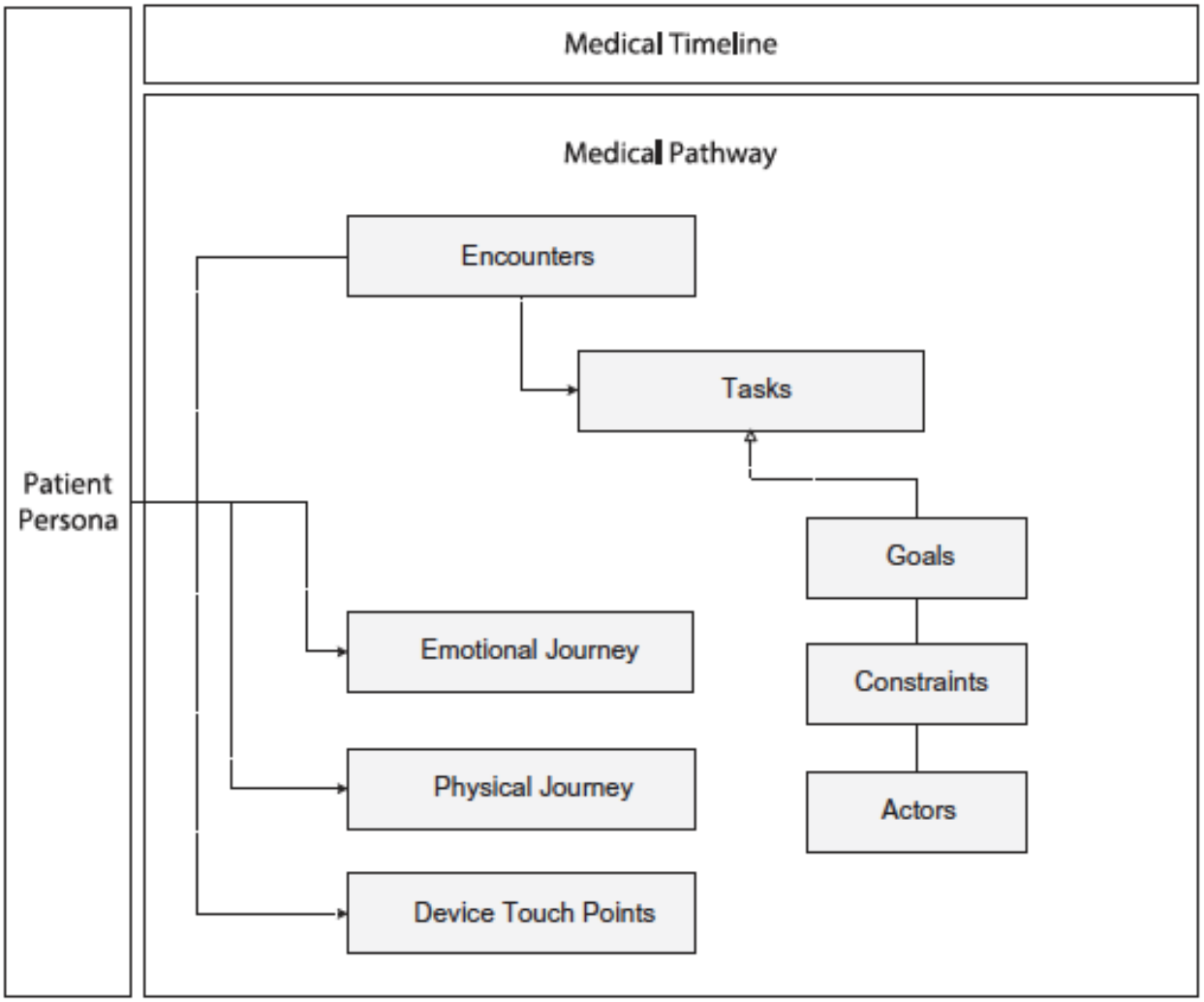
Appendix B: Patient Journey Map Data Collection Process

(Trebble, Hansi, Hydes, Smith, & Baker, 2010)

Method	Description	Advantages	Disadvantages
Multi-disciplinary meeting[6]	Single or short series of meetings of representative staff, in a non-clinical environment[6]	Obtains results in a defined time; allows interaction between staff involved in the process	Depends on attendees' knowledge of patient journey; absence of direct observation
Walking the journey[16]	Following the normal route of the patient journey; one-to-one patient and staff interviews in the clinical environment	Allows a realistic assessment of the patient's journey, particularly if repeated; direct observation	Effectiveness is influenced by availability of staff time and openness of staff and patient's responses
Direct observation of patient journey	Following a patient's journey in real time with direct observation and informal interviews	Provides information from patient's perspective on patient journey	Time consuming and influenced by day to day variations in clinical environments and patient selection
Patient's self reported experience	Patients record their experience of the journey in real time	Represents patient's experience from patient's perspective	Depends on patient selection and expectations (elderly, sick, frail, or illiterate patients may be missed)

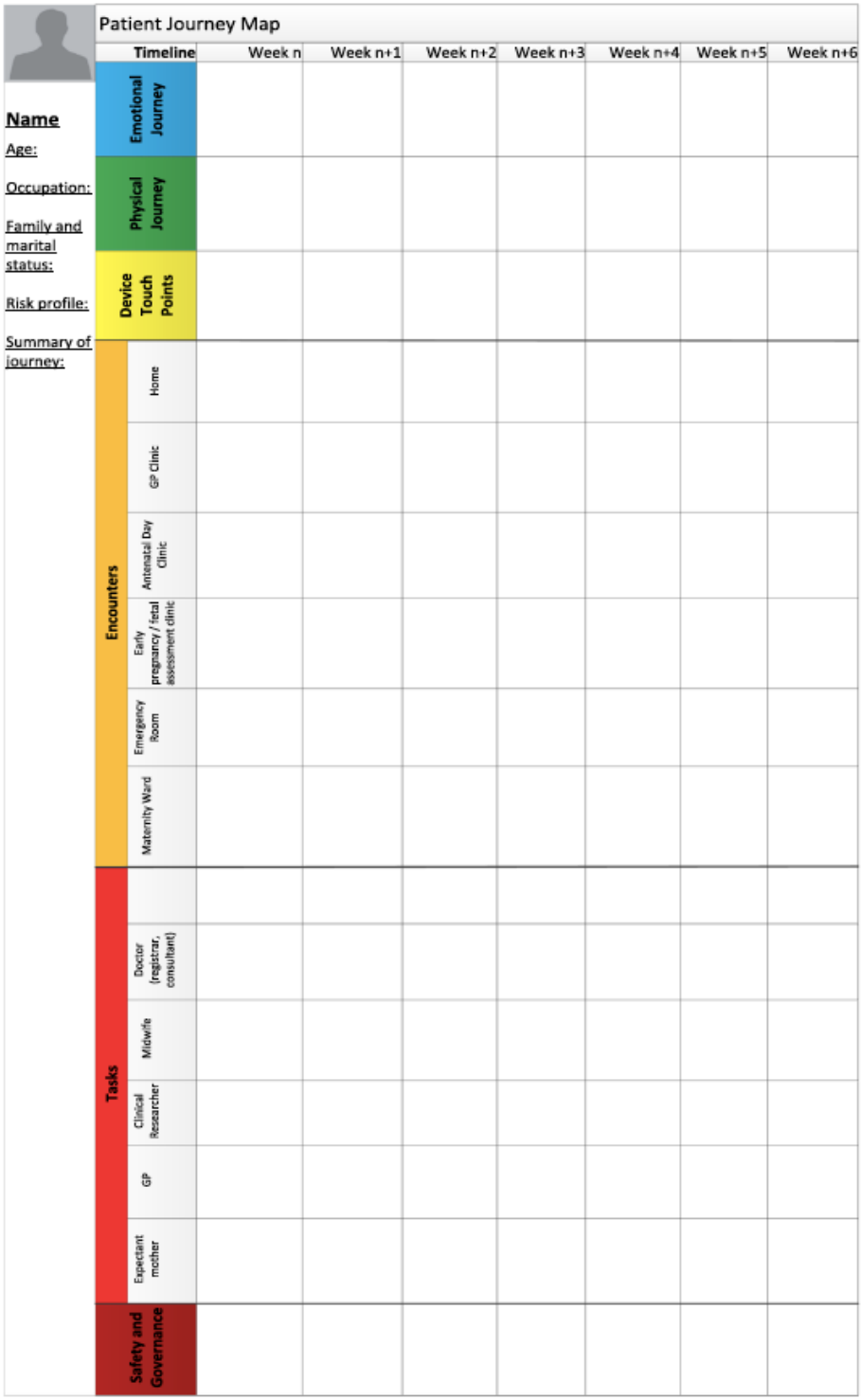
Appendix C: Patient Journey Map Ontology

(McCarthy, O'Raghallaigh., Woodworth, Lim, Kenny, & Adam, 2016)



Appendix D: Base Patient Journey Map Template

(McCarthy, O'Raghallaigh., Woodworth, Lim, Kenny, & Adam, 2016)



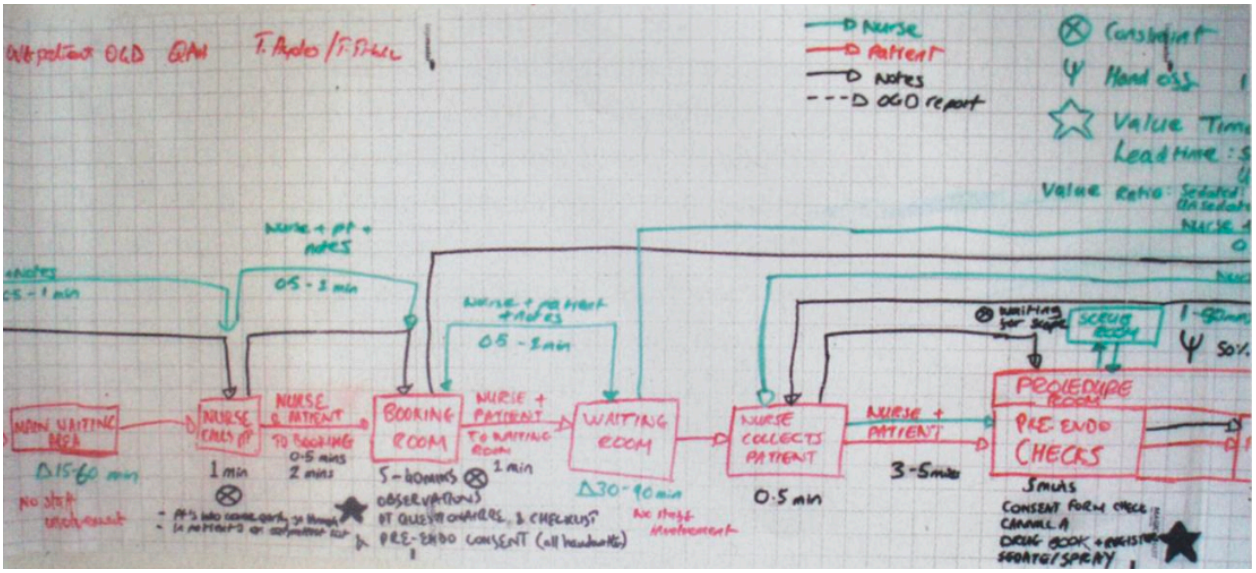
Appendix E: Patient Journey Map, Data of Written Steps

(Trebble, Hansi, Hydes, Smith, & Baker, 2010)

Step		Minimum (minutes)	Maximum (minutes)
1	Patient referral is received in endoscopy department requesting an outpatient endoscopy		
2	Endoscopy administration team send appointment letter to patient		
3	Patient receives appointment letter		
4Δ	Patient arrives at outpatient reception desk	1	5
5≠	Details confirmed by receptionist	2	3
6Δ	Takes seat in waiting area	5	60
7≠	Admitted by admitting nurse (who may also be discharging patients). Consent and health questionnaire	5	30
8Δ	Takes seat in waiting area. Transfer to recovery area	5	30
9≠	Pre-procedure checks in recovery unit (further review of questionnaire)	2	3
10	Baseline observations	2	5
11Δ	Wait in recovery for transfer to endoscopy suite	5	30
12≠	Transfer to endoscopy suite (?by trolley) (25 metres)	1	1
13	Endoscopist completes consent (form partly filled in)	2	5
14	Position patient; prepare patient (observations checked again)	2	2
15	Throat spray administered	1	2
16	OGD endoscopy performed (the procedure)	3	10
17	Check observations post-procedure	2	3
18	Transfer to recovery (on or with a trolley, by nurses from endoscopy suite)	2	3
19	Recovery on a trolley: check observations	2	3
20	Transfer from trolley to waiting area		
21Δ	Wait for nurse to discuss post-procedure	5	120
22≠	Post-procedural advice; findings and report discussion by nurse	5	30
23	Home		
Δ=wait, ≠= bottleneck			

Appendix F: Patient Journey Map, Visual

(Trebble, Hansi, Hydes, Smith, & Baker, 2010)



Appendix G: Survey, Servicescape for hospital healthcare

(Adapted from Suess & Mody, 2017)

Topic	Survey item
Atmospherics of the healthcare environment	The ambient lighting creates a comfortable atmosphere
	The music is pleasing
	The ambient temperature is comfortable
	Walls, floors, and ceiling color schemes are nice
	The scents in the air are pleasant
	The overall decoration is attractive
	There are enough plants and flowers
	The paintings and pictures are appealing
	There is enough quietness
	Overall appearance of staff is nice
	There is enough artwork and decoration
	Furnishings are comfortable
	Equipment is visually appealing
Service delivery by healthcare staff	People receive a nice welcome from the staff
	There is a good cooperative atmosphere among staff
	It is easy for patients to identify the name, surname, and function of the staff
	Staff are informative
	Service from staff is prompt
	Staff are willing to help patient
	Staff are polite
	Staff are sympathetic and reassuring
	Staff are organized
Physical design of the healthcare environment	The furnishings are in good condition
	The quality of the furnishings is good
	The walls, floors, and ceilings are well kept
	The patient areas are kept clean
	The number of seats (chairs and sofas) is appropriate
	Patient waiting areas are well-equipped (chairs, sofas, tables, TVs, newspapers, magazines
	The restrooms are well kept
	The equipment is in good condition
Wayfinding	It is easy to recognize the entrance of this healthcare unit
	In this healthcare unit, there are enough signposts to help you find your way around
	In this care unit it is easy to find your way around
	In this care unit, you can easily find information points
	Waiting areas are clearly defined
Overall satisfaction with healthcare experience	I am satisfied with the quality of services, in general
	I am satisfied with the logistics of service delivery
	I am satisfied with employees' attitudes
	I am satisfied with the general atmosphere of the facility
Loyalty intentions	I am willing to recommend healthcare unit to others (friends, colleagues and family members), who seek my advice
	If I need medical service in the future, I would consider this healthcare unit as my first choice
	I would visit other healthcare units run by the same parent group
Willingness to pay out-of-pocket expenses	If the healthcare unit raised out-of-pocket expenses relative to other hospitals, I would consider this healthcare unit as my first choice

Appendix H: Coding Mind Map

Artemis

- **Patient Journey**
  - The Practice
    - 
    - Original
      - "Everything's your job; the practice is your job"
      - I tell patients all the time. If you're not comfortable with me if you're not comfortable with the other person if you're not comfortable with your practice, find someone, because we're not here for us we're here for you. And if you can't communicate freely with your provider for whatever reason, then you're not getting the care that you need.
    - New
      - Hire the right people
      - Attitude has to fit
      - I've had people come in startup few days and then the way their attitude their way like I feel that doesn't fit in our way that we are as a family. I don't think they're going to succeed here.
      - Patient Track is good because as the patients leave a survey the site leaders or the admin team will also receive the survey, so we'll see at what point in their journey, that they did not like because they can actually read every single thing, like friendliness wait time, etc,
  - Stellar Care
    - Original
      - place to come feel safe
      - you're only as good as your follow up you do tests, what are you going to do you only do a test because you're going to do something with it. So, what are you doing with your results, how are you communicating with the patient, how is the patient being helped
    - New
      - we're just super professional and I feel like patients see that and they respond to that

- I also try to provide compassion, you know, stellar care on the customer service end of things, which is, you know, dealing with the surveys and stuff like that so it's every step that I could get my hands in would just feels like almost every step minus a couple things like, it's just trying to provide the best care throughout it, it doesn't change
- If they don't have that compassion for the patient or we don't see that. That's what their main priority is, to care for the patient or the patient comes first, then I don't think they should be here

Design

Original

- The only reason I'm as efficient as I am. And the only reason it can be as streamlined as it is, is the system I have is so ridiculously user friendly. I can I can wipe through labs in a couple of hours, I can get through messages very quickly. That helps me out to be as efficient as I can as quick to respond with the patients as I can.
- the challenges are. Just to stay on top of that, to stay to help the new providers to not feel overwhelmed because to jump into a practice like ours,[or the new model] whatever is a little daunting to say okay, here's our schedule for surgery patients have fun. I think it's to stay on top of them

New

- Dr. Chip has, like, Baby proofed everything whereas we have like treatment protocols that can be found anywhere and so even a new provider can just open it up and see exactly how to do certain things
  -
- in each office that everything is the same. So from checking process all the way to check out every single thing that the patient experiences should be the same along the way
- we just started using is this platform called Patient Track, and what that actually does is that it takes reviews from our patients from all different platforms, whether it's like Doximity or Google or Yelp, and it brings them all into this one platform where we can see all of it. And it's not like we can, like, decline certain reviews or anything like that but what we can do is push out or encourage some of the reviews that are more beneficial to our practice, and maybe just like push those out a little bit more so that patients have like a very, I guess, consistent understanding consistent review from each of the three practices

- we actually do have them write in how they heard about us on the sign in sheet, and it's always either Google or from a friend. So, word of mouth is really big for our patient population
- PJM/New: Patients feel if coming in without appointment, should be fast.

- Touchpoints
  - Pre-Visit
    - original
      - google gynecologist
      - ✪ word of mouth
        - the journey starts with Person A going to person B going oh my god I had this great experience, blah blah blah, that person calls the office. So, first interaction. They have this impression from their friend, which apparently was good enough to get them to call
      - they call the office, front desk person. How easy is it to make their appointment how friendly are they on the phone,
      - they're reminded in different ways. There's an email reminder there's a text reminder there's a phone call
    - New
      - Set standard before walk in
      - we actually do have them write in how they heard about us on the sign in sheet, and it's always either Google or from a friend. So, word of mouth is really big for our patient population
      - I think the patient journey is going to be a little bit different for 🚩 someone that makes an appointment versus [someone who does not]
      - she'll post regularly on the Instagram so I don't know, that attracts patients, people who aren't in our office
      - Dr. Chip being such a well known, you know, figure in gynecology. A lot of people just know her, get her referral through word of mouth and then they find out that she is the owner walk in and they're also intrigued by that and they come in because they know oh this is Dr Chip's practice
      - I would say almost like once a day like it's very frequent that we get the referrals from city MD

- by word of mouth, or they'll bring their family members. Last week I had a mother, grandmother and mother and a daughter, So three generations that came into the office together which I thought was really cool
- we want a welcoming sign we want it to look inviting, you know, not like a cold, normal doctor's office, we want the patients to feel comfortable

- The Visit
  - Original
    - when the patient comes in, they get a chart, but it's not it's not the old fashioned charts right everybody's electronic these days. It's basically just like a face sheet, and it has everything about a patient, or about that visit on that face sheet
    - they have this paper in front of them, that shows exactly what their, their visit was and what the plan basically is, so when they go up front, the front desk is taking that paper from them, and they're saying okay, you need to come back in six months. Let's make your appointment now
    - your first impression of how nice the staff was but also what happens from here everyone walks out of a doctor's office and goes well, well now what... knowing what the plan is. It's it's the follow up
  - New
    - definitely our website
      - join website, It's actually super comprehensive, that's where patients can either look up articles that are written by Dr. Chip that pertain to like certain diagnoses that we give them during the visit, so we always refer them back to that. We also have QR codes in the office, that the patients can scan that will actually link them to those articles as well, which is really cool.
    - every step of the way they always know who they are and what their title is
      - it's more just every person that they interact with
    - the wait time between medical assistant and provider can also be a touch point in a way because they don't want to be waiting there for so long
    - the front desk is one of it's probably the main one at this point because you want to, that's like first impression. I think that is really critical

- we tried to meet even the exterior office is very welcoming, and something that we use is actually these chalkboards that we place on the street right outside of our office that have like different various sayings for each month
- they always say welcome to [Artemis] because we want to make all of our patients feel that they are welcome here
- our goal now is to make a follow up appointment for every single patient, whether or not they choose to do so that there is a will, they will just make an appointment for you now and then you can give us a call if you need to cancel or reschedule
- exit questions that we always ask our patients, which is, how was your visit today. And is there anything that we can do to improve the visit here, and then we always have them answer and let them know that they're going to receive a survey at the end of the day
- how fast you can feel the tablet and so, you know someone who's younger and maybe a little more electronically savvy may fill out the tablet faster than someone who is in their 50s or 60s and is in great with an iPhone or a tablet. So that can definitely change I think the experience for a patient a little bit depending on what age you are
- for any one who's a...patient [without an appointment] as soon as we do the check in process at the front desk, the patients will get an email to sign up for the patient portal. So that's super important that that happens right away because one of the most common questions that patients ask before they leave is, how do I get my results
- if someone really values, you know, friendliness and they walk in the door and they don't get a friendly greeting that may disrupt their whole experience. Even if everything else is great

▾ Post Visit

▾ Original

- follow-up; really important part of the journey; may not have family
- ▾ if the patient can't make the appointment they will put something called a tickler and it's a reminder for the staff. So in six months time. An alert will come up. Hey, you need to go call Joe Schmo they're due to come back in.
  - There's a reminder that goes into the chart so that the patients don't fall through the cracks so that we can call them, get them back in and continue to follow up and continue the relationship and the care

- if you're scheduled for a procedure, the surgical coordinator has she'll contact you will tell you when your pre surgical testing is if you need it, when your follow up is, etc, after your procedure.
- if they forgot to ask us something they can reach out to us on the portal

New

- We'll also write a letter and we'll always say, we're supposed to sign a letter in the bottom to let them know who is sending this letter.

Personalization of an Emotional Journey

Original

Validate feelings

PJM/Original: Weight. Take off 2 lbs for clothes (does this up front)

- PJm/Original: Pat #3 tells MA issues; MA is clear, she can't solve the problem. The provider will see and problem solve with provider.

- it might be my 25th Pap smear the day but it's her first ever and she's scared to death. So it's assessing what's going on... and just telling patients that you're in charge here. What issues or concerns do you have, and let me see how I can address them as best as possible

New

- Treat "as if close to us"; "How you would want to be treated"

Communicate with patient throughout

- PJM/New:: Sono apologizes when hits pain point with patient

Accommodate them

- PJM/New. Pat #3: upset with weight "that's not my weight"; MA: "we will take off a few lbs"

- I think those are very sensitive things, so I will send out like a personal message to that patient and also sign with my name
- we try to keep up with them, even just outside of, like, medical visits I guess just like their personalized just always trying to ask them, like how they're doing or how their holidays were or if there's anything new in their lives

- some people who have very sensitive issues I've found can get upset if they feel they're telling their story too many times, and some people don't realize that the MA is not going to be the one that's like fully taken care of them, so they'll tell the MA the full story and then I'll get into the room and then they'll be like, Well, I just told this whole story. And so I think it's important for the MA is to limit the information that they're getting. And also if it's at all noted that it's a really sensitive issue or the patient feels uncomfortable to tell the patient or make sure that Ma is are reassuring the patient that's okay you don't have to tell me you can speak with the provider so I think that's a really important point that is sometimes missed by our Mas

- try to like communicate with the patient as well. Being their shoes, because again it's not easy going into a GYN office

  - PJM/New:: Pat #1 seems nervous; MA is kind and empathetic

    - PJM/BK: Provider uses humor

- PJM/New:: Pat #!. Number of problems. Dr., provided solutions. Asked: "are you going to come back?" Patient: "I like coming here"; At checkout, Patient asked me "will you be here when I come back?"

- **Patient Experience**

  - team approach

    - Original

      - willing to do things that aren't your job

        - It's trying to keep up the attitude and morale of the staff, because if it's an entire team approach to get that patient, in, out, everything it's not just the provider they can have an awesome provider and feel amazing, and have the best visit ever, but if they're pissed off because the girl at the front desk was rude, or the medical assistant and triage wasn't making eye contact or couldn't get her blood. There's so many different things that can happen and can impact. It's not one person in that office that makes a difference it's the entire team.

      - even last week, there was a provider that was there, and we were having a conversation about a different way to approach the same problem. And it was eye opening for both of us, because I brought in a perspective he hadn't thought of, he brought in a perspective, I hadn't thought of. I've been doing this 20 years I was grateful, so it should be. It should be always trying to keep going forward. There's always a different way to do it your way is not always the only way the right way

- so it's making sure that you're aware that you're part of the team, so I can be as efficient as possible with the front desk isn't checking patients in on time or the medical assistant and triage is being slow where she's backed up or has a million labs, it backs me up, everyone is part of the team.
- remember how it is for new people. That's how they feel when they're thrown into this. We're used to running as efficiently as possible so we have to help everybody else to get to that point so that there isn't a monkey wrench on it.
- People will come in and they'll say, Oh, your patient said blah blah blah. They're not my patient, all of them are Dr Chip's we all work under the girl there for everyone. If you can get past that and past your own ego, then it's gonna work out better

New

- our site leaders, we're a team of three;I think we've been doing a really great job of always checking in with one another, and helping each other with difficult things or giving each other advice
- we can always reach out to senior providers to ask them what we can do
- I think teamwork is really big and I think that helps us continue to maintain our flow and really I guess overall satisfaction of working
- how can we make this practice, the best that it can be to meet the goals that we want and how can we provide the best kind of care for our patients without, you know, with also helping our employees along the way.
- we treat each other as a family here
- working together to kind of troubleshoot and figure it out. So, thank God for that because it would be struggling.

Provider/Employee Characteristics

Original

-

New

- We need to be extremely organized level headed warm and compassionate
- what drives us, I guess because we all believe in the mission of our organization. I think that's the biggest driving force

- So if you're unable to juggle that balance of seeing the patient in a timely manner, discussing everything they need being clear and concise. And then, assuring follow up and getting all your notes done, and adding your labs and adding the referral that if you're unable to juggle all those things in the 1015 minutes that you have to designate for that patient, it's going to be really tough for anyone who works in our office
- Learning as go

Solving Problems

Original

- if you have somebody that comes in and you help them figure out the problem or help prevent it from coming back, you've solved a huge problem. And they're going to be grateful, they're going to come back and they're going to tell their friends
- If you come in every day and there's a mess on the floor, and every day you clean it up, and it's fixed. That's great. You've handled the you've handled that. But wouldn't it be better to figure out what was causing that mess on the floor every single day so that you weren't repeating the same thing over and over and over. So, if you can talk to your, your supervisor, supervisors, instead of just you know we all we all do we all complain about our boss or about our day or about our co worker whatever we all do. But if you can go with a constructive issue and say look, this, this is why that messes on the floor every day and this is why we keep cleaning it, let's fix that we solved the problem

New

- if you address just the problem first and then tell them to come back for their like screening, perhaps they're the patients never come back for their pap smears and we want to make sure that we're practicing preventative medicine as well. So the follow up part is, is really important for most patients because it's just impossible to fix everything in one visit

Co-Creation

Original

- there's patients that come in and they say I had this problem for three years and I saw, whoever, and they listened to me, and then they'll, they'll tell their friend that. That's how you get people in

- So then it becomes a patient education of, why did you get it again. What can you do to not get it again. It's the patient education and just taking that extra two minutes to explain what's going on would be the, how it works.

New

- We always try to manage appointments versus walking. And so, Dr. Chip kind of said, you know, we need to make the standard across the board that for every three appointments, we only take one walk and because the appointments have to take precedence over the walkins. And so, I guess in that way, that's an example of how we co created with patients.
- an important question that I asked every patient that maybe not everyone may do is I before I leave the room say Is there anything else that I can help you with Do you have any other questions or concerns today. And I think the patients really value that because if there is anything, they're going to tell you at that point. And I think a big reason why people are dissatisfied, a lot of the times is because they leave and they say well the provider didn't ask me about this
- even the negative feedback that we get from these people we can use it as a way to grow
- but some people will walk out the door and say no I didn't get what I want from that provider, even if it's the completely wrong thing and they don't need it, if they, if you're going into a doctor's office with that mentality, and you walk out and that provider didn't give you exactly what you wanted, you're going to be. You're going to have a negative experience regardless of whether it was right or wrong. So I think that's something that can create a negative experience in people's minds. And like I said, sometimes you can talk them out of it and sometimes you can't. But that's sometimes something that's kind of like out of the control of the provider if it's something that they believe in or like giving antibiotics when patients don't need it. That's a really tough because people want to go to the doctor and they want antibiotics they want a treatment, even if nothing's wrong with them. So that's something that I personally sometimes struggle wit
- So always try to accommodate the situation and not make it worse.
- medicines always changing so you kind of have to be open to suggestions and things like that
- I think co creation has a big influence on our practice and we're always changing based off of patient suggestions because if one patient's feeling that way there's probably other patients...that are also feeling, you know, possibly similar so. And I think that's important in a practice

- telehealth visit so I think that's a great opportunity for patients that don't want to leave that to their visit online

Patient Response

- Loyalty/Satisfaction

  - Original
    - I think if they schedule their follow up appointments, and they're following up with you and they're communicating with you, that shows that you're, you're doing something right.
  - New
    - we have patients who are so loyal that we follow up like almost every month, every couple of months, reach out directly to certain providers through the portal
    - as like a provider role like how likely are they going to come back and request you specifically as a provider, because if a patient does that you know that you really made them satisfied with the care that they're giving so I take that as like the almost like the highest compliment that you can ask me like they're coming back, they want to see, you're helping them
    - QUESTION: So what steps or actions would you take to ensure patient retention and loyalty is maintained.

      PROVIDER ANSWER:
      So I'm not directly involved in that,
    - there's no real way to measure it
- Barriers
  - Original
    - I think there's a challenge you're gonna face every day, I think it's going to be staying on top of changes with healthcare
    - keeping up in training new people to come in to help stay with our flow and stay, and I have to say the system that we have, especially in my office. The only reason I'm as efficient as I am. And the only reason it can be as streamlined as it is, is the system I have is so ridiculously user friendly

- there's a lot of decisions that are taken out of the providers hands because of insurances which are not run by medical professionals. So if I think that this care is the best for the patient but it's not covered by their insurance. It's it's frustrating. ...always have to try and keep getting creative and figuring out how to get around it

New

- overflow gets really overwhelming like sometimes we don't. We can't predict the walk ins we'll get. We don't know if we're going to be exactly prepared for that day. Yeah, I think that's the biggest barrier we just don't know how many patients are going to see that day sometimes
  - From PJM/New: flow is unpredictable; could have 4 patients walk-in at a time (worked at original practice; flow predictable)
    - From PJM/New: Solution. Solve problems. *Can move people through faster b/c technology for check-in/all online/easier/faster.
      - From PJM/New:: Can get overwhelming.
- I want to make everyone happy so I want to be everyone's friend and I don't want to discipline people but that's a new ROle that I've had to step in, which has been tough for me.
- my biggest personal challenge right now is balancing my role as an administrator, with my role as a provider
- making sure that we're able to maintain our clientele...we're fitting in offering services like tele visits which prior to COVID-19 We weren't really doing and now it's become a big challenge as far as like scheduling like how do we manage these tele visits and how do we assure we have enough providers to cover these tele visits
- one thing that I think is hard for the providers is a lot of patients still do want to pick up the phone and get on the phone with the provider and it's really tough to provide that when you're working for such a big practice, and also when...you're available all the time
- it's always going to be challenging because you need to draw the line between, you know, being manager...and also being...a staff member with them.
- we went live with payport which is our new for, You know payments and time cards and things like that so a lot of it is learning how to use payport for sign off on top cards, what's going on vacation like so tedious, but it's like one of the bigger challenges we're having now because we literally went live and I was like, Oh, you're gonna do this you're gonna do this you're gonna do this and nobody really knew how to do it.

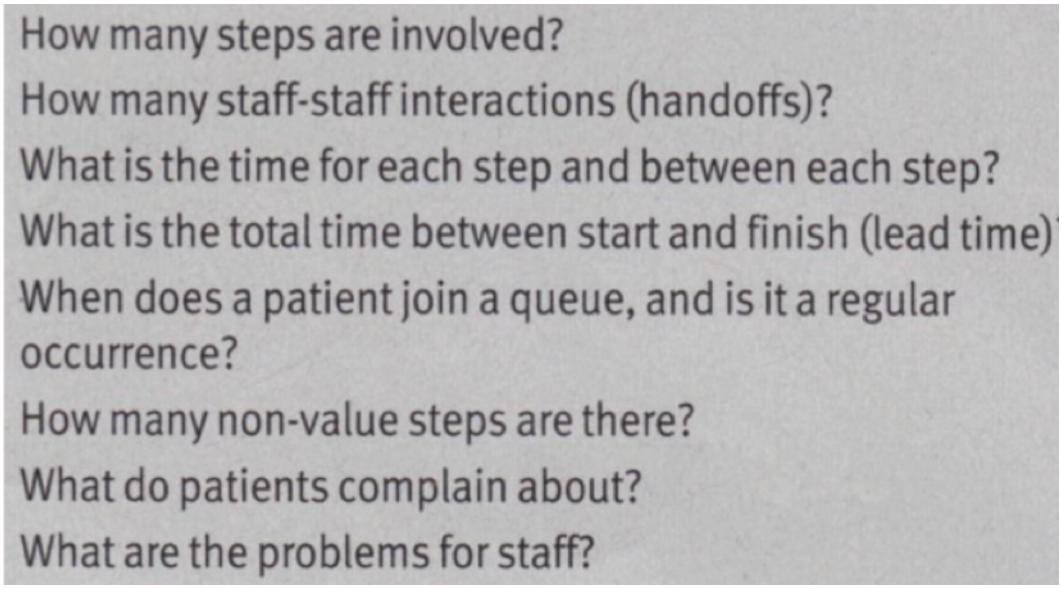
- just getting used to, more skills in my role that are for more tasks that I'm, you know, being assigned to and just kind of learning how to do them.
- Covid impacts
  - we're seeing a lot of big population of people who have kind of neglected their health for so long. So it's just challenging at the end of the provider just knowing what to do and how to adapt
    - a lot of providers are closed a lot of offices are closed, we stayed open the entire time and I think people now know that so it's everybody's just coming here so it's just a bigger population
  - why am I waiting so long it's like there's so much that goes in before getting to you, you know, I think that's just a big barrier we definitely struggle with
  - PJM/New: MA shared, space issues, do get complaints because people are walking in and out.
- Competition
  - Original
    - Competition within selves
  - New
    - that you're comparable online to other doctors offices and what they're doing and what they're offering because it's at people's fingertips to find a new clinic or somewhere that looks more appealing online so I think the whole like social media, and being online and keeping up with the times is one of the biggest challenges that everyone's facing in healthcare

Terms

- Original
  - Calm
  - Patient
  - Empathetic
  - Listening
  - Compassion
  - Flow
  - Open
  - Comfortable

- New
  - Compassion
  - Care
  - Calm
  - Communication
  - Listener
  - Empathetic
  - Multitask
  - Flow
- **Luxury Experience: Delivery on promise of a brand's name**
- **Designing delivery on the promise of a brand**
- **Factors of Influence on Patient Experience**
- **Understanding the patient response**

Appendix I: How to Analyze a Patient Journey Process Map



Appendix J: Demographic Profile of Survey Respondents

Variable		Count Total	Percent Total	Count Original	Percent Original	Count New	Percent New
Gender							
	Male	0	0%	0	0%	0	0%
	Female	67	99%	18	94.70%	49	100%
	Trans male	0	0%	0	0%	0	0%
	Trans female	0	0%	0	0%	0	0%
	Gender queer	1	1%	1	5.30%	0	0%
	Agender	0	0%	0	0%	0	0%
	Other	0	0%	0	0%	0	0%
	Refused to respond	0	0%	0	0%	0	0%
Age							
	Older than 75	1	1%	1	5.30%	0	0%
	60-75	2	3%	0	0%	2	4.10%
	45-59	4	6%	3	15.80%	1	2.00%
	30-44	20	29%	6	31.60%	14	28.60%
	18-29	41	60%	9	47.40%	32	65.30%
	Refused to respond	0	0%	0	0%	0	0%
Average length of time							

spent in healthcare unit							
	Less than 1 hour	39	57%	12	63.20 %	27	55.10 %
	1-3 hours	24	35%	5	26.30 %	19	38.80 %
	4-6 hours	0	0%	0	0%	0	0%
	7-9 hours	1	1%	0	0%	1	2.00%
	9-12 hours	1	1%	0	0%	1	2.00%
	More than 12 hours	0	0%	0	0%	0	0%
	Refused to respond	3	4%	2	10.50 %	1	2.00%
Visit frequency to healthcare unit							
	Once a year	10	15%	4	21.20 %	6	12.20 %
	A few times a year	51	75%	15	78.90 %	36	73.50 %
	Once a month	1	1%	0	0%	1	2.00%
	2-3 times a month	0	0%	0	0%	0	0%
	Once a week	0	0%	0	0%	0	0%
	2-3 times a week	0	0%	0	0%	0	0%
	Daily	0	0%	0	0%	0	0%
	I don't know	5	7%	0	0%	5	10.20 %

	Refused to respond	1	1%	0	0%	1	2.00%
Employment Status							
	Employed full-time	29	43%	5	26.30 %	24	49.00 %
	Employed part-time	15	22%	6	31.60 %	9	18.40 %
	Unemployed	15	22%	3	15.80 %	12	24.50 %
	Temporarily laid off	3	4%	1	5.30%	2	4.10%
	Retired	1	1%	1	5.30%	0	0%
	Other	3	4%	1	5.30%	2	4.10%
	Refused to respond	2	3%	2	10.50 %	0	0%
Income (yearly)							
	Less than $15,000	14	21%	2	10.50 %	10	20.40 %
	$15,000-less than $30,000	16	24%	2	21.10 %	11	22.40 %
	$30,000-less than $45,000	9	13%	5	26.30 %	6	12.20 %
	$45,000-less than $60,000	7	10%	3	15.80 %	6	12.20 %
	$60,000-less than $75,000	5	7%	1	5.30%	4	8.20%
	$75,000-less than $90,000	2	3%	1	5.30%	2	4.10%

	$90,000 or more	6	9%	3	15.80 %	3	6.10%
	Refused to Respond	9	13%	2	10.50 %	7	14.30 %
Education							
	Grade school	1	1%	0	0%	1	2.00%
	High School	12	18%	2	10.50 %	10	20.40 %
	Some college	10	15%	3	15.80 %	7	14.30 %
	College	30	44%	8	42.10 %	22	44.90 %
	Graduate school	11	16%	4	21.20 %	7	14.30 %
	Refused to respond	4	6%	2	10.50 %	2	4.10%
Ethnicity							
	White/Caucasian	18	26%	9	47.40 %	9	18.40 %
	Black/African-American	20	29%	0	0%	20	40.80 %
	Asian/Pacific Islander	5	7%	2	10.50 %	3	6.10%
	Native American/Alaskan Native	2	3%	4	0%	2	4.10%
	Multiracial	7	10%	1	5.30%	6	12.20 %
	None of these	12	18%	5	26.30 %	7	14.30 %

	Refused to respond	4	6%	2	10.50 %	2	4.10%
Hispanic background							
	Yes	20	29%	5	26.30 %	15	30.60 %
	No	44	65%	11	57.90 %	33	67.30 %
	Refused to respond	4	6%	3	15.80 %	1	2.00%