Visioning a Hospitality-Oriented Patient Experience (HOPE) Framework in Healthcare

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Abstract

Purpose: This paper considers the question: what would happen if healthcare providers, like their counterparts in the hospitality industry, adopted the principles of customer experience management in order to facilitate a more holistic and personalized patient experience? It proposes an alternative vision of the patient experience by adding to an emerging hospitality-healthcare literature base, this time focusing upon customer experience management. A hospitality oriented patient experience (HOPE) framework is introduced, designed to enhance the patient experience across all the touchpoints of the healthcare journey.

Design/methodology/approach: This is a conceptual paper which draws upon three distinct literatures: hospitality literature; healthcare literature; and customer experience management literature. It utilizes this literature to develop a framework, the HOPE framework, designed to offer an alternative lens to understanding the patient experience. The paper utilizes descriptions of three unique patient experiences, one linked to chronic pain, a second gastro issues, and a third orthopaedic issues, to illustrate how adopting the principles of hospitality management, within a healthcare context, could promote an enhanced patient experience.

Findings: The main theoretical contribution is the development of the HOPE framework that brings together research on customer experience management with research on cocreative customer practices in healthcare. By selecting and connecting key ingredients of two separate research streams, this vision and paradigm provides an alternative lens into ways of

addressing the key challenges in the implementation of person-centered care in healthcare services. The HOPE framework offers an actionable roadmap for healthcare organizations to realize greater understanding and to operationalize new ways of improving the patient experience.

Originality/value: This paper applies the principles of hospitality and customer experience management (CEM) to the domain of healthcare. In so doing it adds value to a hospitality literature primarily focused upon extensive employee-customer relationships. To a healthcare literature seeking to more fully understand a person-centered care model typically delivered by a care team consisting of professionals and family/friends. And to a customer experience management literature in hospitality which seeks to facilitate favorable employee-customer interactions. Connecting these separate literature streams enables an original conceptual framework, a hospitality oriented patient experience (HOPE) framework, to be introduced.

Keywords: customer experience management; person-centered care; cocreation; shared value; multi-stakeholder experience design.

Introduction

In the developed world, advanced healthcare systems have been credited with many accomplishments that have cured diseases, eased suffering, and prolonged the lives of millions of patients. However, while contemporary healthcare systems have made tremendous advances in addressing complex medical issues, there remains work to be done to fully attend to the nuances of the patient experience (Seuss and Mody, 2017). That is, while contemporary healthcare systems have made great strides forward in the treatment of disease through advancements in diagnostics, surgical processes, and technology, there is still much to be gained in the implementation of these advancements when it comes to caring for the cognitive, affective, emotional, and social needs of the patients that receive the treatment (Berry and Bendapudi, 2007; Kandampully *et al*., 2018). Whilst a changing healthcare landscape contributes to this, often missed in associated narratives is that such needs impact not only upon the patient experience, but also serve to frustrate the ability of a caring profession, themselves responding to a 'calling' (Duffy and Dik, 2013), to successfully execute their role.

In responding to this, one area of growing interest in the clinical literature is examining the role that hospitality services might play in the patient experience. Steele *et al*., (2015) explored the application of service science to improving the patient experience through a pilot study of radiology. Zygourakis *et al*., (2014) sought insights from the hotel industry into caring for neurosurgical patients. Arguing that both hotels and hospitals share many core characteristics, these authors outline opportunities to leverage patient satisfaction, in turn improving patient experiences and overall wellbeing. Slatcha (2018) questioned what radiologists might learn from hospitality professionals, particularly in relation to customer service, citing digital technology applications as a way forward. Whilst Suess and Mody (2018) examined service design, particularly the influence of servicescape elements including

atmospherics, service delivery, physical design and wayfinding upon patients' overall satisfaction with healthcare experiences concluding that each had a significant impact upon patients' loyalty intentions and willingness to pay out of pocket expenses. Another angle contributing to understanding of the patient experience is offered by Vogus and McClelland (2016) who apply customer experience and service quality learning to the healthcare context.

The competitive nature of the hospitality industry (particularly the lodging and accommodations sector) forces organizations to place the customer experience at the heart of strategic decision making (Bharwani and Jauhari, 2013; Kandampully *et al*., 2018; So and King, 2010). The idea of emphasizing the customer experience in organizational decision making is referred to in the marketing literature as customer experience management (CEM) (Berry *et al*., 2002; Homburg *et al*., 2017). Among other things, the CEM framework emphasizes a customer touchpoint journey that is integrated throughout the consumption process (Homburg *et al*., 2017). Accordingly, this paper proposes a framework for healthcare service provision that utilizes the principles of CEM in order to facilitate a more holistic and personalized patient experience. In so doing, the paper offers a theoretical lens onto complex, multi-stakeholder settings and practical insights into opportunities to further improve healthcare outcomes through enhanced doctor-patient interactions.

In order to better understand the potential applicability of CEM in the healthcare industry it is necessary to appreciate the particular characteristics of the healthcare environment. According to Lee *et al*., (2010, p. 4), "health care delivery is an extreme work context characterized by the unique work condition of risk of patient death as a work outcome". The Industrial Revolution was a pivotal moment in the development of modern day healthcare systems (Porter, 1999) that fed an industrial approach to medical service provision in which hospitals and other providers produced a product that consumers were then allowed to consume as needed. However, healthcare is not a commodity that can be

manufactured. Healthcare professionals do not automatically associate with the notion of being service providers, and patients are not consumers. Healthcare providers are motivated by a calling to heal. Patients are unique human beings with equally unique biological and psychological needs. Accordingly, healthcare systems should not be seen as manufacturers that produce commoditized industrial output, but as high-touch interactions creating personalized solutions to unique (and highly complex) problems across a wide array of organizational stakeholders. Adopting this lens opens opportunities for healthcare systems to benefit from a focus upon CEM, both strategically and culturally (Homburg *et al*., 2017). Accordingly, this paper builds upon clinical interest in hospitality services by introducing a hospitality oriented patient experience (HOPE) framework. This framework represents a hospitality-based, CEM-driven approach to healthcare provision in which patients and care providers/staff work together to enhance individual patient's experience across all the touchpoints of the healthcare journey.

In addition to drawing from the CEM literature, the HOPE framework adopts many of the existing principles of patient-centric, person-centered care. The Institute of Medicine (IOM) (2001) defines person-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." This approach to care is positioned as a dynamic relationship among multiple stakeholders that includes patients, family and friends, doctors, nurses, technicians, dietary staff, and a host of other support, all of which represent an essential aspect of the healthcare experience for the patient. The HOPE framework sees each stakeholder in the healthcare provision system as an actor that has the capacity to influence the patient experience in a meaningful way. Further, this framework proposes that when all actors work together to create a shared vision of the patient experience, additional value will

accrue not only to the patient, but throughout the entire system, benefitting all actors accordingly.

Many notable healthcare organizations including The Mayo Clinic (Berry and Seltman, 2008), the Cleveland Clinic (Small, 2018), and newer entrepreneurial organizations such as Cancer Treatment Centers of America (EHL, 2019) have been successfully implementing patient-oriented care systems to great effect for many years. These, and other organizations, have for some time borrowed ideas from hospitality, and a number of hospitals have worked with groups such as Ritz-Carlton, Four Seasons, and Disney on training and other initiatives. The Montefiore Health System in New York for instance employs a patient experience and customer experience director tasked with embedding hospitality features into healthcare (West, 2018). The Henry Ford West Bloomfield Hospital in Detroit adopts a similar strategy (Weed, 2016), whilst the Farrer Park Company in Singapore offers an integrated healthcare and hospitality complex, 'Connexion', built upon the delivery of hospital, hotel, food and retail, training and education and health promotion and screening services (The Farrer Park Company, 2016). In these, and similar organizations, the principles of CEM often play an important role in service provision.

However, organizations such as these are still not the norm. Accordingly, the purpose of this paper is to propose a hospitality-oriented patient experience system that is equally accessible (from an implementation standpoint) to all healthcare systems. As such, the HOPE framework should be looked at not as an operational expense (on the provider end), or as a luxury service (on the patient end) that can only be implemented by raising the costs of healthcare. Rather, in accordance with the tenets of CEM, the HOPE framework should be seen as a cultural mindset that emphasizes personalized touchpoint management at all stages of the individual healthcare experience (Homburg *et al*., 2017) through the implementation of ideas from hospitality-oriented CEM that are not necessarily expensive, but can have

measurable impacts. It represents a vision, a direction to a way forward, not necessarily a solution to existing problems. This vision is applicable to multiple stakeholders and multiple circumstances. The implementation of the framework will be country specific, influenced in part by the healthcare structures operating in the geographical footprint. It will also be condition specific influenced by the nature of the healthcare presentation and consequential healthcare response, be it curative, treatable, or palliative care.

Conceptual Background

The constitution of the World Health Organization in 1948 represents a pivotal moment in the evolution of modern day healthcare. A global definition of health was introduced as "a complete state of mental, physical and social well-being and not merely the absence of disease or infirmity" (WHO, 1948 cited in Huber *et al*., 2011). The definition of health in this manner set the scene for a flurry of changes in policies and practices in the healthcare system which, at the time, were founded in the traditional medical model (TMM) which focused primarily on disease management. In the TMM landscape, the healthcare system's architecture was predicated on services *being delivered to* a patient (often anxious, sometimes fearful) by a medical doctor (McColl-Kennedy *et al*., 2017a). Accordingly, the patient became a bystander in their treatment, *a recipient of* the wisdom and prowess of the expert, and complex decisions related to their treatment were made based on procedures and protocols developed within stringent legal regulations. Scenario one typifies the practical norm (see Table 1). Seventy years later, while complex patient needs, rigid protocols/regulations, and reliance on skilled providers are still ingrained parts of the healthcare system, the architecture of this system has evolved from the TMM into a more person-centered care model intent upon delivering a service which is "holistic, flexible, creative, personal and unique … is not reductionist, standardized, detached and task-based.

Not unless the person wants it to be" (Edvardsson, 2015, p. 66). Scenario 2 (see Table 1) typifies this transition. The dialogue moves from prescriptive in Scenario 1, "You need to... I need to…" to inclusive in Scenario 2, through the introduction of a decision-making language of options enabling personalized choice, "You could consider... **How would you like to progress**?"

[Insert Table 1 about here]

This shift toward patient-centric care is true both in practice, as well as in the medical and healthcare literature. For example, in July 2019, searches using Google Scholar for keywords "patient-centered" and "person-centered" in the four most prestigious medical journals (*New England Journal of Medicine*, *Journal of the American Medical Association*, *The Lancet*, and *The British Medical Journal)* returned more than 2,800 articles. There has been a steady growth in the number of publications related to patient-centered care in the past four decades, indicating that the patient-centered clinical model has moved from the periphery to center stage of research (Bergeson and Dean, 2006).

The idea of patient-centered care emphasizes several core activities during the provision of care. Specifically, patient-centered care (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients' world – that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor (Stewart, 2001, p. 445, cited in Stewart *et al*., 2003). However, while the healthcare system has undoubtedly evolved towards person-centered care over the course of the past several decades, it remains a work in progress, complicated in part by a system predicated upon an architecture measuring success in terms of performance targets (e.g., how many elective surgeries are performed per quarter) as opposed to incentives that target

specific patient needs. Adopting a consumer centric, service research lens, allows us to shift our appreciation of care into a holistic understanding of the patient as a cognitive, emotional, and social being. It celebrates the individual health journey as relational rather than transactional, and as a process of care cocreation that takes place among multiple stakeholders with diverse needs.

A Hospitality-Oriented Patient Experience (HOPE) Framework

The HOPE framework (see Figure 1) is the result of an examination and further conceptualization of research on both the healthcare and hospitality industries to identify areas of overlap that can be used to achieve a symbiosis between existing knowledge in these research fields. The purpose of proposing a hospitality-and CEM-based approach to healthcare is to ensure that, in addition to enhancing the patient experience, opportunities to gain organizational competitiveness might also be realized. Thus, the HOPE framework is not merely another push for closer attention to the patient's personal/medical needs, it is a business strategy that suggests that the healthcare organizations that can best meet these needs will achieve competitive advantage. Specifically, this approach integrates the ideas of (1) a shared vision of a given healthcare experience between the patient and his/her caregivers and (2) the design and implementation of this experience. A successful implementation of the HOPE framework at the institutional level is proposed to positively affect several of the most important healthcare stakeholders including the patient (and his/her family), the care providers (e.g., doctors, nurses, etc.), the healthcare organization, and the community it serves.

(Insert Figure 1 about here)

As implied by its name, the HOPE framework is rooted in contemporary perspectives of hospitality service provision, drawing particularly upon CEM. The application of CEM in

hospitality, whilst acknowledged as pivotal to gaining competitive advantage (Palmer, 2010), has been under-researched. Responding to this shortfall, Kandampully *et al*., (2018) synthesized associated literature into a research agenda opening up opportunities for the application of CEM beyond hospitality. A key aspect of CEM in hospitality is to facilitate favorable employee-customer interactions (Bowen and Schneider, 2014). Employees who perceive a strong service climate are motivated as well as enabled to engage in interpersonal interactions to create memorable, unique and positive customer experiences (Kandampully *et al*., 2018). Similarly, thoughtfully designed interpersonal interactions before, during and after medical visits are necessary for gaining a good understanding of the unique medical history and condition, social determinants, and goals of the person seeking care. Such contribute to building common ground, developing a personalized care plan and fostering a long-term relationship.

Likewise, service design has long been recognized as a core element of the customer experience in hospitality. Specifically, servicescape elements (i.e., facility aesthetics, layout, ambience, and wayfinding), service product design, and social factors are integral to the hospitality experience (Kandampully *et al*., 2018; Ryu and Jang, 2008; Nixon and Rieple, 2010). These factors impact the functional and experiential dimensions of interactions between the patient and the care team, as shown by the emerging literature on health environment and design (Shepley and Song, 2014).

Based on this discussion, the HOPE framework leverages three aspects of hospitality service provision. To begin, it emphasizes building a culture of CEM that enables a holistic understanding of the patient as a cognitive, emotional, and social being. Second, it acknowledges the importance of creating a service environment in tune with the cognitive, emotional and social needs of the patient and their family/friends to ease and support the

healing journey. Third, it proposes a multi-stakeholder experience design centered on care cocreation.

By attending to these three key principles of hospitality management, the HOPE framework aims to provide an integral theoretical foundation for solving problems in a wide variety of healthcare settings. As follows each of the attendant aspects of the HOPE framework are discussed in greater detail, beginning with the central concept of the shared vision. Rather than being passive recipients of healthcare services, this shared vision aligns with contemporary person-centered care literature which emphasizes the importance that the person receiving care be active (Gallan *et al*., 2013) and engaged in value cocreation (McColl-Kennedy *et al*., 2012, p. 371) to improve their wellbeing (McColl-Kennedy *et al*., 2017b).

Shared Vision: The core interaction in healthcare is between patients and care providers, such as physicians and nurses; but it can also involve patients' friends and family and external service providers such as rehabilitation centers and pharmacies. The shared vision of the HOPE framework is for patients and the care team to engage in cocreative practices for improved wellbeing. Janamian *et al*., (2016) explored the benefits of consumer value cocreation in health-care concluding that they are entwined with increased efficiencies; improved healthcare outcomes; increased trust; reduced healthcare costs to both the patient and system; increased value and medical research; increased satisfaction; and adherence to treatment regimes. Cocreative practices include engaging with basics, coproducing, colearning, diet and exercising, changing behaviors and distracting from illness (McColl-Kennedy *et al*., 2017a). Although some of the cocreative practices focus on medical interventions, others focus on activities directed to wellbeing improvement and prevention. For medical interventions, hospitality can have an indirect influence on the practices, while

for activities directed to improving wellbeing the influence is more direct. These ideas are considered more fully in a discussion of the two key constituents in charge of creating a shared vision: the patient and the care provider.

Patients: The HOPE framework is responsive to patient needs. It recognizes the changing healthcare landscape today which has seen a move from passive to active consumption (see Pasman *et al*., 2009). It shifts healthcare users from "being 'users and choosers' to becoming 'makers and shapers' of services" (Janamian *et al*., 2016, p. 12) and is responsive to the changing patient health trends dominating society today. These include the following: Globally, life expectancy has increased by almost 20 years over the last five decades. Overall morbidity rates have not changed. Non-communicable diseases now account for over two-thirds of all global deaths, and are set to rise (WHO, 2012). The aging population and projected death boom in the next two decades (NHPCO, 2015) indicates an increasing demand for palliative care services in the longer term (Bone *et al*., 2017; Clark *et al*., 1997). It recognizes that as patients are now living longer with more complex needs which require medical interventions (Pollock, 2015) the nature of the services sought are also in flux. This is compounded by the greater employment opportunities for family members, alongside smaller and more scattered families which are fuelling a demand for on-site healthcare services (Clark *et al*., 1997; Corner and Dunlop, 1997). Add to this the higher level of consumer expectations among baby-boomers who are moving into the years of higher health services consumption, for which the demand for more consumer-responsive services will only increase. An example of patient cocreation is the Patient Innovation Open Platform (https://patient-innovation.com), which is designed for patients and caregivers to share solutions they have developed to help them cope with the challenges imposed by a disease or health condition.

Care providers: The HOPE framework is responsive to a changing healthcare landscape impacting upon frontline staff in many developed nations. These changes are encapsulated in the acronym VUCA (Bennett and Lemoine, 2014). Global competition and *volatile* economic conditions have prompted changing work structures and *uncertainty* for organizations and individuals, tasked with providing personalization at a time of diminishing resources, workforce in particular. So *complex* and without precedent are the challenges presenting that *ambiguity* has emerged, fed by the blurring of boundaries between work and non-work, and technological advances more generally, telehealth and telemedicine for instance (Quinn *et al*., 2018). With the need to accommodate such a changing financial and demographic landscape comes the need for a cultural change in the way healthcare services are delivered. Such is pivotal to the HOPE framework which has the capacity to champion the need to personalize healthcare services, accommodate changing regulations, workforce challenges and spiralling consumer expectations of healthcare.

Enabling cocreation practices is pivotal to the HOPE framework. To influence cocreative practices, it is essential to consider issues related to both experience design and experience implementation. McColl-Kennedy *et al*., (2017b) suggest that health care providers can enhance patient wellbeing by recognizing, supporting, and eliciting positive patient and family emotions. The specific actions that can be taken to provide conditions under which patients can emotionally flourish include: improving the design of the physical environment (servicescape); purposefully designing service processes to provide emotionally supportive actions; and, re-imagining employees' roles in order to create a supportive culture for all people involved in care provision.

For example, some of this may be facilitated by the support staff who fill the so-called “hotel functions” (housekeeping, maintenance, nutrition, etc.) in hospitals and other

healthcare organizations. Progressive hospitality management purposefully engages the frontline by promoting a supportive culture of equality and energizing every part of the organization toward increasing the system overall performance and ultimately guest experience (Kang, Gating and Kim 2015). Transferring this learning into the healthcare context means developing a culture that acknowledges the entire care team's extraordinary efforts due to their perceived calling of work (Duffy and Dik, 2013) and highlights the support staff's instrumental role in creating a more pleasant healing environment (Slåtten and Mehmetoglu, 2011), among others. In addition to a supportive culture, providing the support staff with relevant training in noticing and empowering them to report on changes could help avert serious situations and may help reduce the burden on an already busy clinical staff due to personnel shortages (The Lancet, 2018). Such investment in cultures and human resource management requires a cultural mindset shift instead of financial resources, yet the potential gain in positive emotion among staff could spread to the patient and family by increasing cooperation and decreasing conflict (Barsade, 2002).

Experience Design: The patient experience (PE) can be defined by adapting the definition of a customer experience from Homberg *et al*., (2017, p. 384) and Lemon and Verhoef (2016, p. 70): PE is a multidimensional construct that is holistic in nature and includes the patient's sensorial, affective, cognitive, relational, and behavioral responses to a healthcare provider by living through a journey of touchpoints along pre-treatment, treatment and post-treatment situations. The entire patient journey from pre-treatment to treatment to post-treatment entails touchpoints which might involve multiple health providers (Lemon and Verhoef, 2016). Touchpoints are anything that affects the patient's experience (Calder and Malthouse 2005, p. 357) and could include pre- and post-treatment emails, phone calls, text messages, and other instructions, and the treatment itself including interactions with personnel and all aspects of the design of the physical space.

Homburg *et al*., (2017, p. 384) go on to define customer (patient) experience management (PEM) as consisting of three components: "the cultural mindsets towards [PEs], strategic directions for designing [PEs], and firm capabilities for continually renewing [PEs], with the goals of achieving and sustaining long-term [patient] loyalty." It is these three components that are included in the shared vision part of the HOPE framework. There needs to be a clear statement of the vision that is communicated to the different stakeholder groups. The purpose of the vision is, in part, to maintain thematic cohesion, consistency, context sensitivity and connectivity of touchpoints. By firm capabilities, Homburg *et al.*, (2017) gives different sub-capabilities. One is touchpoint journey monitoring, where measures are recorded and monitored to ensure that they are in accordance with the health provider's goals. Another is touchpoint prioritization, where monetary and human resources are allocated to different touchpoints.

While CEM has been a growing topic of importance over the past two decades and has been used in many different industries, applying it to the healthcare setting is uniquely challenging because of the number of stakeholders involved. As the HOPE framework shows, stakeholders include the patient, family members and friends, and medical professionals such as primary care physicians, specialists, nurses, therapists, and pharmacists. There are also administrators within the care facility as well as a variety of payment organizations such as insurance companies and government agencies to take account of. There may also be legal restrictions and stipulations that could vary by geography. Healthcare facilities are also embedded in communities and a health organization may have community outcomes as part of its mission. Complicating the task of experience design further, there are often life-or-death situations, ones where there are only undesirable choices, or ones that are physically, emotionally and mentally draining creating fatigued stakeholders. It is difficult to think of

another industry with as many stakeholders and other complexities, making patient experience design especially challenging.

Given these complexities it is more useful to conceptualize this as a problem of *multi-stakeholder experience* design rather than the (single-stakeholder) customer experience design problem discussed in the literature. The notion of multiple stakeholders is central to the work of Line *et al.,* (2019) who examined three literatures, market orientation, a core concept in marketing strategy and a critical determinant in firm performance, stakeholder theory and shared value, and service dominant logic to better understand the incidence of a multiple stakeholder market orientation. In multi-stakeholder situations, decisions must be made that balance the needs (or utility) of one group against those of another. The basic idea for a particular decision is to determine how much utility different solutions provide each of the stakeholders and how much weight to give to the utility of different stakeholders. There could be *constraints,* such as government or insurance provider regulations, that make certain decisions infeasible. Selecting the decision that produces the greatest weighted utility across the stakeholders is most desirable.

Most research to date adopts a consumer perspective of the customer experience (e.g., Hirschman and Holbrook, 1982; Homburg *et al*., 2017; Pine and Gilmore, 1998). Kranzbühler *et al*., (2018) suggest that customer experience management includes: (1) identifying ways to design and manage interactions with customers; and (2) analyzing how the servicescape and employees influence customers' experiences. These ideas are discussed in turn as follows.

Experience Implementation: The governance and operation of healthcare systems regularly places the patient experience as a central marker of quality and standards. Collecting patient feedback about their experiences, is seen as a necessary, desirable, even

essential feature of improving the quality of healthcare delivery. It is positioned as a function to improve patient and clinician communication, minimize patient dissatisfaction and enhance patient empowerment. It is seen as a mechanism for changing healthcare processes, building trust and confidence and for improving clinical performance with the ultimate goal of achieving better healthcare outcomes (Beattie *et al.,* 2014). Such discourse is pivotal to 'person-centered' care.

There are no shortages of traditional survey type tools which solicit information on the patient experience e.g. the Hulka Patient Satisfaction with Medical Care Survey, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Press-Ganey, and The Friends and Family Test (UK). The Health Foundation (2013) also detail methods of descriptive feedback which providers might consider: interviews, critical incident techniques, patient narratives and observation. There are also multiple unsolicited opportunities for the patient to provide feedback, particularly online, as evidenced by sites such as www.iwantgreatcare.org and www.patientopinion.org.uk.

There are entire organizations devoted to understanding the patient experience, the Picker Institute (see www.pickereurope.org) just one example, and others that seek to work with the healthcare community such as the Beryl Institute (see https://www.theberylinstitute.org/). There are on-site teams tasked with collecting patient experience data in different parts of the healthcare sector (e.g., Hankins *et al*., 2007) and teams collecting data at an individual and population level. There are academic researchers working alone and in conjunction with health professionals to explore the area (Beattie *et al*., 2014). There are no end to studies examining the role of clinical staff (Kreofsky, 2013) and utilizing any number of increasing ways of capturing data, in-person, online, real time, asynchronous. Yet even with all this data being collected, studies seldom ask patient-centric,

market-oriented questions. Consequently, questions exploring whether family members could park, or the patient digest the food distributed, whether the patient could make contact with loved ones whilst an in-patient, or access a clinician out-of-hours, whether the relative could eat on-site during the evening whilst awaiting the outcome of lengthy investigations, or the in-patient seek support at 3am when frightened, are largely absent in existing studies. Adopting a CEM lens provides a vehicle to capture these insights and complement existing clinical understanding.

Servicescape Design: The profound impact on people as a result of their interactions with the environment has led to much research in diverse disciplines including psychology, geography, architecture, and design sciences. There is also a growing body of literature in Evidence-Based Design (EBD) and research-informed design fields for healthcare, something that can be tapped into in conjunction with hospitality-oriented servicescape design (Cama, 2009). Deep understanding has developed regarding how to align the physical surroundings, or servicescape, with experience management, thus promoting desirable behavioral responses from both customers and employees toward better experience (Bitner, 1992). In practice, service outlets such as stores and hotels have become quite adept at applying many servicescape design principles (Durna *et al*., 2015). For example, hotels have established distinct chain scales that enables customer free choice and set appropriate customer expectations about service level and amenities. Each hotel layout follows certain standards and installs clear signage to navigate a guest in an unfamiliar environment. Touchpoints such as concierge are placed at highly visible and accessible areas to encourage employee and customer interaction.

The servicescape design in a healthcare setting are faced with several unique challenges (Hamed *et al.,* 2019). The person seeking care, together with their family

members, arrive at the premise, often not by choice. Care providers share their working environment with others that are unfamiliar with the layout and are distracted by other priorities on their mind. Reducing the cognitive and emotional load on everyone involved in the service journey becomes a priority in this context. Unique opportunities exist to shift the burden of managing the behavioral responses from various stakeholders to the physical surroundings. Interventions in design improvements for instance might include adding moveable furnishings with a more patient/family-oriented design, such as an innovative chair that allows family members to sleep next to and interact with the patient (CAMA bed chair) much as the hospitality world has found innovative furnishings to improve the customer experience.

*Implementation***:** Figure 2 illustrates how the HOPE framework can aid hospitals to create better patient experiences. Descriptions of unique patient experiences from chronic pain, gastro and orthopedics patients help to exemplify this. The experiences shared here are not intended to be comparable as each are linked to entirely different healthcare presentations. Instead each serves to illustrate the need to research the healthcare journey and different touchpoints in more detail to understand the nuances of the patient experiences involved. These patient experiences have been captured using diaries (Elg *et al*., 2012) and are used in McColl-Kennedy *et al*., (2017b) to describe cocreative practices in health care. The individual patient experiences of Lina, Magnus and Frank, organized according to the HOPE framework in Table 2, demonstrates that, whilst all three patients received the medical care they needed, their employee-customer interaction experiences fell short. Each could have been improved by using principles of hospitality management. In none of the cases, the medical treatment, or the wellbeing of the patients, in a long-term perspective would have changed. Take the situation of Lina, a female patient with chronic pain. Lina received a referral to a pain clinic, but the journey to this option was complex and caused Lina and her

family distress. In a similar way, Magnus, experiencing gastro complications, endured unnecessary questions from a nurse and failed to receive the right medicine due to physician over-sight. With a focus on the patient experience, such behavior and neglect can be designed not to happen or aided by digital modules in healthcare administration systems.

[Insert Figure 2 about here]

[Insert Table 2 about here]

Discussion

This paper has proposed a vision and a paradigm, underpinned by the hospitality-CEM literature, illustrated through a new framework, the HOPE framework, designed to aid understanding of the patient experience. In particular, the HOPE framework provides a cultural mindset that prompts healthcare personnel to emphasize touchpoint management at all stages of the patient experience. Applying hospitality management learning to the provision of healthcare offers a mechanism for improving the patient experience without necessarily increasing costs. A number of implications arise from this paper including theoretical, managerial and policy implications. Each are now addressed in turn.

Theoretical implications

The interest in service research in healthcare sparked new energy with the contribution of Berry and Bendapudi (2007) and McColl-Kennedy *et al*., (2012). These studies showed that service research can add to existing knowledge in healthcare and that empirical research in this context can help to further develop existing theoretical models in service research. The main theoretical contribution in this paper, showing how CEM might apply to complex, multi-stakeholder settings, has been realized through the development of the HOPE framework which brings together research on CEM (Homburg *et al*., 2017) with

research on cocreative customer practices (McColl-Kennedy *et al*., 2017b). By connecting two separate research streams, the HOPE framework provides fresh insights into tackling the key challenges in the implementation of person-centered care in healthcare services.

In healthcare research, concepts such as patient centeredness, patient participation, shared decision-making, patient empowerment, person-centered care and collaborative care (McColl-Kennedy *et al*., 2017a) have been introduced to improve the patient experience and wellbeing. However, these existing concepts lack some of the key ingredients of CEM based on hospitality management, suggesting that the HOPE framework can work as an actionable roadmap for healthcare organizations. Service research offers unique knowledge on the role of touchpoints and servicescape in the patient experience, an area hitherto under-explored within healthcare research. Given the customer can be a patient, family member or friend, and that the patient can be sick, vulnerable and weak, opportunities exist to add to our understanding of healthcare concepts through mid-range theories designed to operationalize how to improve the patient experience. The HOPE framework, an original conceptual framework drawing together the different literature streams of hospitality, customer experience management and healthcare, presents one lens for such theoretical discussions.

Managerial implications

The HOPE framework is built upon a base of CEM as applied thus far primarily in hospitality and service research. This paper applies the principles of CEM to a healthcare context which is fundamentally different to former applications. It is populated by a workforce 'called' to heal. A workforce who address complex, life changing circumstances which might present in unique ways. This work involves actions which may necessitate pain and consequence in the pursuit of a 'successful' outcome. A 'successful' outcome might not necessarily mean a cure. It is delivered by multiple stakeholders, the combination specific to the presentation under scrutiny, influenced also by the composition of the healthcare

economy, be it private-led or public-led. The key now is to marry the different CEM contextual backdrops to best support the patient experience. The appetite to achieve this is growing in the healthcare literature as evidenced by the work of Steele *et al.,* (2015), Zygourakis *et al.,* (2014), Slatcha (2018) Suess and Mody (2018).

A central question for healthcare professionals to consider is what does the HOPE framework bring to the patient experience conversation that is not already known? Adopting a CEM approach introduces touchpoints to the patient experience conversation. These touchpoints extend beyond a snapshot clinical encounter and, as Figure 2 illustrates, involve experiences pre, during and post visit. This extended journey introduces multiple touchpoints and multiple-stakeholders into the patient experience conversation. These might include, non-clinical amenities, transportation, parking, caregiving, booking systems and billing, co-ordination between pharmacies and clinicians for instance. Examining the patient experience cognizant of these different touchpoints would provide another form of intelligence into means of optimizing patient wellbeing.

This is a considerable opportunity, but also task for professionals. As Table 2 illustrates, the healthcare journey is person specific. The needs and experiences of a patient attending for an elective surgery where the focus is upon cure, will inevitably be considerably different to the needs and experiences of a patient with a chronic condition where the focus is upon treatment and management of the condition rather than cure. Similarly, the needs and experiences of a patient receiving treatment to cure a condition such as influenza for instance, will be considerably different to those of a palliative care patient where holistic care is prioritized.

The picture is complicated further when we look at the characteristics of different conditions. For example, chronic pain management primarily occurs outside the healthcare encounter, and therefore demands a high degree of patient activation and engagement to

ensure elevated quality of life. Addressing lifestyle factors and having a focus on discussing these issues demands a different kind of provider relationship - one that requires trust and free exchange of information (e.g., about lifestyle and social determinants of health) which may be a far more intensive experience than a more straight forward acute surgery, where 'success' may be more related to the quality of the clinical outcome, versus the nature of the interpersonal service experience.

The HOPE framework is a vision, a paradigm, a cultural mindset, built upon the notion of touchpoint thinking. It encapsulates multiple components of the healthcare servicescape and in so doing has the potential to be applied across these quite different, distinct healthcare circumstances. It does not detract from the primary focus of healthcare, contributing to the healing (where possible) and wellbeing of the patient, but is designed to offer an alternative, complementary lens onto viewing the patient experience. Adopting a journey approach, it offers the potential to uncover opportunities to enhance patient experiences without necessarily incurring significant cost:

- Take for instance a patient experiencing terminal cancer. The quality of the patient experience in palliative care may be significantly enhanced by the appreciation that appointments later in the day are easier for this particular patient to attend due to their circumstances. The clinical encounter does not alter, but the patient experience is enhanced by the attention to personal detail. In turn the capacity of the patient to attend their appointment is likely increased, reducing, in turn, often high levels of wastage experienced by appointment 'no-shows'.
- Take for instance a private-healthcare system where patients pay for healthcare themselves. Attention to different touchpoints of the healthcare experience might identify revenue streams that can be pursued to enhance the

care of patients and their families, additional food and beverage resources on site for instance, or high end amenities for attending family members to use during visiting. Again this will not necessarily have any direct impact upon the clinical encounter, but may make a considerable difference to the patient experience where a patient is anxious about the impact of their health circumstances upon their loved ones.

Research shows that attention to detail can have a large effect upon the customer experience (Bolton *et al.*, 2014). The HOPE framework provides a means of uncovering this experience detail by teasing out what different factors impact upon the patient experience across the healthcare journey and how different healthcare encounters may necessitate different actions. It offers a further insight into person-centered care, this time providing a mechanism to better appreciate both the multiple touchpoints, alongside the multiple stakeholders, who contribute to the realization of this care.

Policy Implications

An important factor that can drive changes in organizational behavior is the impact of policy decisions on a national level. One policy change example in the US healthcare system is the adoption by the Centers for Medicare and Medicaid Services (CMS) of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. While for many years hospitals had conducted internal patient satisfaction surveys with groups like Press-Ganey, there was no standard survey administered to all hospitals and reported publicly. The introduction of the HCAHPS survey changed this. According to CMS, "the HCAHPS survey asks discharged patients 29 questions about their recent hospital stay. The survey contains 19 core questions about critical aspects of patients' hospital experiences (communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness

and quietness of the hospital environment, communication about medicines, discharge information, overall rating of hospital, and would they recommend the hospital)".

Because of its public reporting of data to consumers, and the fact that a portion of government reimbursement is tied to the results, the HCAHPS survey has generated a great deal of interest in improving patient experience and quality performance (Centers for Medicare and Medicaid Services, 2019). This reporting enables a national comparison of hospital performance. One firm that had a high degree of success with its advisory clients noted that its "Partner Hospitals Outperform the Nation by 20 Percentile Point and Improve Nearly Three Times Faster on HCAHPS" (Studer *et al.*, 2010).

One knock on consequence of this policy change has been a move by hospitals to seek advice from consulting firms. Changes in hiring practices have also been observed including a move towards the employment of individuals with hospitality backgrounds to serve as chief experience officers, chief executives, advisors etc. Hospitality trained individuals have also been hired to apply their skillsets to specific areas such as the hospital support services, sometimes referred to as the "hotel functions". One example of the latter is a position within Hackensack University Medical Center/Meridian Health System held by a former executive with Ritz Carlton, whose title is Vice President, Hospitality Services. The HOPE framework provides a common reference point for this changing staffing base. It identifies the key stakeholders within the healthcare relationship who are all likely to contribute to the realization, or otherwise, of patient experience strategies.

Conclusion

This conceptual paper set out to examine what would happen if healthcare providers, like their counterparts in the hospitality industry, adopted the principles of CEM in order to facilitate a more holistic and personalized patient experience. In answering this question a

new vision and paradigm was introduced, encapsulated with a new framework, a hospitality oriented patient experience (HOPE) framework. This framework represents a hospitality-based, CEM-driven approach to healthcare provision in which patients and care providers/staff work together to enhance individual patient's experience across all the touchpoints of the healthcare journey. It is underpinned by three distinct literatures: hospitality literature; healthcare literature; and CEM literature and offers an alternative lens on to some of the problems associated with the patient experience.

By utilizing the descriptions of three unique patient experiences, one linked to chronic pain, a second gastro issues, and a third orthopaedic issues, ways in which the principles of hospitality management might be adopted within a healthcare context to promote an enhanced patient experience are visioned. This vision, premised upon an evolving person-centered model of healthcare, is illustrated through the HOPE framework which shows how a shared-responsibility model may be implemented. This framework celebrates the expertise of the care team in attending to the ailment and treatment, including also the patient and family in the conversation to enable a holistic appreciation of the condition and the social determinants that affect access and adherence to treatment regimes. Adopting such an approach in turn offers several fruitful areas of future research:

- How to capture relevant social determinants to support medical treatments and even prevention? Hospitality providers are financially incentivized to acquire the pillow preference of their guests and use that information to meet guest expectations at any of their properties around the world. Electronic medical records could be greatly enhanced by incorporating measures that build shared vision in the HOPE framework. One-on-one conversations at the start of the care journey should focus on understanding the patient as a cognitive, emotional and social being. Capturing and

storing related data via an adaptation of Electronic medical records could inform future care planning.

- How will disruptive technology affect the service environment, interaction and relationship between the care team and the patient/family? Robotic care workers and smart environments are emerging. The HOPE framework offers guidance on how to prioritize the integration of these technologies into the collaborative relationship between the care team and the patient/family. For example, utilizing AI technologies such as speech recognition to reduce the data entry burden on the care team and facilitate more patient/family-care team conversations to sustain shared vision over time should be a priority.
- How to build the care system that responds to changing care needs over an extended period of time? For example, a knee surgery may take two hours, but a full recovery to health may take six months with the help from many care providers. The parallel with hospitality is apparent, the entire hospitality team (concierge, housekeeping, health center, restaurant, and valet services) are well aware of how to respond to a guest's needs after she checks in with the front desk. The HOPE framework connects all care team members allowing each to anticipate and organize care. Heightened connections offers a greater potential for smooth and productive interactions throughout the healthcare journey.

Alongside these area of future research exists an agenda for the practical testing of the HOPE framework. Multiple opportunities exist here including: testing the implementation of the HOPE framework in both public (eg., UK) and commercial (e.g., US) healthcare settings; exploring it within the context of different types of health presentations, be it palliative care, ambulatory care, mental health care, emergency admissions and so forth; applying it to better support the needs of an aging population; and testing its application in helping to enable a

smoother patient flow through intersecting healthcare departments, from emergency room to discharge for instance. Exploring these areas will enable a fuller appreciation of the value of the HOPE framework, equipping it to offer an actionable roadmap for healthcare organizations to realize greater understanding and to operationalize new ways of improving the patient experience.

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Table 1: Scenarios to illustrate the development of patient-physician interaction.

Practice approach	*Traditional Medical Model: Scenario 1*	*Modern Healthcare: Scenario 2*
	Patient: *I am finding I am short of breath when climbing the stairs.* Healthcare provider: *You need to look at your exercise patterns and dietary intake. Plus roll up your sleeve. I need to take your blood pressure statistics.*	Patient: *I am finding I am short of breath when climbing the stairs.* Healthcare provider: *There could be a number of factors contributing here. You could consider working on the following. Your diet, exercise and monitoring your blood pressure**. How would you like to progress?***

Table 2: An illustration of how the HOPE Framework can face patient experiences.

Illustration	Lina (37 years)	Magnus (45 years)	Frank (67 years)
Patient Experience	Problems in care clinic, but good experience from pain clinic	Problems in care clinic, but good experience from gastro clinic	Getting surgery for hip replacement
Type of patient	Patient with chronic pain	Patient with stomach pain	Patient needing hip replacement
Personal situation	Married with three children	Married, no children	Married, with grandchildren
Shared vision between patient and care providers	Learn to live a life with pain that does not hinder normal activities.	Get rid of the symptoms from the gastrointestinal problems.	Hip replacement to be able to continue walking the dog,
Experience Design	A clinic especially designed to care for chronic pain patients.	Being questioned by the nurses if the gastro problems were real.	A quick painless surgery, and starting rehabilitation the next day.

Experience Implementation	Confirmation of the visit with information about facilities including locations of restrooms, waiting rooms and cafes. Reducing stress is important for reducing my pain.	If a physician does not have a real solution to my problems, they should be better on referring to someone that can understand my needs.	The night nurse turns on the light when coming in at night and is very rough in putting in the catheter.
Customer Experience	A feeling that the physician takes me seriously and listens to my needs.	The physician forgot to prescribe me my medication.	Satisfied with surgery, but not with treatment from one nurse.
Outcomes Patient	Learning exercises to deal with pain	Feeling betrayed by healthcare	Successful surgery
Family	Our mother will be able to play games and watch TV with us children	Cannot hold on to work leading to financial difficulties	Happy to get her husband back home
Provider	Feeling that they have helped the patient	Feeling of being inadequate	Surgeon happy, nurse not happy about complaints

Hospital	Right person getting the right care	Expensive care that is not efficient	Successful operation
How HOPE can aid patient?	HOPE Can help patients to aid in the transfer from the care clinic to the pain clinic to make it quick and effortless for the patient.	HOPE can design a better patient experience, through providing empathy and listen to the patient. Also making sure that the patient meets the right competence.	Provide a better experience during recovery from surgery. Exchange of nurse, when chemistry does not work.

Figure 1: A Hospitality-Oriented Patient Experience (HOPE) Framework

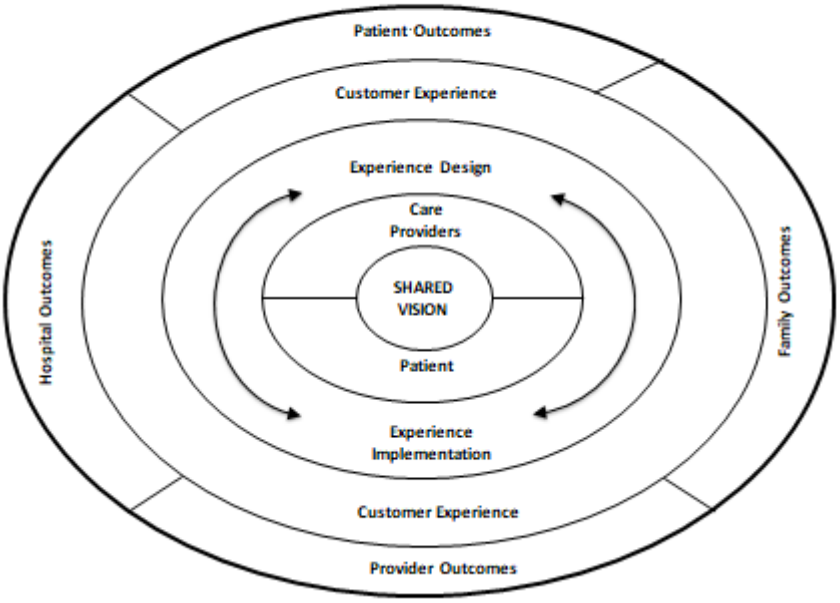

Figure 2: Application of the HOPE Framework