THEGOODGUIDES

Pragya Mishra + Swar Raisinghani | Thesis 2013-15 | Design for Social Innovation, SVA

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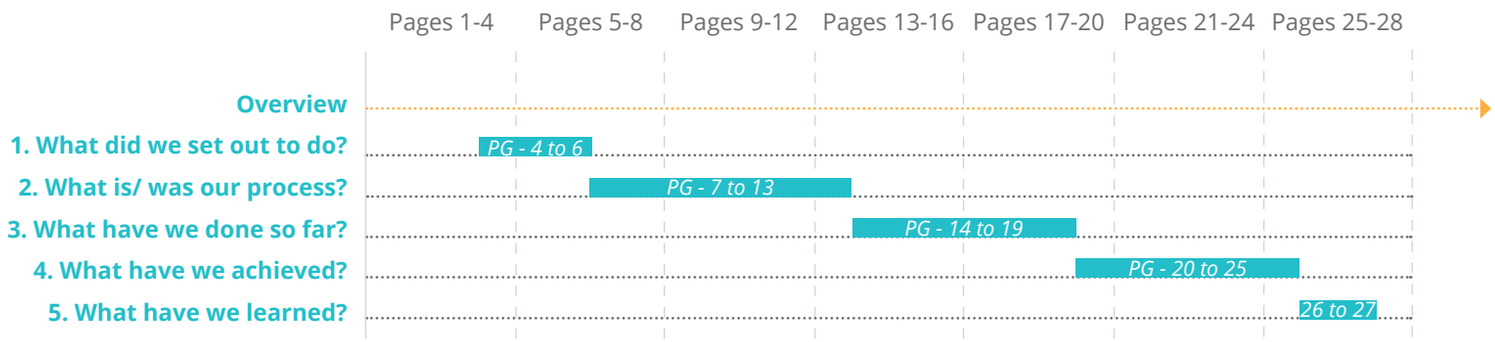
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Pragya Mishra and Swar Raisinghani developed a volunteer-based program to reduce the waiting time for patients in government hospitals in India over an year long project. This program is unique because it is an organized mobilization of young, motivated volunteers to improve the health-care experience for an underserved population in India. The volunteers are trained to be mediators between the staff and the patients to communicate the right information and provide support to ensure smoother patient flow. They are in the process of launching an organized platform of information and resources for hospital management, healthcare consultants or NGOs to be able to adopt this model for their own hospitals.

1 WHAT DID WE SET OUT TO DO?

MAY 2014 - OCT 2014: ***GOAL***

Much before either of us thought of our thesis or even came to DSI we had several memories of our fathers working in hospitals treating an endless stream of patients. As young children our primary concern was perhaps the fact that our fathers were kept away from us for long hours on most days. However, as we grew older, we could feel the pain and the suffering of the patients more acutely. The work our fathers were doing inspired us to do something that felt meaningful to ourselves. It was these memories and shared stories of our childhood that prompted us to work together on something that still feels deeply personal.

1:1800...

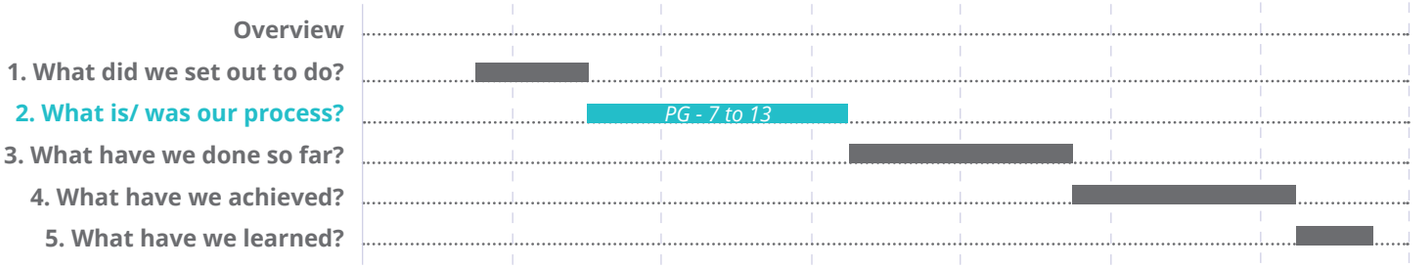
That is the doctor to patient ratio in government hospitals in India. To understand the effects of this skewed ratio, we took a closer look at the Out Patient Department (OPD) of the Govind Ballabh Pant Hospital (G.B. Pant Hospital) in New Delhi, India. It was hard to miss the irony of the situation where patients and their families in this over-crowded hospital, waiting in long lines for endless hours to meet a doctor, but say they had no complaints when asked. The real reason behind their seemingly 'good' experience was the fact that most primary health care setups in rural India don't have even the most basic facilities. In comparison, to them, a functioning urban hospital despite all it's other shortcomings would be considered good. However, it was not hard for us to find several areas of intervention that could potentially help doctors, patients and the hospital itself. After having mapped the challenges faced by doctors and patients in government hospitals, we found

ourselves gravitating towards the problem of the long waiting hours for patients in these hospitals. We knew we wanted to reduce the waiting time for patients in government hospitals by providing them with accurate information and support.

While it was not our primary objective, we have always seen this as an opportunity to showcase design and design thinking as valuable tools in tackling difficult problems. By coming up with good solutions to the problems we were trying to tackle, we hoped, we could convince doctors, administrators and others to consider embracing design in the future when faced with such problems.

A regular day at Govind Ballabh Pant Hospital in Delhi where patients are waiting for registration.

An initial visual board created showcasing the problems observed in th OPD of GB Pant Hospital.

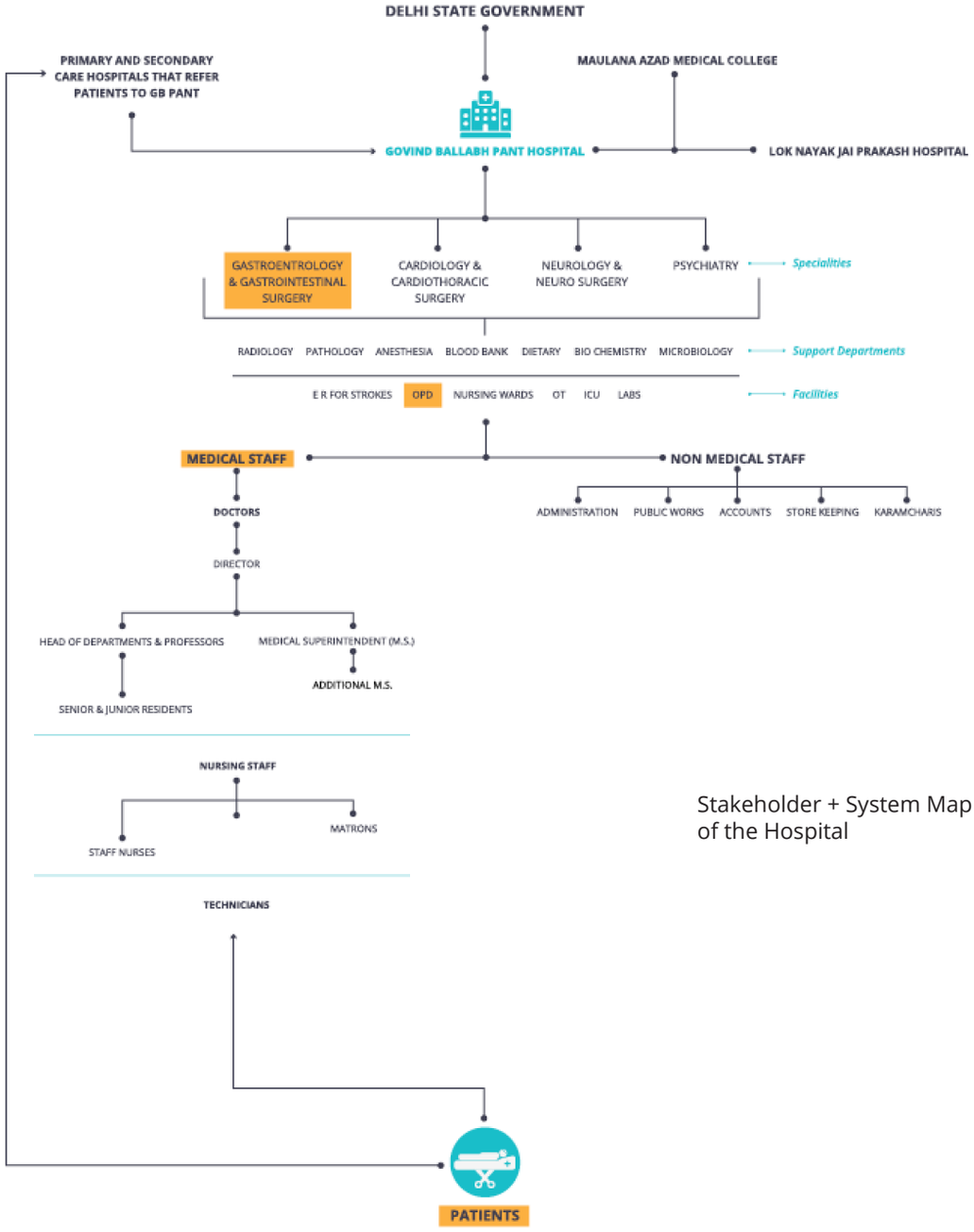


2 WHAT IS/ WAS OUR PROCESS?

OCT 2014- DEC 2014: ***PROCESS***

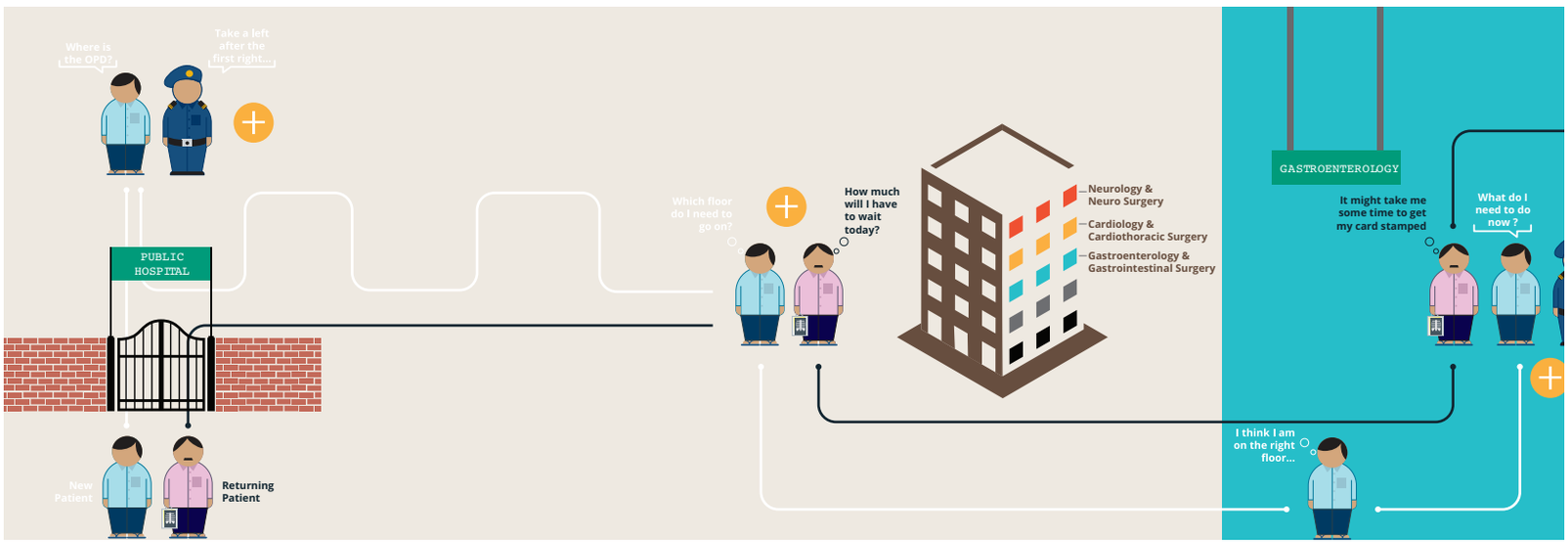
As we researched the topic and gathered first hand information and experiences related to the topic, we mapped a patient's journey and identified various reasons for the bottlenecks in the space. One of the major reasons for the time it takes to see the doctor is the lack of information and support for patients in the hospital. This leads to increase in the crowd of misdirected patients. Doctors in GB Pant spend 1/5 of their time in the Out Patient Department (OPD) dealing with misdirected patients. Considering our access, capabilities and motivation, we realized we could influence this the most.
But even before we even began ideating in this direction, we were aware of the challenges of the environment that we were working in—Government hospitals in India are bureaucratic, managed by doctors who have multiple responsibilities and little time to spare for other tasks or projects. All the possibilities we designed had to be developed into a model that could be implemented by bypassing the bureaucracy while being sensitive to the issue and the environment we were working in. Disrupting the routines (however flawed) of a hospital where terminally ill patients with minimal resources are treated was simply not an option. The success of our ideas and design we felt was dependent on ensuring they were non disruptive.

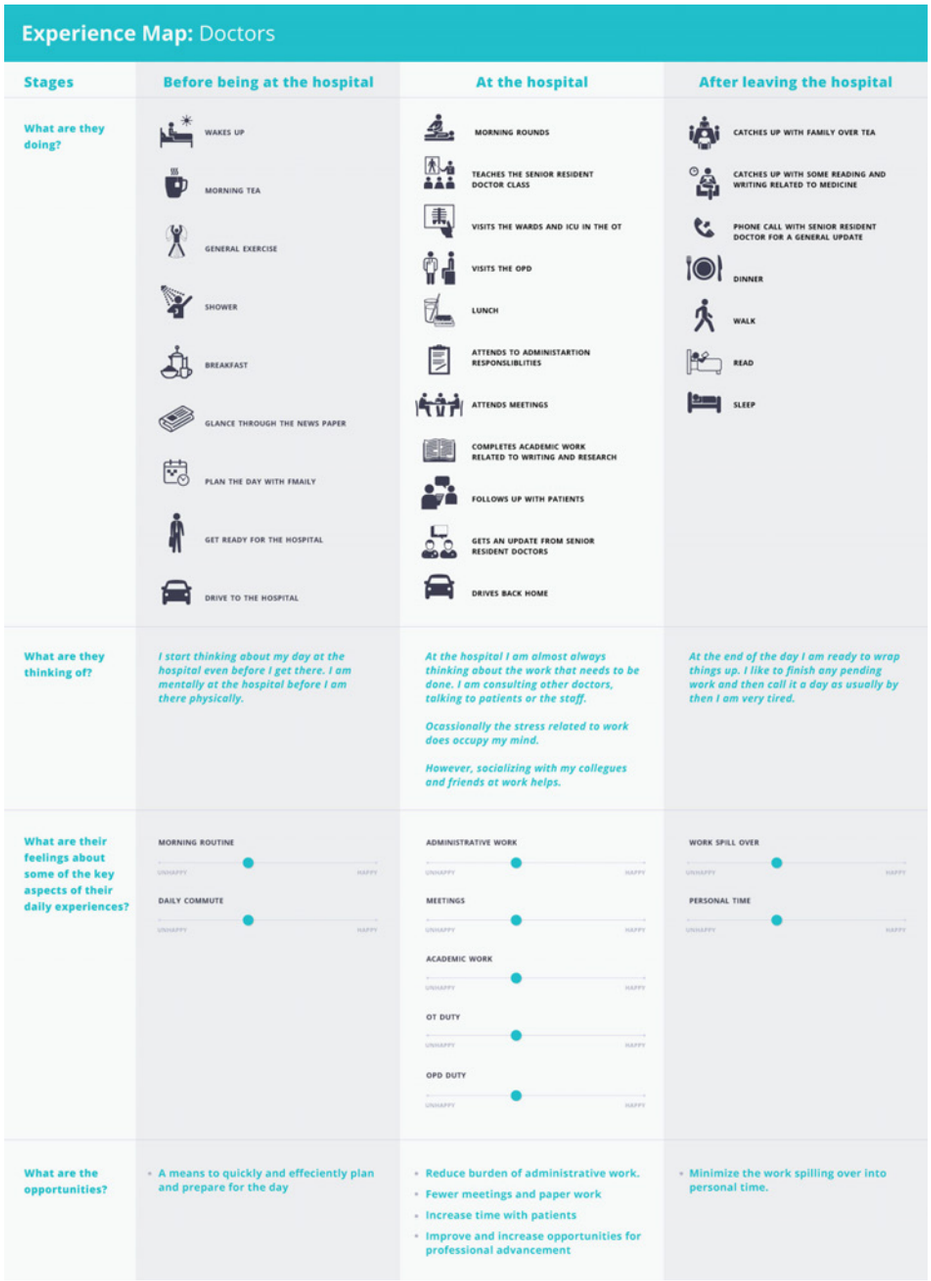
The ideas clustered into three themes: How do we use **human resource** to solve for waiting time? How can we **leverage technology**? How can we change the **existing processes** (like registration) in the hospital?



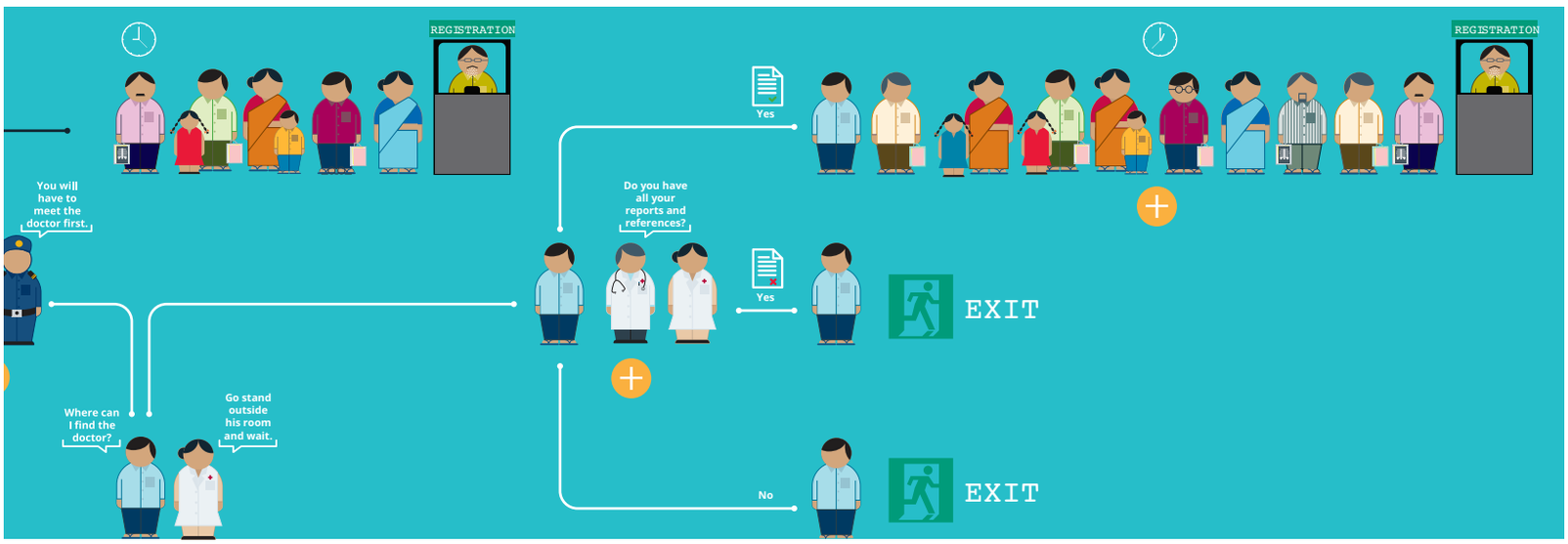
Stakeholder + System Map of the Hospital

Patient User Journey





Experience Map



This is where we hit our first road block.

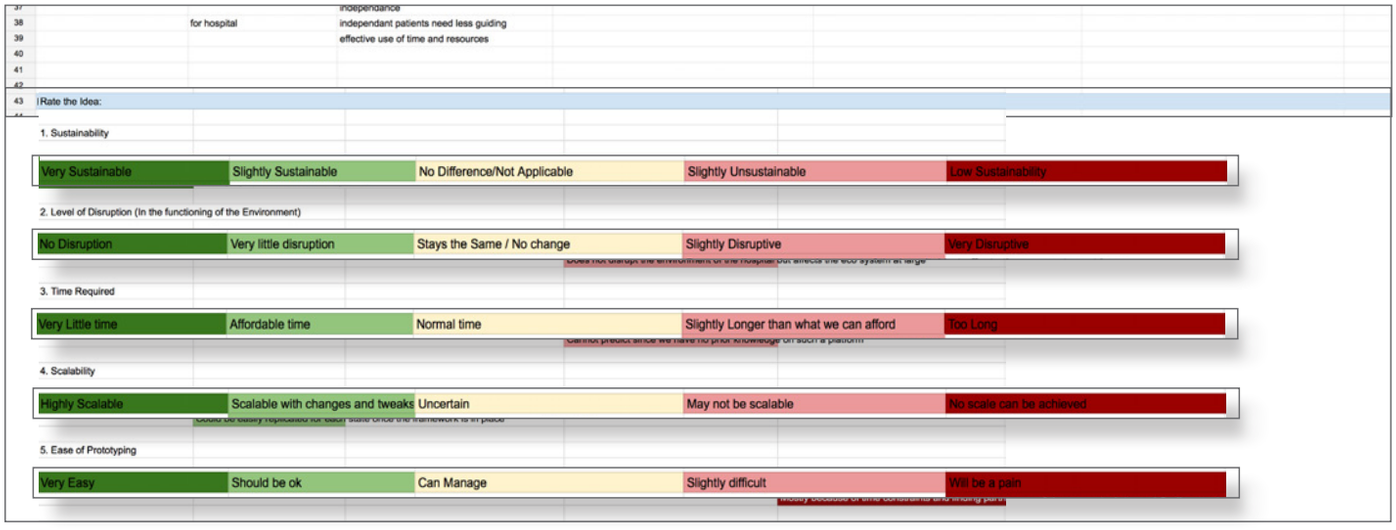
We had all these ideas but needed a logical explanation to narrow these down to one.

We laid out our assumptions around the ideas and reached out to people with experience in the field of medicine and design. These people were consultants who have worked in the medical field and doctors, and were also specific people we needed a buy-in from, for each of our ideas to be implemented. This was our way of checking our assumptions and the validity of our ideas while working remotely. We worked with people who are on the ground and close to the issue physically and professionally. Very soon, we gained insights specific to our ideas and our direction. These insights shaped our current ideas and helped us iterate. We asked, listened, analysed, iterated over and over again with 9 advisors.

Our Advisors from Left to Right: Despina Papadopoulos , Maggie Breslin, Montana Cherney, Mark Rettig, Dr. P.K.Mishra, Dr. Sunil Matwankar, Dr. satish Vyas, Dr. Shyamkumar Raisinghani, Potential Volunteers

While conducting these validation interviews, we were also building spreadsheets to analyze each idea on a scale of measure for sustainability, scalability, resources needed, degree of disruption and the impact generated. These scales gave us a realistic view of specific aspects of these ideas.

	A	B	C	D	E
1		TECHNOLOGY	BREAKING DOWN THE PROCESS	RELATED COMMUNITIES- RETIRED DOCS	UNRELATED- GUIDED GROUPS
2	DETAILS				
3					
4	SIMILAR CASE STUDY		Embassy- Visa Process	ZocDoc	Religious Orgs (Gurudwara, punjab)
5				Agricultural case study by Dalberg	Accidents
6				Community leader sends texts	Teach for India
7		Digital Democracy			School functions- Class Monitors
8		Phone helplines- DD			
9					
10	VALUE PROPOSITION		Clarity in process	For doctors: Engaging the doctors	For youth: Incentive (TBD)
11			Spreading the crowd over	More patient access might bring	Community involvement
12				more patients in	Postive engagement
13				For patients: 24/7 access to info	For doctors: Streamlined crowd
14				remote access	without wasting their time
15				reliable source	For patients: Trained guides to
16				less expenditure	help them with directions & info.
17					
18	MEDIUM for execution		Hand outs and critical points	text messages + phone calls for	Training with doctor/ professional
19			Registration process: breakdown into	remote communication	Identifying critical places
20		and follow ups	multiple desks	Emails or website? (doubt)	Appointing volunteers at places
21			Registration and appointment on two		- First Filter near registration
22			days		- Second Filter to OPDSs
23			Specific Signages at Critical points		- Third to Surgical or Medical Dept
24					- Forth- Stamping
25					- Directing to appointment
26					- Sixth answers follow up Qs
27					- Silent- observes and helps when
28					needed
29					Identify the qualitites req. in the
30					specific roles of volunteers
31					Info kit
32					Communication between the
33					volunteers
34					Overseen by an auhtority figure
35					Stamps/desks etc.
36	LEVERAGE				
37			Design skills + Strategic thinking	Spring break- Reunion for doctor	Friends and family+ their network
38				feedback or registration	
39					
40	BUY-IN		Hospital Admin	Doctors	Youth volunteers
41			Patients	Retired doctors	Hospital admin
42			Funders?	Patients	Hospital staff
43		Hospitals for info		Hospitals to be registered for the	
44		Developers		service	
45		Design companies to share			
46		experience+ collaborate			
47		- Digital Democracy			
48		- Reboot			
49					
50	REACH OUT				
51				Retired doctors	Friends
52				Practising doctors	Hospital Staff
53		Elyse and Ravi from Dalberg		Dad	



Top: A sample from the spreadsheets we created to research each of our ideas.
Bottom: A scale we developed to measure each of our ideas against our constraints.

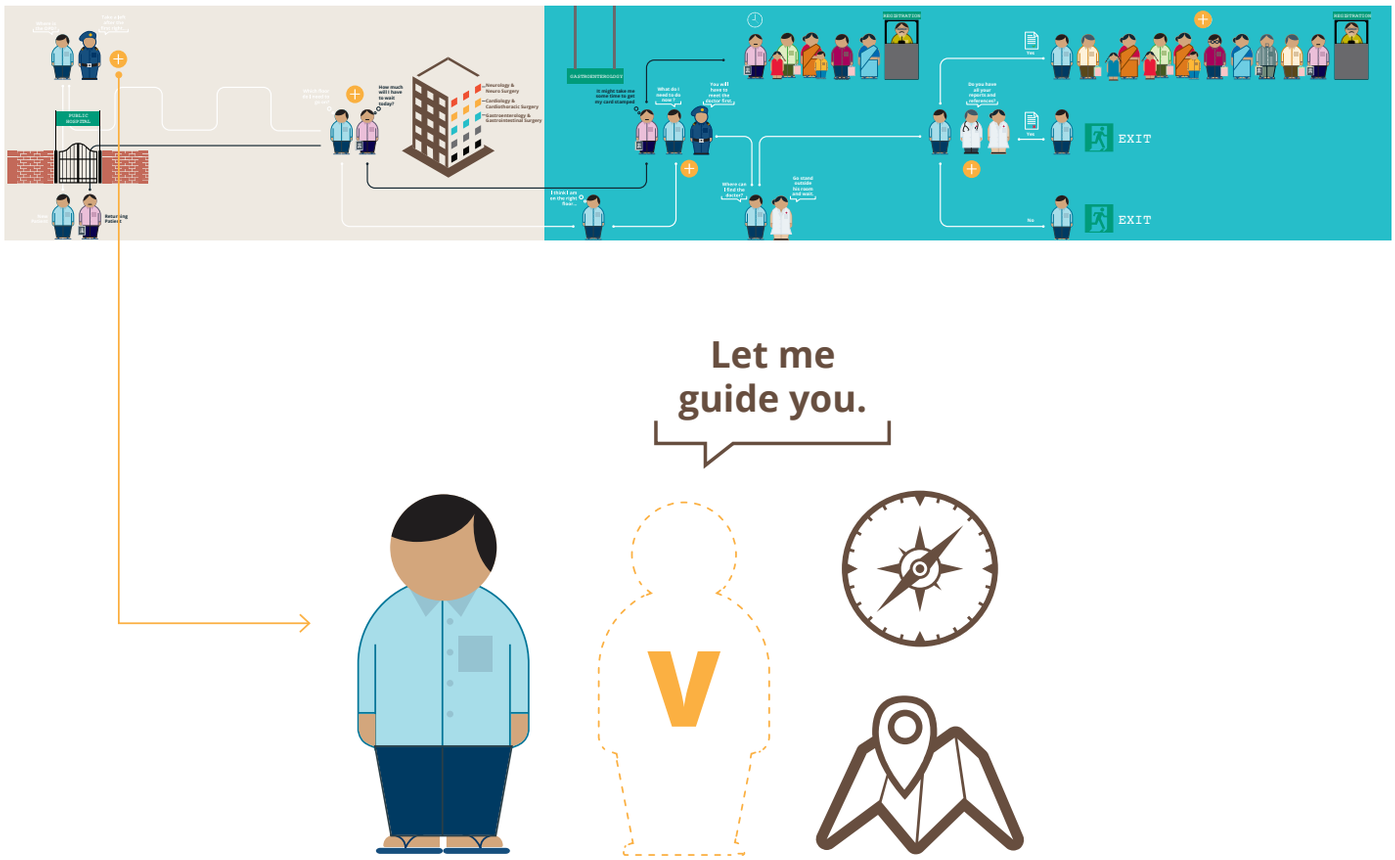
During this time, we were also planning our trip to India to test our ideas in the field. Our challenge of gaining trust and access in a second government hospital to test (the first being, G.B. Pant Hospital) was solved when a healthcare consultant suggested that we work for one of his clients, Maharaja Yashwantrai Hospital (M.Y.H) in Indore. We were stubborn about testing it in at least two hospitals to be able to design for scale and validate the existence of common problems faced by hospitals at large even though our research was specific to one. As we were developing this plan, we also had a call with Maggie Breslin who would lead us to our next big leap.

Maggie suggested that since our ideas were categorized into three distinct buckets, we design small experiments directed to answer specific questions instead of testing a whole model. This approach answered the most important question we had—how do we implement and measure such diverse ideas together in a short time in a highly volatile environment. This is exactly what we had to do next to plan our activities in India. Our questions and experiments were focussed on human behavior, adaptability to technology and the effectiveness of current or suggested processes.

STAGE 1 Entering and going towards the right building	STAGE 2 Entering the OPD block and reaching the correct floor for registration	STAGE 3 Registration process (Queuing, registering information, getting the OPD Card)	STAGE 4 Waiting outside Doctors room with the OPD Card	STAGE 5 After Hospital (Admitted, rejected or Follow up)
Q1: What medium of guidance do the patients respond to? **Q1.1: If patients respond better to materials then what language and visuals should be used?** **E:** Have volunteers to direct patients vs. maps and signs vs. guards **Q2: How do we track the waiting times once patients enter the OPD?** **E:** Time tickets	**Q3: Can volunteers independently direct patients?** **E:** Give volunteers a basic training with the help of doctors and then make them direct patients or have the nurses direct patients. **Q4: Are there ways in which the departments could be differentiated?** **E:** Color coding as a differentiation technique used in all collaterals.	**Q4.1: Is it easier to identify misdirected patients according to their colored bands?** **E:** Continued **Q5: Can patients be identified as new and old patients for providing correct directional information?** **E:** Continued **Q6: Can we speed up the registration process by providing accurate information earlier?** **E:** Looking at clerks preference of receiving information on paper vs. texts. **Q7: How comfortable are the patients and staff using text messages?** **E:** Patients texting/ volunteers texting/ filling paper forms.	**E2:** Continued To record wait time before and after our experiments.	**Q8: Willingness to implement/co-create?** **E:** three questions, survey, interviews, workshop (?) **Q9: Why will people volunteer?** **E:** Three questions, conversation, feedback, observation.

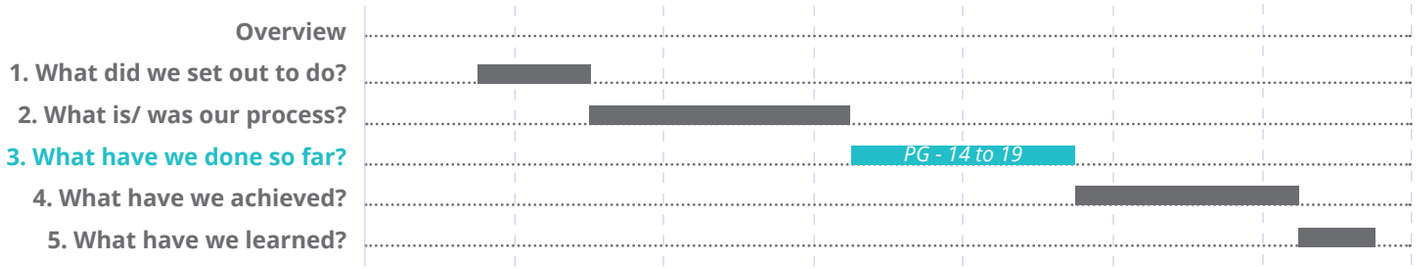
Our Small Experiments: We created a series of small experiments throughout the journey of a patient that would answer specific questions for us at each stage. We used this while we prototyped in the field.

We placed these questions and experiments along the journey of a patient in the hospital to identify strategic points to implement these experiments. We also imagined a possible scenario of the outcome of these experiments.



Our visual map of the patient's journey: This illustrates the possible interaction between the volunteers and the patients at this particular point in the journey

By the end of this process we had a **volunteer-based assistance model to guide and support the patients** to improve their experience in the hospital.



3 WHAT DID WE SET OUT TO DO?

*DEC 2014- JAN 2014 -**TESTING***

As our trip to India came closer, we had a realistic timeline that included our plan of action within the limited time there. We had built relationships over the course of time with the people that we planned to work with. With the help of Pragya's sister, Bhavya, a motivated, young college student who is an active member of the student body, we were recruiting volunteers to work with us for the test run at GB Pant. As ready as we could ever be, we reached Indore for our first test run at the Maharaja Yashwantrai Hospital (MYH). We hoped this would serve us in understanding the differences and similarities of the challenges, and the experience of the stakeholders in different public hospitals of the country. We also wanted to play the role of volunteers to guide the patients to empathise with the motivations, needs and challenges of the volunteers. The exercise we felt would help us anticipate the support the volunteers would require for our experiments in Delhi. The first day in Indore, we observed and asked questions to understand the processes, stakeholders and the challenges that they faced at MYH. The lack of guidance for patients proved to be a major challenge in this space too, for not only the patients but the staff of the hospitals as well.

The next day we spend time in conducting interviews and documenting the stakeholders' experiences to understand our audience better. On the third day, we were approached by patients under the assumption that we were staff members with questions about the processes, paperworks and directions. We were confident and equipped to guide them based on the immersive research that we had been conducting. By the end of day three, we had recruited

a potential volunteer, Sonu. She was a young, unemployed woman looking for a job at the hospital. She approached us timidly to ask about our initiative after witnessing the results. She followed us for some time asking us questions, and then to our surprise, assertively offered to volunteer to help. We were hoping to help patients in the process, but were not prepared to accept volunteers on the ground. At the end of our trip, our greatest achievement was not that we could help the patients (which we had hoped to achieve) but the fact that our work convinced Sonu to join us in our efforts and give her time to volunteer.

The crowd asking staff for help at Maharaja Yashwantrai Hospital (MYH)

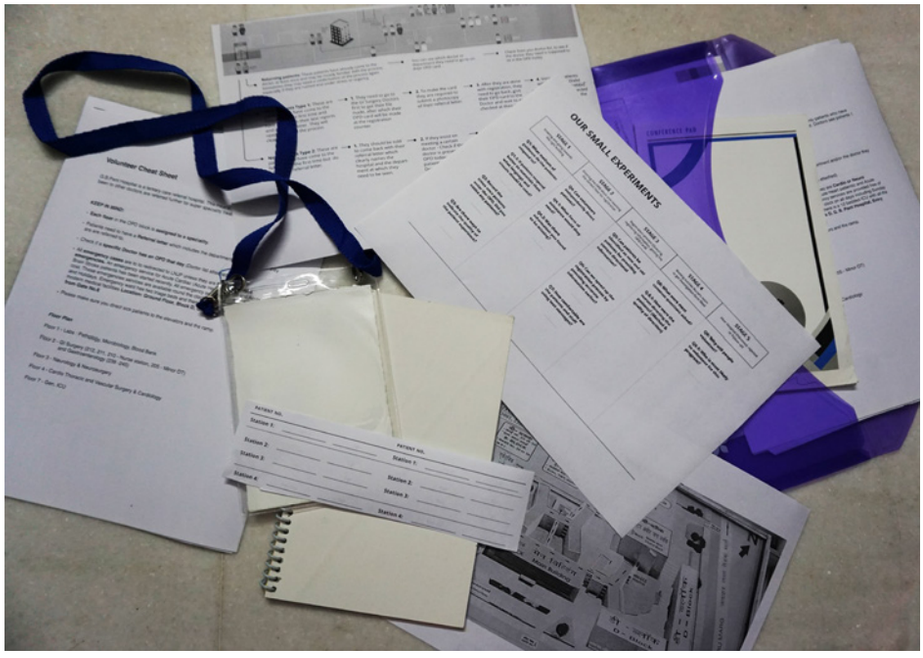
Sonu, the impromptu volunteer

By the time we reached Delhi for our second round of testing, we had built a team of 9 volunteers excluding us. These volunteers were eager to listen and motivated to work. They were college students from Delhi who were actively involved in community events around social issues. On the first day, we held a briefing and co-creation session with Dr. PK Mishra from GB Pant and our Lead Volunteer. We set up a communication channel to connect all volunteers and shared our plan with them.

Briefing and co-creation session with Bhavya and Dr. P.K Mishra

On the second day, we held a briefing session with the volunteers to explain the model and the plan for the test run. We also introduced them to the OPD space to familiarise them to the environment. They were confident to answer questions for patients immediately after the briefing session and took initiative to do what was necessary to get them the required support.

We spent that evening developing toolkits for the volunteers with resources that we knew from prior experience(in Indore) they would need to guide the patients effectively. These toolkits included name tags, a map of the hospital, a schedule with the on-call doctors list, the list of services and departments in the hospital and a time sheet to track the time that each patient takes to go through the system.

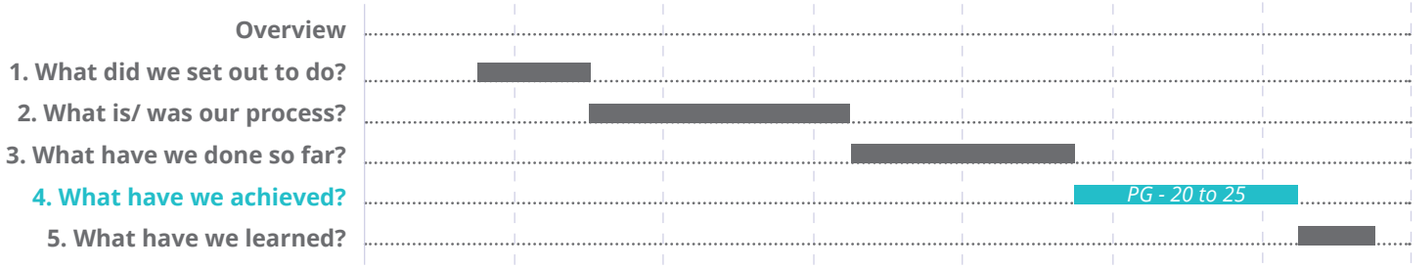


Top: Briefing session with the Volunteers in GB Pant

Left: Content of the toolkit

The third day, was our final test run. Surprisingly, the volunteers had invited their friends to join the test run and had taken the initiative to brief them. We explained their roles and positions that we had thought through with the lead volunteer based on the requirements of the role and the capabilities of each volunteer. The volunteers effectively interacted with at least 90-100 patients in a span of two hours. Based on feedback after the test run, we know that the staff, patients and the volunteers could sense the positive impact of this intervention. In fact we observed that after some time, the patients themselves or on advice of staff members started approaching our volunteers with their queries. The volunteers were positively surprised by the fact that they had earned the trust of the staff and patients. 8 out of 9 volunteers chose to volunteer for this program again. Soon after this ninth person changed her mind and said she would do it again if her friends did it as well.

Volunteers at work guiding patients and collecting feedback, at various points in GB Pant hospital during our prototype in Delhi



4 WHAT HAVE WE ACHIEVED?

JAN 2014- APRIL 2015: ***IMPLEMENTATION***

We came back to New York overwhelmed by the amount of information and feedback that we had received through prototyping. We synthesized this information into observations and insights to turn them into actionable strategies for a volunteer model. For example our learnings on the field about the people who were the most motivated to participate in our pilot helped us build effective strategies around the people who would play the roles of volunteer and how to reach out to them. By following this process, we had build a matrix that offered several effective combinations of resources to implement the volunteer model in the hospitals. Our idea behind offering a combination of resources instead of one strict model was for it to be flexible enough to fit each hospital's unique needs and capabilities *(image on the right)*. This makes this program most effective and relevant to a broader global context as well and allows the possibility of scaling.

At this point, we had an idea of a volunteer-based assistance model which we knew worked, we had a build a ready-to-implement model by finding the right mix of tools and resources that the hospitals would need. However we had to figure out how to make this available to the hospital in a way that they can believe in the value of this model and implement it within the constraints of a public system.

Through the process of building relationships with the two hospitals that we had eventually tested in, we had realized that talking to healthcare consultants proved to be the best way to initiate a change in the hospitals. That is because health care consultants are

trusted by the hospitals and have an influence in the system. Most importantly, they are working with the hospital to make the system work in a more effective manner which makes them more receptive to feedback, suggestions and ideas to initiate a positive impact. Knowing this through experience, we decided to make this volunteer program available to healthcare consultants and management through a digital toolkit. This digital toolkit will give them a step-by-step guideline to implement this program. They can also use resources such as user journey maps and toolkits for volunteers that we provide as they go through each step. With this, we allow consultants from any part of the world to access this model and implement it at a low-cost.

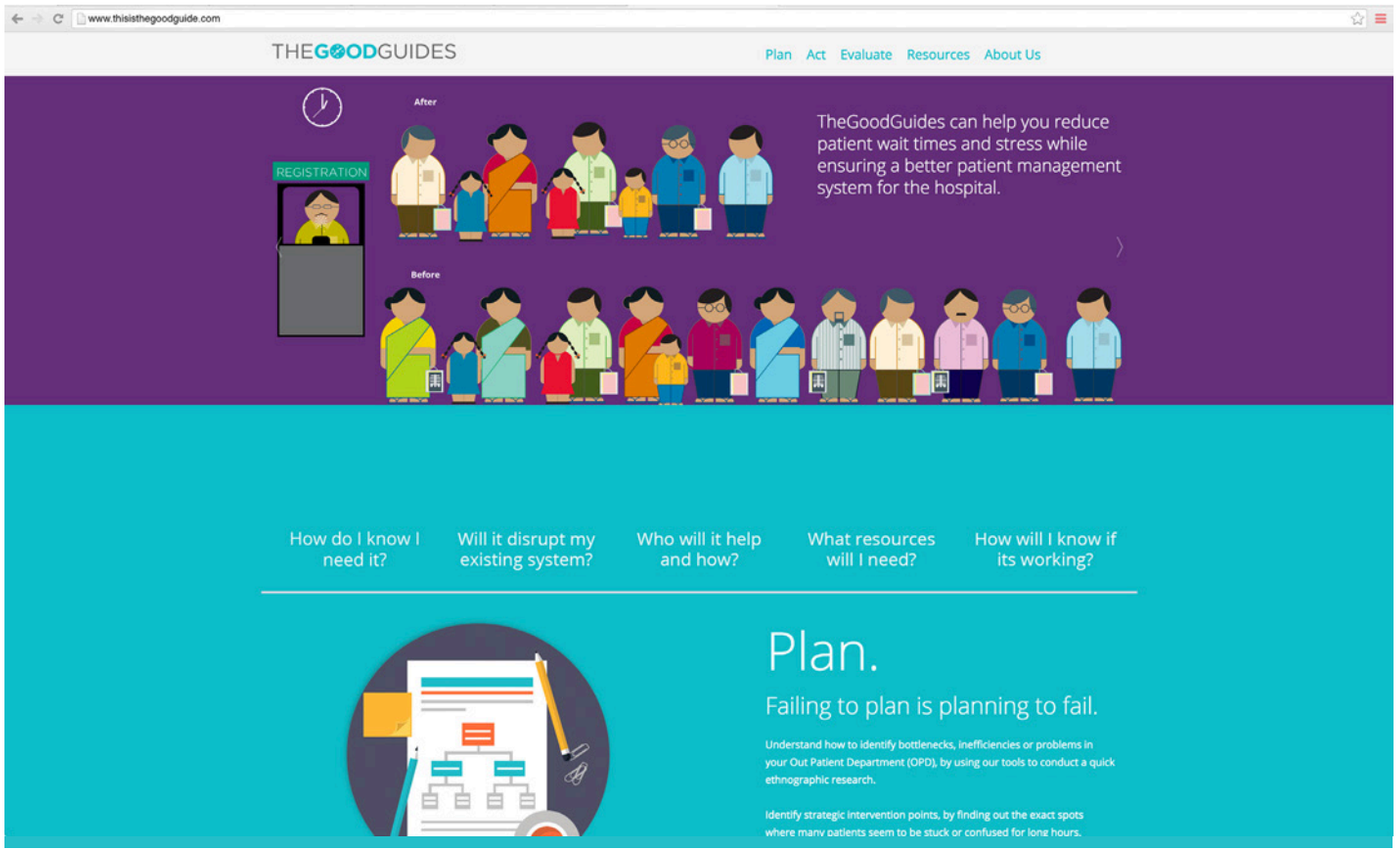
All throughout this process we had been receiving positive feedback on the process that we had followed to tackle the challenges of working in a complex system like public healthcare in India. On reflection, we realized that we were faced with many constraints and obstacles but we had found a way to navigate through the system despite this by following a robust method to initiate impact.

IMPLEMENTOR	MASTERS IN SOCIAL WORK (MSW) DEGREE PROGRAMS	EXTERNAL MANAGEMENT *(e.g. NGO's, Individuals, Consultants, Funders)*	HOSPITALS	CORPORATE SOCIAL RESPONSIBILITY (CSR) PROGRAMS
MANAGING STRUCTURE	• Board of Directors • Group of Faculty or Doctors	Full-time managers of the program	• Committee of Doctors • Hired (Paid) Staff • Outsourced to External Management	CSR Management
FUNDING	• College Fund • External Sponsors	• NGOs / Individuals/ Corporations • Hospital Budget	• Grants / Donations • Hospital Budget • Corporate Partnerships	Corporate Sponsorships
VOLUNTEER	College (MSW) Students	• MSW Students *(Longterm Partnerships)* • Unemployed Women/ Workers *(Longterm NGO Partnerships)*	• MSW Students *(Longterm Partnerships)* • Unemployed Women/ Workers *(Longterm NGO Partnerships)* • Hired Staff	Student Volunteers *(through P.R. Marketing Campaigns)*
INCENTIVES	• Credits & Training • Certificates	• Credits & Training • Stipend & Training	• Credits & Training • Stipend & Training	• Discounts • Brand Association Certificates
CLIENT : HOSPITAL				

Strategic possibilities to build and implement the volunteer program in any hospital

We realized that sharing these challenges and this process with changemakers working to solve wicked problem similar to ours, might help them preempt challenges and overcome obstacles. We We decided to share this as a digital toolkit to make it accessible to changemakers across the world who are motivated to replicate and grow social impact.

This is The Good Guides. thisisthegoodguide.com is the toolkit for healthcare consultants to implement The Good Guides program in the hospital and thisisthegoodguide.org is the guide for changemakers to follow the process built on our learnings and use resources that have helped us design the program.



Screenshot of the thisisthegoodguide.com

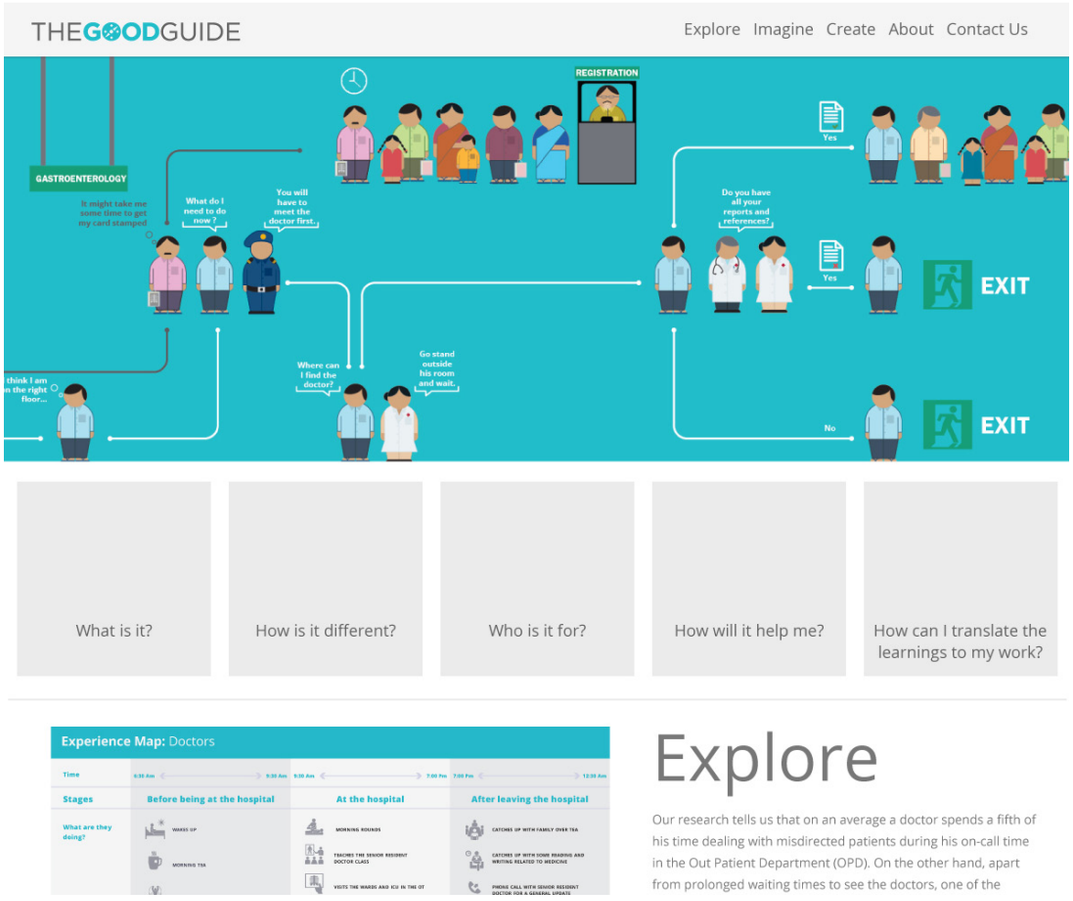
We spoke to Ashley Willhite, a talented writer to understand how to go about writing the content for TheGoodGuides platforms. We received great suggestion from her on thinking about the ‘experience’ before thinking of writing or designing the content. This was a great trigger for us to realise that the experiences that we wanted to design for the platforms were drastically different because they were aimed at two distinct audiences. The healthcare consultants are pressed for time, and want to know the details about the program in a quick and easy way. The changemakers who maybe students would want to understand the process in detail and spend time on the platform.

With this intention in mind, we started developing the the content for each platform by finding a balance between the tone of voice, writing and the resources that we wanted to make available for them in the form of links and to-view and to-download pdfs.
To create an experience tailored to the needs of the healthcare consultants, we divided the implementation process in our toolkit into only three distinct phases: PLAN, ACT AND EVALUATE.
Each section is supported with resources that will help the audience understand and execute each phase.

Five most important questions answered on the website for the audience as a quick rollover feature

PLAN: This will guide the audience on how to best plan to implement this model in their hospital. This starts from studying and evaluating the current problems to planning for implementation.
ACT: This section provides an extensive description into how to implement this program in your hospital with the help of a flexible structure/process.
EVALUATE: Identifying and evaluating the impact of the model is key to understanding its effectiveness to iterate or expand it to initiate change. ‘Evaluate’ will help them do exactly this.

Apart from these three categories, we have used design principles intentionally for every element of the website to answer specific questions quickly that the healthcare consultants might have when they visit the website.



Screenshot of the thisisthegoodguide.org

Thisisthegoodguide.org is delivered to the audience in three separate chapters: EXPLORE, IMAGINE, CREATE with a library section containing tools for changemakers.

EXPLORE: This is a guide to exploratory and directed research. It will answer questions that every student or changemaker may have at this phase, whether it is broad like Where do I start from? or specific as How do I identify a need?
IMAGINE: Imagine provides a structure to changemakers within which they can ideate to create effective ideas and solutions while keeping the ultimate goal in focus.
CREATE: From prototyping to executing the solution to bring your idea to life, this section in the toolkit will guide the changemakers to test, iterate and implement.

Both these toolkits have a distinct voice to appeal to their distinct audience but follow an approach of creating collective impact and include a call-to-action in the vocabulary when we ask them to share their stories on how they used this toolkit to collect their feedback. Intended impact: We hope that TheGoodGuides builds a community of changemakers from across the world who are driven to work in a complex system to accelerate positive impact. The .com is focussed on implementing a volunteer-based program designed specifically for hospitals to help, assist and support patients to reduce the waiting time, while the.org is flexible to be used for any complex issues or environments that the changemakers choose to focus on.

TheGoodGuides program in the end resulted in not only impacting the lives of the patients and staff of the hospitals but also change makers. We hope that this expands and connects the community of people interested in social impact to support each other and collaborate. Such collaborations we believe will bring collective impact liberated from the constraints of rigid systems through a structured process that leads to clarity.

TheGoodGuides program in the end resulted in not only impacting the lives of the patients and staff of the hospital but also change makers.

5 WHAT HAVE WE LEARNED?

MAY 2014- APRIL 2015: ***LEARNINGS***

Patients prefer to ask questions to nurses and staff than study signages or rely on available technology in the hospital.

During this past year, we have learnt many things personally and as students of social innovation. We have tried to break down our learnings for better understanding:

1. **Value of cultural behaviors:** Our solution came from the a deep rooted understanding of the cultural context. We realized that within the time we had it was difficult for us to change human behaviors that stem from the challenges that the environment presents. Therefore, we listened to the people, understood their intrinsic motivations to develop a model which is effective because of its simplicity. Thinking about this in the context of our thesis, an example of this would be our learning about typical patient behavior in India. In highly stressful hospital environments, patients preferred human interaction and guidance instead of trusting technology and signages for the same.

SVA NYC DSI
Design for Social Innovation

CERTIFICATE OF PARTICIPATION

We appreciate the active participation of

in our volunteer-based pilot program at GB Pant, New Delhi, from 5th-6th Jan 2015.
With sincere gratitude we acknowledge your willingness and dedication
that contributed to the success of our program.

Project Leads

Pragya Mishra
Student, MFA Design for Social Innovation

Swar Raisinghani
Student, MFA Design for Social Innovation

Project Mentors

Despina Papadopoulos
Thesis Advisor

Cheryl Heller
Chair, MFA Design for Social Innovation

2. **Incentives:** All stakeholders need incentives. Their motivation does not replace the incentives. Incase of college students, we provided them with certificates of participation from DSI program.

   Read about it more on:
   http://dsi.sva.edu/blog/2015/02/dsi-students-are-designing-better-patient-experiences-in-indian-government-hospitals/

   This decision was taken based on the feedback from them. We decided not to work with retired doctors for one of our ideas because we learnt that we would need to provide them with financial incentives which were beyond our capacity.

3. **Collaboration:** We understood our capabilities and limitations. We reached out to different groups of people for feedback and interviews to learn from the experts about areas that we did not have enough knowledge about. This has taught us the value of constructive feedback that we have invited in our process at various stages. For example outsourcing the volunteer recruiting to Bhavya who understood what would appeal to her age group and reached out to her network worked out well for our prototype. Not only did young volunteers come and participate, next day they brought more friends.

4. **Value of structure:** We have always aimed for clarity in our process and activities. Looking back we realize that all those interviews, excel sheets and specific experiments were directed to provide a structure and clarity to our process. Based on feedback from our peers, we have learned that we have always asked questions that lead us to the relevant thought or action that needs to be addressed in order for us to move ahead. This is how we have reached to a point of clarity at times when we have hit a dead end. The toolkits that we are designing emphasize the value of structure.

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