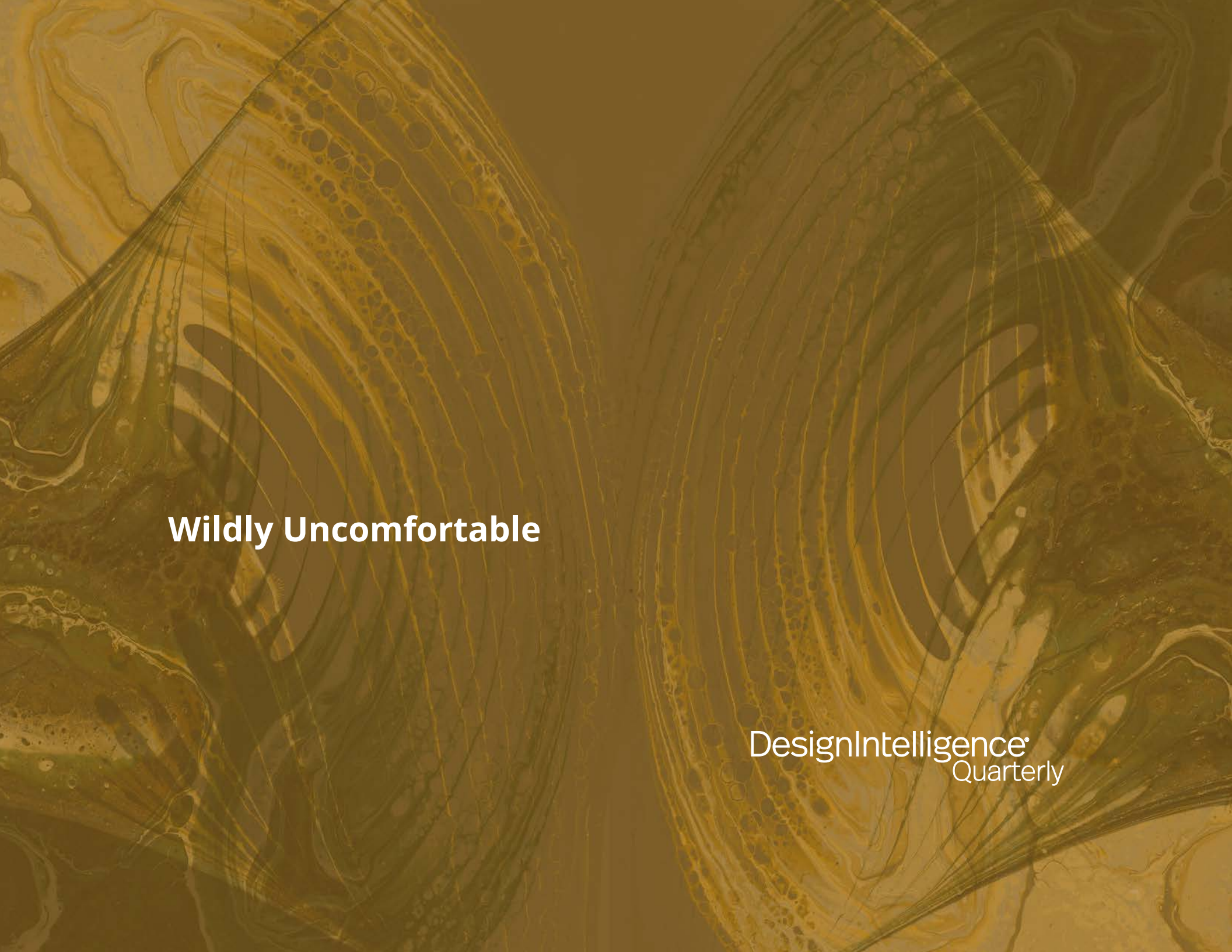

Wildly Uncomfortable

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HKS' global director of healthcare research & strategy discusses connections between research, experience, strategy and design

DEBORAH WINGLER

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DesignIntelligence (DI): To level-set for readers, your role is a unique one, atypical in the design industry, leading healthcare research and strategy for HKS globally. How do you spend your time? Describe your world.

Deborah Wingler (DW): Every day is different, which is extremely rewarding. Around 60 to 75% of the time, I'm engaging with clients or working on client projects. That can be a wide range of applied research services such as developing an experience strategy, doing current state analysis, conducting a functional performance evaluation or leading evidence-based ideation. The remainder of my time is spent on deep-dive research that focuses on strategic areas of interest for the firm. My focus is on ensuring that our applied research services are constantly being fed by things we're learning in our deep-dive efforts and that our deep-dive research is simultaneously being informed and evolving based on our client's needs.

DI: Deep-dive research is longer term, not necessarily applied, and potentially done by a different team?

DW: Most of our researchers at HKS do a combination of both deep-dive and applied research to some degree. For example, Dr. Upali Nanda has done some incredible work recently on neurogenesis that focuses on how the physical environment can help support brain health throughout the aging process. As we work on developing an experience strategy for senior living facilities, we can think meaningfully and deeply about frameworks outlined in that deep-dive research to ensure that our applied research reflects and resonates with what we have learned from our deep-dive work.

DI: How do you relate to innovation and R&D within HKS?

DW: At HKS we do them synchronously. They don't live in separate bubbles. Rather, what we are learning on projects and from client feedback informs both our deep-dive and applied research efforts so we can continue to innovate and lead with knowledge within the AEC industry.

DI: You talk about experience strategy and the intersection between research and experience. In my years in practice, we didn't do those things. There was no strategy or research. We weren't focused on experience. It was all about just us as all-knowing, singular beings — and the building. What you're doing is a far cry from the way design was taught and practiced decades ago. Can you speak to your process? How do you engage on a project? How do you bring those three aspects to your work?

DW: I would argue, maybe it's not so different. For everything we design, whether that be products, processes, platforms or environments, there's a core set of experiences are trying to create. For design to be most effective, we need to make sure that the core experiences we are creating support the outcomes we hope to achieve.

DI: In my experience, there may have been a core set of experiences we were going for, but they were tacit, assumed, not explicit. We were always focused on the building not the outcome or the experience.

DW: When you invert that thinking and first lead with deeply understanding users' needs, wants, mandates and capabilities, then you can develop an experience that enlivens users and supports the health outcomes we all humanly deserve.

In healthcare, we operate in a different context than private industry. Other industries have the luxury of valuing innovation solely based on monetization. However, in healthcare, our valuation of true innovation is based on outcomes and their level of clinical effectiveness. If we believe that the physical environment can support the healing process, then to what degree of clinical effectiveness do we believe that can happen? The onus is on us as researchers to measure that. Therefore, our measure for healthcare is in lives impacted, lives touched — and therefore evidenced in meaningful and measurable outcomes. If done appropriately, monetization will follow.

Other industries have the luxury of valuing innovation solely based on monetization. In healthcare, that's not a luxury we have. Our valuation of true innovation is based on outcomes and their level of clinical effectiveness.

DI: It's still relatively novel that you're doing any of those things. When I put that in the context of my past paradigms, are you speaking a different language than the rest of the design team? How are you aligned with the design team given that you're potentially speaking a different language, have different motivations and operating on a longer timeline?

DW: That's such a great question. Our designers are often essential contributors to the research process. Research helps to inform design, not mandate what or how they design. It provides an avenue for bridging evidence with empathy and linking design intent to outcomes.

DI: That's genius on your part, knowing the mindset of the design community to give them the strategy or endpoint but not get prescriptive or dictate how they get there. Few design professionals would appreciate that.

DW: There are always multiple avenues in which design can respond to solve a given challenge. That's where creativity and true innovation can occur. By definition, for a design solution to be innovative, it must solve a meaningful problem. How can you be solving for a problem you don't know? First you must understand the challenge, then you can meaningfully design for it.

DI: A traditional failing in our industry. We're taught to solve problems and to design, we leap to the solution before we know the right question or the right problem.

DW: You're so right, Michael. If we want something different, then we must do something fundamentally different than we have done before.

DI: Let's investigate that for those who may not have had the luxury of having someone like you on a team — maybe a smaller firm who hasn't engaged with a research team member. We've got a project starting up. When are you brought on board? How do you engage with the design team? What's your process?

DW: It has many forms. Often, I'm on board at the tip of the spear and leading business development pursuits, but not always. When fully integrated into the design process, research can provide valuable and timely information all the way from pre-design through occupancy. At the beginning of a project, setting your operational and experience strategy is essential to understanding what and who you're designing for. Throughout schematic design and design development, insights collected through evidence, user engagement and simulations of varying types and levels of fidelity can be leveraged to identify the highest performing design alternatives. Following occupancy, facility evaluations allow us to measure how well the design performs against the intended outcomes. We always get incredible lessons learned that can be carried forward to other projects. Our lessons learned aren't always in the wins. Some of our best insights come from things we were unable to achieve as we had hoped.

DI: Since your service occurs across the project life cycle, through operation and lessons learned, I'm curious about the economics. How is your work funded?

DW: Are you asking if we make money on applied research services? Absolutely. But to our discussion earlier, we believe a base level of applied research is fundamental to delivering good design on any project,

and that is included in our base fee. For our clients that would greatly benefit from additional services, we are transparent on what we would recommend based on their unique needs.

DI: Because they're further along in their evolutionary development or standards?

DW: Yes and no. For some healthcare organizations, their templated standards are what they want for good reason. It's not right or wrong or that they are further along. Healthcare organizations take different approaches to their buildings. There's a place for all of it. Every project is about understanding client needs and doing what is appropriate. Not everything is for every client.

However, informing your design on the best available evidence is for everyone at a fundamental level. We ask our design teams to document their design intent. We ask them to document what they are hoping to achieve through their design.

DI: Over my career, we cared about the building. Less so, the client or outcomes. We just wanted to do a great building because we were taught to by our educational experience and cultural development. Thankfully, now you're trying to do very different things, challenging owners, focusing on this new set of missions, strategies, experiences and outcomes. You said those things need to be measured because, "Innovation without validation is just another good idea. If you don't measure, how do you know how you did?" I'm struck by these new kinds of metrics. What kinds of things are you're measuring?

DW: There are lots of layers to that answer. In simple terms, if we want to understand clinical effectiveness and suggest you can achieve 30% greater efficiency because we are going to reduce your walking distance with this new floor plate, then we should be able to measure those efficiencies. There are different ways to do that. If we say we want an enhanced patient experience, there are patient experience metrics commonly used and anybody can get them. Right now, we are in a talent war for staff, and it is not going to get better. Our healthcare clients are in the heat of it, trying to attract and retain top talent every day. If we are suggesting we can create a space they want to be in and create great communication across teams, then that should show up in their engagement and retention scores. These are viable metrics any system can capture.

DI: Your point goes beyond just users and patients — retaining staff has become an equal or greater issue in the COVID-19 era. I'm still having difficulty throwing off my own self-imposed "I do buildings" shackles, but much of what you're talking about is how they're running their business, their processes and outcomes. How do staff outcomes, research or strategy translate into a physical or facility solutions to retain doctors, nurses and staff?

DW: One design feature that has come to light during pandemic is the need for staff respite spaces that help reduce stress and facilitate recovery. Simple things such as: Do staff have access to fresh food and fresh air to support inter-shift recovery? Do staff have the ability to make a private phone call if needed? These features may seem obvious, but many healthcare facilities do not have sufficient spaces to support staff respite needs. Providing spaces that can help staff manage the margin between their load that they carry every day while delivering care and their limits that we all have as human beings in terms of physical, emotional, social and spiritual needs can help reduce staff fatigue and ultimately, burnout.

> *I help clients become comfortable with being wildly uncomfortable.*

DI: We may have faced some common challenges. In the last 20 years of my career, I wasn't a mainstream provider, I was a support resource person, often a disruptor. In your role, beyond being a researcher, facilitator and suggester, you must also be a persuader or change agent — exerting force in some instances. What are your techniques for changing minds — on the spectrum from powerful healthcare CEOs busy running their hospitals to designers? It's one thing to be collaborative and build consensus, but somebody's got to set direction, especially when it's a change in direction. How do you pull that off?

DW: I help clients become comfortable with being wildly uncomfortable.

You can encourage and inspire, but at the end of the day, it is our clients who have to decide to take that leap towards innovation — or not. My job is to support our clients regardless of where they may be along their innovation journey to be able to operate and deliver the highest quality, most effective care possible. Making sure we are pushing the boundaries appropriately and at the scale in which each organization operates effectively is where the elegance resides.

DI: All this sounds wonderful when it's mutual, synergistic and you've supported them in the way and pace they need to be supported. But that could take forever cycling through those committees in the spirit of innovation. What's in your bag of tricks to defy the laws of time and shorten the planning cycles?

DW: Every project needs a champion. That's where I can have the greatest impact. Sometimes you have multiple champions, but you need to find those people who can champion the innovations. Ultimately, our clients live with the innovations. I come, I leave, but they stay, and somebody has to own those changes. Somebody has to own the willingness to do the work, to accomplish that innovation. Someone has to own that spirit of continuous quality improvement to say, "This is a huge change for us. We may not be able to make it day one, but we are going to make it by day x. "

DI: If we get to the right person, with leverage and motivation, and get them to own the issue, we can build momentum. I've seen school boards and healthcare planning boards call emergency meetings at midnight to make declarations because something had to happen. They did it because they wanted to, had to, someone championed it.

DW: Exactly. COVID is a prime example. Look at how innovative we could be when we had to. There's opportunity everywhere. Great CEOs surround themselves with people who can be those change agents — vision keepers who can own ideas to completion.

DI: Since we're shooting for radical change, can you give us a glimpse of the future?

DW: In healthcare, the boundaries are blurring so much between what healthcare is and how it is delivered. We are doing things in the home that 10 years ago we would not have considered doing outside the four walls of a hospital. That's just one aspect. If we think about the shift happening right now in trying to get costs of care and quality more aligned, it's huge. We are also facing the challenge of a rapidly decreasing healthcare workforce. It begs some very interesting questions to consider:

- Who is this new generation of healthcare professionals?
- What core competencies do they need?
- What is the most effective way to train them?

By the time they are delivering care, it's not going to be the way we deliver it today.

DI: It's intriguing to consider. I read recently some doctor is using the new iPhone 13 camera to do scans of patients' eyes, likely remotely from their homes. Maybe we are beginning to redefine some of the laws of physics, time and space ...

DW: We are, and I believe the future is limitless. We're poised for some incredible innovations and advancements across the physical, digital and human realms as we step into this new era of healthcare. Exactly what those innovations will be, remains to be seen.

Dr. Deborah Wingler's research focuses on improving the patient and staff experience through research studies to elicit insight into patient and staff physiological, psychological and neural responses to high-stress healthcare environments. As vice president and health research lead for HKS, Wingler collaborates with research and design teams to develop and implement research initiatives that drive innovation and achieve a measurable impact across the healthcare practice globally. Through her research, Wingler has had the opportunity to work with some of the most forward-thinking healthcare organizations, manufacturers and design firms in the industry to support their respective research agendas. Her work has integrated of research into the design process at varying scales, from the development of emerging models of care through multi-year capital projects, to the development of tools to support evidence-based design decisions, and the design of products and platforms to support the delivery of care.