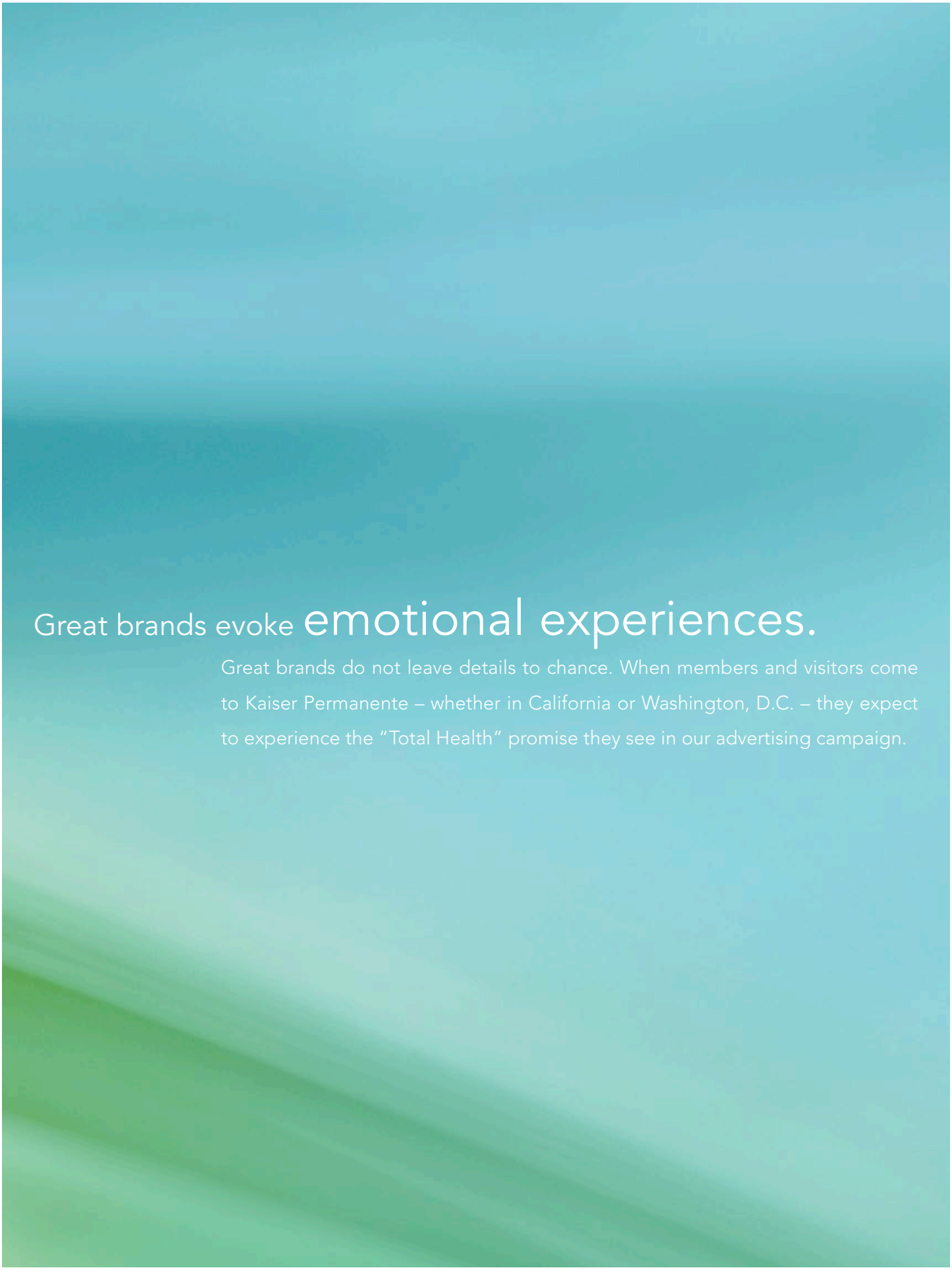
Creating the Total Health Environment

A research-based, member-focused initiative for Kaiser Permanente. June 2010.



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A research-based, member-focused initiative for Kaiser Permanente June 25, 2010

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1. Executive Summary

Great brands evoke emotional experiences. Great brands do not leave details to chance. When members and visitors come to Kaiser Permanente – whether in California or Washington, D.C. – they expect to experience the "Total Health" promise they see in our advertising campaign.

The Total Health Environment initiative began as a study into creating a distinct and consistent environment across Kaiser Permanente buildings and to provide a setting for care that was consistent with the company's brand promise of "Total Health." A successful project, from the point-of-view of the Kaiser Permanente management team, would generate attainable and relevant design solutions to enable quality human experiences at our facilities and would generate appropriate strategies for implementing these solutions across all eight Kaiser Permanente regions.

The initiative began with a clear set of business requirements, or success criteria:

- Collect pertinent information, best practices, and insights from numerous regional brand initiatives that had begun throughout the Kaiser Permanente Program;
- Develop improved standards that ideally cost less or the same as existing standards. The Kaiser Permanente capital plan could not be increased; and
- Create consistent, repeatable, signature brand elements that support the Kaiser Permanente mission and business.

The Total Health Environment initiative began in September 2007 and was completed by December 2008. Research was conducted in all eight Kaiser Permanente regions. The research findings informed design solutions for "21 key experiences," or touch points that make up the fabric of the Total Health Environment.

Incorporating these signature brand elements into Kaiser Permanente's facilities design program continues and is scheduled to be complete by December 2010. Meanwhile, the project team continues to develop and refresh the company's design resources toolkit, which consists of on-brand colors, materials and finishes, furniture, fabrics, lighting, and signage and way-finding.

The design resources toolkit combines aesthetics with function, durability, maintenance, sustainability, safety, and cost containment. Together with the Kaiser Permanente Procurement and Supply Department, we continue to collaborate with key manufacturers and vendors to not only develop new products, but to leverage Kaiser Permanente's purchasing power to purchase those products at significantly reduced prices.

1. Executive Summary (continued)

National Facilities Services implementation leads have been appointed in all regions to work with capital projects teams to incorporate Total Health Environment into all types of projects, including both large expansion projects and small renovations to existing buildings. Total Health Environment initiative continues to gain momentum across the Program and the strong working partnership among several Kaiser Permanente departments, including Brand, Service Quality, Information Technology, and Operations, continues to flourish, which is key to the movement's success.

2. Introduction

The momentum and excitement created by Kaiser Permanente's Thrive advertising campaign continues to grow. The objective of this campaign is simple: Position Kaiser Permanente as an organization committed to the total health and wellness of its members, its customers, and the communities it serves.

Since its inception in 2004, the Thrive campaign has helped establish that message. The next stage in developing the Kaiser Permanente brand is to infuse brand awareness into Kaiser Permanente hospitals, medical office buildings, and other facilities. In other words, it is important for Kaiser Permanente members and other visitors to see a relationship between what Kaiser Permanente says about itself and what they experience when they visit Kaiser Permanente.

Building the brand message into the marketplace — and ensuring members experience this message consistently in both facility design and member service — is critical to growing and retaining membership. What members see and experience during a visit will position Kaiser Permanente in the health care market, and ultimately demonstrate that the organization can be a model for the future of health care.

This paper documents the Total Health Environment initiative by describing its meaning; significance; background; process; research findings and the key insights that resulted from those findings; research translation, and finally design guidelines.

Ultimately, the goals of this paper are to provide the rationale for why the Total Health Environment initiative is an important step in the continual effort to build and strengthen the Kaiser Permanente brand and to document and recommend what the organization can do to infuse the Total Health brand into its built environment.

3. Overview of the Project

At the project's inception, the Total Health Environment team started with five key questions related to what people experience in a health care setting:

1. Can an environment inspire, influence, and communicate good health, or at least avoid negative effects that could be detrimental to good health?
2. Are there universal design elements that influence our members' interactions within a health care environment?
3. Are the processes, expectations, and experiences of members different for a medical office visit than a hospital stay?
4. Do people consciously perceive and respond to their surroundings, to what extent, and how?
5. Can design influence peoples' experiences in our spaces?

Creating a Multi-Disciplinary Team and Collaborative Project Process
Approaching the initiative with a healthy respect for protocols and standards, yet understanding the need to challenge the norms both at Kaiser Permanente and in the health care industry at large, the team assembled a list of prospective consultants that went well beyond traditional health care architecture.

The firms we considered had health care experience and diverse design expertise in hospitality, retail, brand identity, financial services, transportation, and education. After a rigorous nationwide selection process, the Kaiser Permanente project team chose NBBJ of Seattle as our consultants. The decision was based on three factors:

- NBBJ's proposed project vision was aligned with that of Kaiser Permanente: that people are more important than artifacts, buildings, or spaces.

- The firm's ability to conduct human-centered research was required to build a research-based initiative capable of producing design solutions informed by a deep understanding of members' and other building occupants' needs. The firm also brought extensive experience in research translation strategies critical to informing the overall project, defining opportunities and guiding design solutions.

- NBBJ offered a multidisciplinary team of experts in human-centered research strategy, health care architecture, environmental way-finding, interior design, industrial design, and furniture design.

3. Overview of the Project (continued)

The Kaiser Permanente project team was also multidisciplinary, including team members from the Brand, Quality/Service, National Facilities Services, and Operations departments. Individual team members brought expertise in brand, quality and service, graphics design, interior design, architecture, and building operations. It was important to combine these diverse disciplines to build a project team that could challenge proposed ideas and design solutions that were practical, doable, scaleable, and cost intelligent. The business requirement to decrease costs was a consistent key criterion in judging whether a design solution was feasible.

The Kaiser Permanente development team was involved in the research and design phases of the project, integrating both organizations into one cohesive team. This is an unusual model. It is more common to have the research done by consultants who hand off the results to the client, who then pass this information to a design team for translation, application, and implementation. In this typical linear model, it is possible to lose nuances or common threads discovered during research. The integration of the Kaiser Permanente development team into the research and design teams ensured that the client stayed involved from the translation and concept phases to project completion.

This new model included researchers, designers, and the client through all phases of the project, which resulted in broad new knowledge and insights that informed and inspired design solutions. The combined research team traveled extensively to gain knowledge from facilities and regions.

A Philosophy Regarding Design and Experience

The project team defined "design" beyond the conventional attitudes of aesthetics, form, and materiality to include the behavioral and emotional components of the human experience. Within the fields of research, design, and branding, "experience" can be defined as a specific instance of personally encountering or undergoing something, and the knowledge or practical wisdom gained from what one has observed, encountered, or undergone.[1] Specific to this project, the research phase was critical to defining, understanding, and documenting what members and visitors experience at Kaiser Permanente facilities. Once translated, the qualitative research informed design solutions as much as possible and provided the foundation to transcend intuition and opinion when making design decisions.

If experience is practical wisdom gained from what members have seen and encountered, then it is critical — and an opportunity — to document, synthesize, understand, create, and affect experiences that members have every time they visit Kaiser Permanente. Ultimately that collection of experiences becomes an "imprint," for which all members is different. Further, we must accept that this imprint can change over time. If our brand is ultimately what members say about Kaiser Permanente, combined with their emotional connection to the organization, the brand, to a large degree, is actually co-owned by Kaiser Permanente and its members and customers. We can participate in this ownership, but can not fully control it.

[1] Dictionary.com

3. Overview of the Project (continued)

To participate in this ownership, the team sought to develop a deep understanding of our members' experiences. A fundamental construct is that one's experience is contextual and affected by the setting or circumstances in which the event occurs. It is influenced by everything else in that member's life, including their emotional mindset at the moment. While design can influence what one experiences by acting as a "scaffold" or stage, it cannot actually create that experience for an individual.

The NBBJ team developed the following "experience equation" to illustrate this point:

	Context	(the entire set of influences that come to bear on any given situation)
+	**Emotions**	(people's mental state and their resulting needs)
+	**Journey**	(the path they will travel through space and time)
+	**Touchpoints**	(a series of events, services, and interactions they encounter)
=	**Experience**	and

Experience = Brand

It was a fundamental ambition of the team to align the environmental perceptions and experiences of Kaiser Permanente facilities with our members' values so we can increase the quality of care, enhance member commitment, and achieve brand alignment.

Listening to and Collecting the Voices of the Member

The team's position that members' needs and experiences are more important than buildings, spaces, and artifacts informed a research strategy that involved and integrated members and other end-users, such as families and visitors. Research was conducted in all eight Kaiser Permanente regions: Colorado, Georgia, Hawaii, Mid-Atlantic States, Northern California, Norwest, Ohio, and Southern California.

Sites included:
- nine Kaiser Permanente hospitals
- six contract facilities in the regions outside California
- 34 Kaiser Permanente medical office buildings
- nine competition benchmark facilities

3. Overview of the Project (continued)

KAISER PERMANENTE REGION	MEDICAL OFFICE BUILDING	HOSPITAL	CONTRACT HOSPITAL OR BENCHMARK FACILITY
California North	Delta Fair Medical Offices	Antioch Medical Center	
	Oakland Medical Office Building	Oakland Medical Center	
	Santa Clara Medical Offices	Santa Clara Medical Center	
	Walnut Creek Medical Offices	Walnut Creek Medical Center	
California South	Los Angeles Medical Center: Culver Marina Medical Offices	Baldwin Park Medical Center	Huntington Memorial Hospital
	Orange County-Anaheim Medical Center	West Los Angeles Medical Center	
	Panorama City Medical Offices		
	East Los Angeles Medical Offices	Panorama City Medical Center	
	Anaheim Hills Medical Offices/ Euclid Medical Offices		
Colorado	Franklin Medical Offices		Exempla Saint Joseph Hospital
	Skyline Medical Offices		Exempla Rock Creek Medical Center
	Rock Creek Medical Offices		Denver Children's Hospital
	Lakewood Medical Offices		

3. Overview of the Project (continued)

KAISER PERMANENTE REGION	MEDICAL OFFICE BUILDING	HOSPITAL	CONTRACT HOSPITAL OR BENCHMARK FACILITY
Georgia	Brookwood at Peachtree Medical Office		Piedmont Hospital
	Sugar Hill-Buford Medical Center		Northside Hospital
	Cumberland Medical Center		
	Glenlake Medical Center		
	West Cobb Medical Center		
Hawaii	Moanalua Clinic	Moanalua Medical Center	The Queens Medical Center
	Waipo Clinic		
	Hawaii Kai Clinic		
	Mapunapuna Clinic		
Mid Atlantic States	Largo Medical Offices		
	Fredericksburg Medical Center		

3. Overview of the Project (continued)

KAISER PERMANENTE REGION	MEDICAL OFFICE BUILDING	HOSPITAL	CONTRACT HOSPITAL OR BENCHMARK FACILITY
Northwest	Interstate Medical Office Oncology Clinic: Center for Health Research Mt. Talbert Medical Office Mt. Scott Medical Office Gresham Dental Office Salmon Creek Medical and Dental Offices	Sunnyside Medical Center	Vancouver General Hospital
Ohio	Cleveland Heights Medical Center Avon Medical Offices Parma Medical Center Strongsville Medical Center		Cleveland Clinic
Totals	34	9	9

3. Overview of the Project (continued)

Post research, the Kaiser Permanente team visited the following sites to assess how our capital project teams were implementing Total Health Environment research findings on current projects:

KAISER PERMANENTE REGION	MEDICAL OFFICE BUILDING	KP HOSPITAL
California North	Delta Fair Medical Offices	Antioch Medical Center
	Oakland Medical Offices	
	Vacaville Medical Offices	Vacaville Medical Center
	Pinole Medical Offices	
	Roseville Medical Offices-Riverside	Roseville Women's and Children's
	Lincoln Medical Offices	
	Folsom Medical Offices	
California South	Pasadena Medical Offices	Downey Medical Center
	Redlands Medical Offices	
	La Mesa Medical Offices	
	Rancho San Diego Medical Offices	
	Otay Mesa Outpatient Medical Center	
Georgia	East Cobb	
	Buford: Sugar Hill-Buford Medical Center	
Totals	14	4

4. The Research and Discovery Phase - SEPTEMBER 2007 TO MARCH 2008

Connective Secondary Research: The team conducted a thorough review of several ad hoc Kaiser Permanente initiatives that had evolved organically in all eight regions. These initiatives were all designed to create a better environment for members, physicians, and staff. They focused on signage and wayfinding, aesthetics or image improvements, retail spaces, and other general innovations. This secondary research was important to integrating lessons learned and best practices from previous efforts; leveraging Kaiser Permanente's investment; and avoiding future redundancies.

Three key insights were gleaned from these initiatives:

- The first was that design solutions had been developed without the influence of research targeting Kaiser Permanente members.
- The second was that there was considerable confusion about Kaiser Permanente's brand strategy. Most initiatives focused on the Kaiser Permanente Thrive campaign, with project teams not understanding that Thrive is an external marketing strategy focused on what Kaiser Permanente says about itself. Kaiser Permanente's brand strategy, on the other hand, is Total Health, meaning Kaiser Permanente's integrated health care delivery system and commitment to preventive care empowers our members to maximize their total health — mind, body, and spirit. It is likely the Thrive campaign will change over time, but Total Health will remain the brand strategy.
- The third was that most initiatives were region-specific and therefore not concerned with leveraging signature brand elements in all eight regions.

Understanding that most regions want to appeal to their members and local demographics in their specific geography, the team employed the concept of "flexibility in a framework" while developing the Total Health Environment project, allowing for limited regional variation and expression.

Immersive Primary Research

Parallel to the secondary research effort, a primary research and discovery strategy was developed to investigate, interpret, and develop new knowledge to reach insights that would ultimately inspire and inform design solutions. The team developed a research strategy that applied to all building stakeholders and occupants, but emphasized members. The purpose was to investigate their unique perspectives and insights through design thinking, believing that the integration of diverse points of view would create new insight. By triangulating information on building stakeholder emotions, future aspirations, and the environment, the team developed a thorough understanding of the intersections of human behavior and the built environment.

4. The Research and Discovery Phase - SEPTEMBER 2007 TO MARCH 2008 (continued)

METHODOLOGY ONE: **WALK-ALONGS**

This methodology was vision-centric. The goal of the "walk-alongs" was to quickly witness the wide range of facilities and conditions within the Kaiser Permanente system. The duration of each walk-along was short because the primary focus was on that of the physical attributes of spaces, not behaviors and/or processes.

A densely packed and intensive exercise was designed to rapidly observe, experience, and assess a select group of existing Kaiser Permanente facilities in all eight regions. As a result, the team observed a wide range of locations, environments, and cultures. Team members recorded their observations, thoughts, and ideas in printed Observation Guides. The guides included a Kaiser Permanente Observation Agreement stating the intent of the observations; what equipment could be used; expectations of the observers; and a statement on media and information ownership. It is important to note that the Observation Guides were designed to specifically separate what one saw and heard from what one thought.

The outcome was a data set that enabled the team to better understand commonalities and inconsistencies between facilities and regions and to develop a basic understanding of brand message and built environments, including both challenges and opportunities. Patterns began to emerge as the process captured particular aspects of existing environments that were found consistently in the facility visits. Synthesizing the findings resulted in categories of issues that included site and nature; architecture; furniture and accommodation; privacy and emotion; information and guidance; personalization; amenity and support; and flow and queuing.

METHODOLOGY TWO: **IMMERSIVE OBSERVATIONS**

This second methodology was more immersive and experience-centric focusing on the links of human behavior, culture, and space. Observations were structured to allow the team to spend significant time in facilities observing people to better understand their daily routines, interactions, and behavior in the context of the health care environment. The outcome was a qualitative description of the building occupants' points-of-view and behaviors based on what they actually do in a space versus what we think they do, which resulted in a deeper understanding of process and dynamics.

As with the walk-alongs, observation guides were given to the team to describe how to observe building stakeholders with a goal of understanding people, their behavior, and their actions. Work was done in actual environments in real time to better understand the dynamics of staff, patients, and families; personal interactions and dynamics; relationships of space and people; environmental arrangements and layouts; and space physicality, including materials and finishes, and objects.

4. The Research and Discovery Phase - SEPTEMBER 2007 TO MARCH 2008 (continued)

METHODOLOGY TWO: **IMMERSIVE OBSERVATIONS** (continued)

The observation guide instructed us, as ethnographers, to discuss and analyze as we observed. At the end of each day, notes were collected, synthesized, and analyzed, and universal themes among the research team were highlighted and recorded. Ethnographers were encouraged to use early insights from the fieldwork to guide and focus subsequent field observations. The observation guide reminded the ethnographers to watch people, and their activities and behavior, postures, gestures and facial expressions, and patterns and adjacencies. In addition, they were to listen for conversations, confusion, questions, and mine for any linguistic insights possible.

Team members were also instructed to look for physical traces[2] in the environment such as:

- Erosions: worn away parts of the environment
- Leftovers: items left behind from an activity
- Missing traces: when there are no erosions
- Props: things people bring to an activity
- Separations: changes made to separate spaces
- Connections: changes made to connect spaces
- Personalization: displays to express individuality
- Identification: displays that enable others to identify you and your space
- Group membership: displays to show group membership (official and unofficial public messages)

METHODOLOGY TWO: **SHADOWING**

Shadowing is similar to observations but has the researchers following the footsteps of building occupants to understand their processes and journeys, and their resulting emotions and feelings. In this methodology, the researchers are able to witness, and, to some degree, participate in the journey of an actual member. This provides a cohesive look into not only what is happening, but also what is being communicated. As a methodology, it is more closely engaged with the people being observed than passively witnessing their actions from a limited and often static vantage point.

The walk-alongs, immersive observations, and shadowing were recorded using not only the observation guides but also technologies including digital cameras, video, and audio recordings.

We created a robust database of more than 1,000 photos of existing conditions found throughout the research sites. Photos were tagged with metadata for future reference during the synthesis and translation phases of the project. The database was coded using metadata that allows searching images by location, facility, date, what was seen (e.g. parking, entry, lobby, etc.), and other more specific identifiers. This database is used to retrieve information about specific sites and topics, and it is anticipated that it will be continually updated and built for the future.

[2] J. Zeisel, Inquiry by Design

4. The Research and Discovery Phase - SEPTEMBER 2007 TO MARCH 2008 (continued)

METHODOLOGY TWO: **SHADOWING** (continued)

At this point in the research, the goal was to empathically observe and witness what people actually do and say, and to some degree feel, rather than what designers think they do or should do. The team looked for links between behavior and physical elements such as how one actually interacted with a signage system and how that system accommodated the needs of the member. In this particular instance, we often found that people worked around the signage and wayfinding by asking directions.

METHODOLOGY THREE: **MOCK JOURNEYS/EMOTIONAL JOURNEYS**

Mock journeys or "emotional journeys," like observations, were designed to be immersive and experience-centric. This methodology focused on providing the ethnographers with emotional input in specific environments based on actual circumstances such as illness or injury. The fundamental goal was to better understand through a "mock experience" what a member or patient has to do and participate in to accomplish a specific health care task or experience. With permission from the participating facility, one member of the team play-acted an illness while the other play-acted as their escort or health care advocate. Both members of the team simultaneously recorded their emotional responses to any touch points — whether the touch points were the physical environment or people. The team members purposefully did not look at the space from a physical mindset but rather at how the space and process/journey made them feel as people and patients. Three complete journeys were completed including an emergency room journey, a visitor journey, and an orthopedic journey.

For the purpose of this exercise, an emotion is defined as a complex reaction pattern that can result from an experience, and it typically involves both behavioral and physiological elements. For example, an emotion can be followed by physiological changes such as increased heartbeat or respiration. It is important to note that an emotion cannot be "felt" by watching, it has to be experienced.

METHODOLOGY FOUR: **INFORMAL INTERVIEWS AND THREE QUESTIONS**

Informal interviews were conducted with building occupants, including members, families, and visitors. The purpose was to ask those being observed specific questions to clarify interpretations made by the researchers or to clarify a specific point of view. They focused on three questions:

1. What was good about your experience today?
2. What could be improved about your experience today?
3. What three words best describe your ideal future experience at Kaiser Permanente?

Ten patients participated in spontaneous interviews using a general discussion guide, and 29 patients participated in the 3-question method from above. This interview guide included the three questions and a list of 64 words to best describe the participant's opinions. This methodology collected thoughts and insights directly from a member while he or she was a patient in the Kaiser Permanente system. In some interviews, a family member was invited to participate and provide information regarding his or her experience.

4. The Research and Discovery Phase - SEPTEMBER 2007 TO MARCH 2008 (continued)

METHODOLOGY FIVE: **PARTICIPATORY WORKSHOPS**

The first participatory workshops, conducted at a research facility in Walnut Creek, Calif. were held in October 2007 with the objective of inviting and guiding members to envision an ideal future health care experience. The workshops focused on two specific health care journeys:

1 An outpatient visit in an exam room; and
2 An inpatient journey and the patient room, with groups designated for each.

For sessions, the research methodology and workshop tools remained consistent.

Each group had five to eight participants selected to represent Kaiser Permanente members that psychographic research identifies as "proactives," "alternatives," and "basics." These psychographic profiles describe attributes relating to personality, values, attitudes, interests, and/or lifestyles. Psychographics should not be confused with demographics, which focus on metrics such as sex, race, age, income, disabilities, mobility, educational attainment, home ownership, employment status, and even location.

A proactive is just that, one who is proactive about his or her health. Medical care is a priority for these members and they take personal responsibility for their health. They trust and rely on physicians, seek out medical information, get regular checkups, and often align with large, full-service facilities and a wellknown health plan.

Alternatives are the same in that medical care is a priority. They lead a healthy lifestyle and seek medical information on their own. They are often skeptical about modern medicine and expect forms of nontraditional medicine to be a part of their care.

Basics just want a "safety net." Health care is often a low priority in their lives. They have a desire only for basic health care because they do not worry about health. They seek care they can count on and competence in the delivery of such, but focus on minimal investment and value for their money. They have low use of care, are the least likely to have a regular physician, and, to a large degree, do not focus on their health care.

The spring 2008 effort consisted of six workshops focused on three specific ethnic groups rather than the psychographic selection of the earlier workshops. Specifically, the focus was Hispanic Americans, African Americans, and Chinese Americans. A total of 42 members participated in the workshops held over three days in three cities, all in Southern California.

Prior to arriving for each workshop, participants were given an overview of what the workshop would encompass, and were given "homework" that asked a series of foundational questions about their household, technology used, and their recent visits to Kaiser Permanente.

4. The Research and Discovery Phase - SEPTEMBER 2007 TO MARCH 2008 (continued)

METHODOLOGY FIVE: **PARTICIPATORY WORKSHOPS** (continued)
They used the supplied homework guide to document and map their journeys, including what they did, how they felt, who was with them, and the highs and lows of their experiences. These were posted and discussed among the group. The intent was to prepare them for what they would do in the workshops and to give us their background. This portion of the workshop addressed their experience "today."

In the second part of the workshop we focused on their desired future experience with a preconceived date of 2012. The participants did an image sort in which they received 30 diverse images ranging from people to technology to nature. They were told to select five images that answered the question, "What matters to you?" and five images that answered the question, "What does not matter to you?" The images were then compiled into a visual narrative about what was and what was not important. The result was discussed with the participants for clarification and alignment.

Participants were then asked to create a visual collage representing their ideal future care experience, including what they would like to experience, and future opportunities. To do this collage, they were given a toolkit that included images, words, symbols, stickers, tape, pens and pencils, and a large sheet of paper to work on.

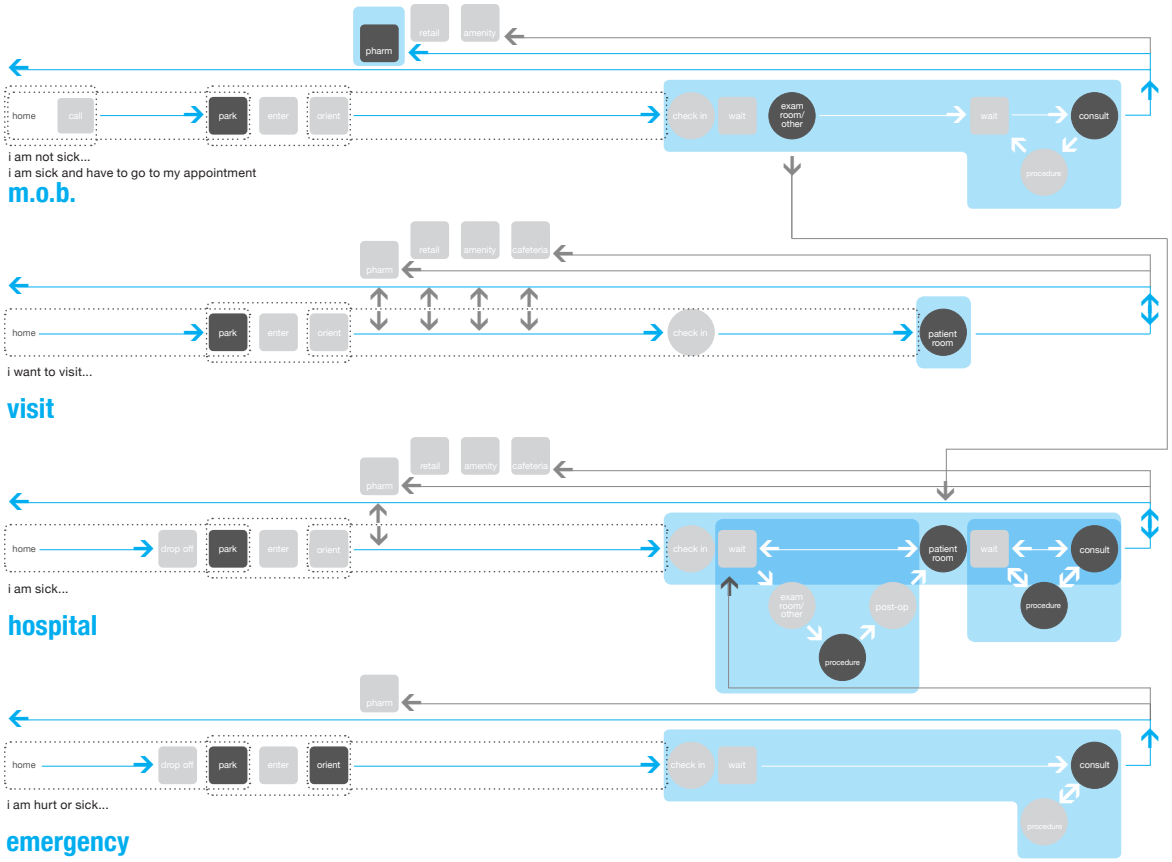
The teams then presented their ideal future experiences and discussed thoughts, insights, and topics they found interesting and/or important.

5. Research Findings and Key Insights

Research translation began in January 2008 by creating a framework to synthesize the research findings in the context of key member and visitor journeys. This framework was created by first defining four key member journeys as described from the first stages of the research, which included the medical office building; emergency; inpatient; and visitor journeys. Journey definition included the purpose of each journey and the research findings associated with each.

5. Research Findings and Key Insights (continued)

Four Journey Types Described



Topics of Importance to Members as Discovered in the Research Phase

The following lists document key points of interest to the members. They are recorded as discovered and not prioritized in any way.

Topics Identified in the Walk-Alongs and Observations

- Efficiency in service and waiting
- Positive distraction
- Quality of service and communications
- Communication and understanding
- Environmental ambience
- Personal control and choices
- Comfort
- Entertainment and education options
- Connection to my life
- Sincere care and face-to-face interaction
- Use and integration of technology
- Separation and privacy as I need it
- Amenities to accommodate my needs

5. Research Findings and Key Insights (continued)

Topics Identified in the Mock Journeys/Emotional Journeys

- The journey to the medical center and the point of service is important
- Timeliness of service and waiting
- Effectiveness and sincerity of interaction and communication
- Ease of obtaining information and understanding the information
- Connectivity to my life
- The importance of cleanliness and organization
- Personal control, privacy, rest, escape and refuge
- Entertainment and educational options
- Environmental comfort and ambiance

Topics from the Interviews and Questions

- Hope for relieved tension/anxiety
- A desire to feel in control
- A need for convenience
- A need for efficiency
- A desire for guidance and connection during my journey
- A need for learning through expertise and communication
- A desire for comfort and support
- A desire to be stimulated in a positive way
- A need to be respected
- A desire that the service and communications align with my personal values
- A desire for privacy and refuge

Topics from the Participatory Workshops

- Quality, personal care - "Who is taking care of me?"
- Simple, understandable, and informative communication - "What is going on?"
- Convenience and accessibility - "What works best for me?"
- Personal control and choice - "What do I want to do right now?"
- Comfort and peace of mind - "Where can I get peace and quiet?"
- Technology - "Is there a more convenient efficient and seamless way to do this?"
- Affordability - "What am I paying for here and is it necessary?"
- Getting back to my life - "How can I be healthy again?"

5. Research Findings and Key Insights (continued)

What Matters to Members — Common Themes and Opportunities

In the process of synthesizing the full body of research derived from the multiple methodologies, commonalities or common themes emerged. It is important to note that the team found each of the methodologies produced similarities and converging perspectives, thereby adding confidence that what we discovered was in fact valid.

The following list categorically synthesizes the topics into common themes. These common themes act as the foundation for design explorations and decisions regarding branded elements and service concepts. Also, they are the driving force behind the development of specific design criteria.

1. The need for understanding and efficiency in the journey to the medical center and point of service.
Members and visitors always speak of a health care visit starting at home, or work, or wherever they are, and ending when they get back to the starting point. It is not limited to their time at the Kaiser Permanente facility or campus. The commute adds both complexity and time and affects how they feel about the service provided.

It is important to consider clear and easily identified facility entrances, drop-off, and parking locations by building, and valet parking if available. Once members have parked, or if they arrive by another means of transportation, it is important they readily understand the route to the main entry of their building, and then to the registration and/or reception area. They also expressed the desire to have efficient communication systems for understanding the reception and copay processes, flow, and queuing, and navigating the wayfinding systems for guidance to their locations.

To be considerate of their needs and desires, we must create efficiencies in the timeliness and understanding of the entire process, starting at the scheduling phase.

2. The need for convenience, efficiency, and timeliness of service and care.
Members are keenly aware of the amount of time invested in waiting, and the uncertainty about when they will be summoned. As stated above, members view this waiting time relative to the whole of their journey.

A key finding is that waiting is not downtime, but rather an active process of using this time for meaningful activities such as entertainment, work, connecting with others, rest and rejuvenation, nourishment, and even exercise. To a large degree, members feel if they have to be there, they might as well be doing something of value to keep their day productive.

5. Research Findings and Key Insights (continued)

2. The need for convenience, efficiency, and timeliness of service and care. (continued)
Members often discussed the possible integration of technology, such as text messaging, as a means to communicate schedules, update timing, and mitigate waiting time. We also found that by simply increasing the frequency of communication, members felt more empowered to use their time effectively and efficiently, thereby minimizing the actual and perceived disruption to their daily regimen.

There is a significant concern that journeys requiring multiple "stops" at either physicians' offices or for service, require multiple wait times, again without predictable outcomes.

3. The desire for guidance and connectivity to life.
Members feel their life is disconnected and disrupted when an illness or injury occurs or when a simple preventive health care visit is necessary. The appointment is not only a change in their daily routine but brings with it logistical, financial, and time pressures, all of which are, to a large extent, unknown. To exacerbate this, any health care visit inherently results in a certain level of anxiety that a health problem could be identified.

Connectivity is not only defined as telephony and e-mail, but also as the ability for one to be productive in doing other tasks during their time at the facility.

Activities defined included shopping for food and medications, getting nourishment without having to make another stop, accessing an ATM, working out, and even just relaxing and finding refuge in a busy day. Having access to daycare services was a common request to not only avoid another stop but also another expense. A desire for extended hours was highly desired as a means to avoid work absence and to have access to other family and friends for support.

The acceptance and integration of family and friends into the care process is important.

4. The desire for entertainment and education.
The experience at a facility and the time spent waiting is perceived as more positive if the environment allows people to select and control their entertainment options, food, general amenities, personal items, and technology access.

This particular theme varies significantly between hospital stays and outpatient visits. In general, during outpatient visits, members have the expectation to get in and out of the journey as quickly as possible — efficiency is key and entertainment is less important. A hospital stay on the other hand carries with it the expectation for more personal communication and connection between the caregivers and the member, and increased entertainment and educational options.

5. Research Findings and Key Insights (continued)

4. The desire for entertainment and education. (continued)
In waiting environments, there exists the complex dynamic of some people accepting, and even desiring, general information such as television or educational media, while others view it as an imposition.

5. The need for interaction, communication and understanding.
This is an important element of care delivery, and encompasses the need for personal connections, sincerity, and members' desire to feel important. Updates on timing, reminders of service, responsiveness, and attentiveness all create the foundation for a pleasant experience. Members have a desire for sincerity and respect that aligns with their expectations and emotional needs. This requires a more conversational dialogue that includes listening, informing and conversing, without seeming rushed or time constrained.

When discussing issues of understanding, members desire to have the purpose and value of any event or procedure communicated to them, the timing involved, and the cost implications. Fundamentally, this is again about needing to be informed and being able to prepare.

Another interesting insight is that members want to know more about those providing their care. They envision being able to access staff bios that could include an overview of the caregiver, photos, videos, personal philosophies toward care, educational background, care specialty, years of practice, languages spoken, and maybe even a personal story. All of this envelops the desire to know more about those taking care of them and the desire to create connections that are more personal.

6. The need for information access and understanding.
Members receive information during their care and/or visit. This information is delivered in media ranging from paper to electronic. This information could address the visit, care process, after-visit care, medications, alternative care strategies and options, etc. They expressed concern that this information is often not organized, cohesive, or consistently designed, and hence less than understandable. This situation affects the future care and compliance of a health and treatment routine.

Further, members and other customers would like more access to information, either electronic or print, while in the facility, to learn about their health and use their time productively.

7. The desire for personal control, privacy, and refuge.
Visits both to receive care and to see a friend or loved one are often stressful to members and customers. It is a combination of travel, time, financial burden, and the general anxieties surrounding any health care visit. Because all people have differing needs and emotional constructs, affording them the ability to control as many aspects of the journey as possible should be considered.

5. Research Findings and Key Insights (continued)

7. The desire for personal control, privacy, and refuge. (continued)
Affording spaces for special human dynamics better supports people to balance their physical and emotional journeys. By providing a range of spaces and zones that focus on privacy, personal conversation, family cohesiveness, and functional needs such as postures, technology support, lighting control, etc., members can better align space with behavior.

Also, many people mentioned the desire to be able to seek a place of refuge to be completely alone.

8. The expectation of comfort and ambience.
Members define this to include more than the conventional notions of space — color, lighting, architecture — or "comfortable" furniture.

Spaces need to address emotional and behavioral issues such as personal control, understanding, perceptions of illness, noise and interruptions, and even odors.

Further, zones are required to accommodate different modes and activities such as social, individual, and work activities; to attract and gather people to support sociality and togetherness; to allow members to escape stimulation and provide rest, refuge, privacy, and quiet; and to create security and a sense of safety for members and customers in all areas of the facility, including parking.

Furniture must accommodate different postures and support various behaviors. We must create serene environments that do not appear or feel commercial or clinical, and we should consider **proxemic** principles, or spatial relationships and requirements, to better support the needs of those using the space.

There is a need for natural light and access to nature, the desire to control temperature in one's room, and the need for positive distractions throughout the environment.

9. The expectation of environmental cleanliness and organization.
People often spoke of the notion that a clean environment and good communication is what matters most in a visit. There is a perception that the quality of service is directly linked to the cleanliness of a space. This perception is not only linked to notions around sterility and infection, but also that "clean" sends a message that Kaiser Permanente cares about them personally by keeping the spaces maintained.

Organization is also broadly defined but includes the placement of signage, especially added and "work-around" signs, plus elements that are non-clinical including charity collection bins, plants, artwork, furniture, and even support elements such as wheelchairs and walkers.

5. Research Findings and Key Insights (continued)

10. The expectation of quality in all aspects of the relationship.
This is likely more a perception that results from the interaction of the above elements. It also depends to some degree on the outcome of members' visits. Communication and connection are the fundamental elements to this perception. It is important to consider that a member's perception of quality care and environments differs between a hospital stay and an outpatient visit.

11. The hope for relieved tension and anxiety.
In all health care visits there is, to some extent, the feeling of anxiety due to the many unknowns that people must confront. Many members in these environments are fragile. The team ultimately recognized that we are not in control of this, but must be cognizant to not in any way negatively affect this.

Modes and Emotions in a Health Care Visit

All positive emotional reactions from members directly correlated to interactions with people. Can we design to support emotional states in addition to space and tasks?

Just as the team discovered patterns or common topics of conversations they also found that a visit or event was shaped by a framework that we termed "common modes and emotions." By modes we mean a common manner of acting or doing in the context of a specific environment. Emotions are one's mood, temperament, personality, and disposition that shape an experience, contact, and journey. The following modes and emotions were consistent among members during outpatient medical office appointments with physicians, or inpatient hospital stays:

Positive modes and emotions include the desire to be trusted and, conversely, to have trust in the situation. Physical and emotional comfort is required both while waiting for and during the visit, appointment, or stay. Members expressed their need to be respected, and for sincerity and authenticity from the caregivers. Creating a connection with the caregivers was very important for members and loved ones. Simply displaying one's name and providing an introduction illustrated an increase in satisfaction. Regardless of one's stage in life, the desire for hope and optimism was emphatically stated, as well as patients' sense of relief when their physical and emotional needs were met and when their appointments were over. Members often said that the end of a visit was somewhat celebratory, and they often treat themselves to a snack or coffee. Positive modes and emotions include:

- Trust
- Sincerity
- Hope
- Comfort
- Authenticity
- Optimism
- Respect
- Connection
- Relief

5. Research Findings and Key Insights (continued)

Modes and Emotions in a Health Care Visit (continued)

Negative modes and emotions arise from impersonal care and communication and a feeling of physical or emotional isolation. They are embedded in the notion that any health care visit is, to some degree, anxiety filled. Feelings of entrapment and exposure, inundation, and confusion brought on by the environment or communication lead to increased anxiety and uncertainty about one's health or the visit in general. Members are often frustrated by the overall process, their worry or fear, or discomfort and pain. If the visit is confusing or inefficient, impatience and a sense of urgency arises, followed by doubt and vulnerability, resulting in stress, exhaustion, and desperation. Negative modes and emotions include:

- Impersonal
- Confusion
- Worry
- Impatience
- Exposure
- Isolation
- Anxiety
- Fear
- Doubt
- Urgency
- Entrapment
- Uncertainty
- Discomfort
- Vulnerability
- Stress
- Inundation
- Frustration
- Pain
- Exhaustion
- Desperation

A certain level of tension and anxiety exists in any health care visit not only because of the visit itself, but because of the issue of money, which may include lost wages for the time away from work, transportation and parking costs, copays, and prescription costs,- all of which are most often unpredictable to members. The time away from work or home responsibilities, and the effort to schedule and go to and from an appointment play a significant role in this anxiety. The planning, journey to a visit, during and after a visit, is complex and can significantly disrupt people's days or lives, and that of their loved ones and family.

The Type of Visit Determines Ones Expectations

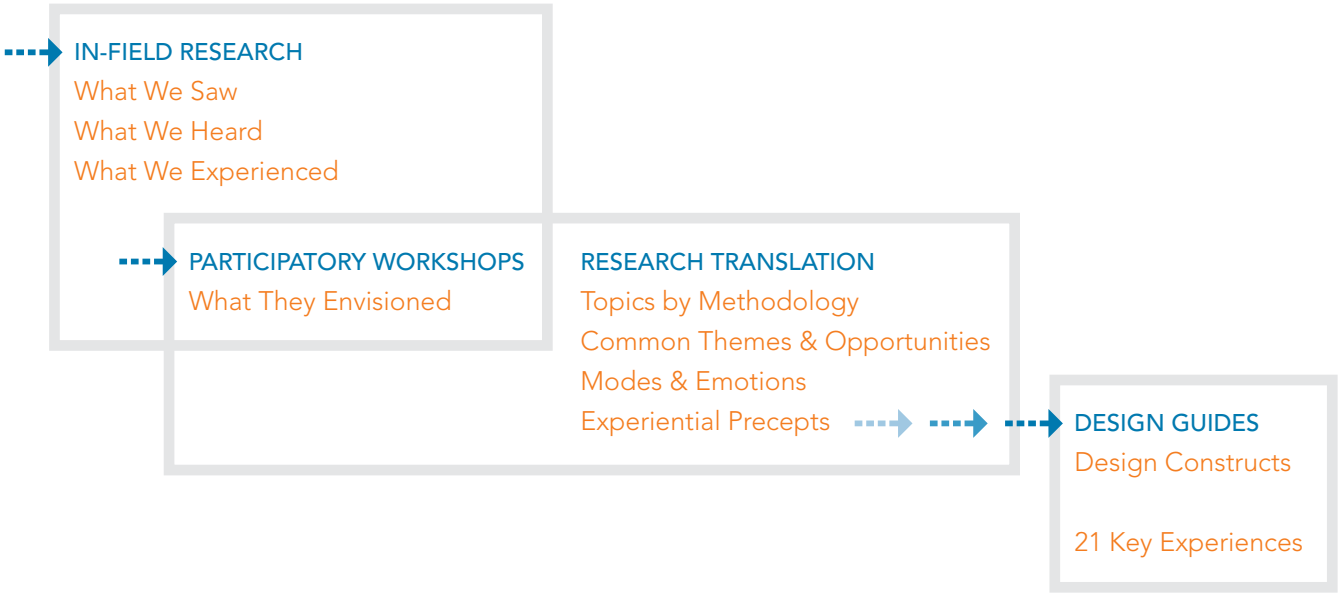
Members have differing expectations regarding personal communication, care delivery, and space as it relates to types of visits. Although there seems to be variations across a wide range of visits, it is worth noting the difference between an outpatient visit and hospital visit.

People visiting a medical office building expect an efficient and informative experience while those in hospital journeys have expectations for a personal and conversational relationship.

MOB VISIT	HOSPITAL VISIT
Clean	Private
Efficient	Personal
Informative	Sincere
Conclusive	Conversational
	Optimistic

6. Research Translation, Concepts and Guidelines

In the process of translating the research findings into actionable design solutions to reposition the design of Kaiser Permanente health care facilities, the team went through a series of definitional phases. Each of these phases continued to develop and refine a framework that would guide design concepts. It is important to note that this process was a constant evolution of thinking regarding what constituted relevant solutions, and **continuously** migrated as the team envisioned possible futures, evaluated the impact of the ideas, and considered the business ramifications of the designs.



This process started with what were termed "experiential precepts," as derived from both member conversations and the common themes above.

The team defined an experiential precept as a general rule consistent with a broad number of members relative to their needs and experiences. These could be applied across all aspects of a health care experience, including people, service, and the physical environment. These precepts make connections between experiences and thoughts and the resulting feelings of those interacting with the Kaiser Permanente brand. It is important to note that these once again are from the member's point of view.

6. Research Translation, Concepts and Guidelines (continued)

The Experiential Precepts

ACCESSIBLE PERSONAL SERVICE + CLEANLINESS = MET EXPECTATIONS

People most often focus on things other than the built environment when speaking about Kaiser Permanente and the service they received.

INFORMATION + PERSONAL CONNECTION = HAPPY MEMBERS

If members have the information they deem necessary, in a way that is easily understood, and they feel a sincere and appropriate level of connection with the staff and service, then they tend to express a happy and satisfactory experience with Kaiser Permanente.

NOT KNOWING = ANXIETY

Members and visitors desire more communication for concerns such as:

- **Time** - How long will this take? I'm taking too much time away from the office. Can I get home in time to pick up the kids?
- **Money** - How much will this cost? Will they accept cash/credit? Do I have enough cash? Is there an ATM machine here?
- And, the reason for procedures - Do I really need that? Why?

MEDICAL APPOINTMENTS = A DISRUPTION TO MY LIFE

Convenience and efficiency are the critical success factors for medical office visits. These factors are defined as short wait times; efficient communication and service; and access to retail services such as healthy food, pharmacies, eyewear shops, health education, and farmers markets. Members and visitors prefer to group their activities for efficiency, such as shopping at the farmers market while waiting for a prescription.

HOSPITAL STAYS = A DISCONNECTION

Patients want to stay connected to their families, friends, and social networks, and they want access to their personal technology. If able, patients even prefer to stay caught up with work while recuperating.

LACK OF CONTROL OR CARING = UNHAPPY MEMBERS

Hospitalization is seen as a loss of personal control, and to some extent, dignity. Patients would like to control the lighting levels and temperature of their rooms. They would like their food to be healthy and served appropriately, and they would like to have food choices. They would like personal privacy, a schedule they can understand, and they want to be able to sleep. Patients would also like to have access to entertainment to pass time.

6. Research Translation, Concepts and Guidelines (continued)

INCONVENIENCE = A PERCEPTION OF A LACK OF CARING

Care processes and procedures must reflect the patient's comfort as well as staff efficiencies. Members who have to endure unexpected wait times, procedures they do not understand, added procedures and/or visits, or anything that does not align with what they thought was going to happen will consider the environment as uncaring.

PEOPLE ARE MORE IMPORTANT THAN AMENITIES AND THE ENVIRONMENT

Service is everything: The services you offer, how you deliver it, and the people who deliver it really matter. The team found that good service will make up for a less than optimal physical environment, but the **converse** is not true. An optimal physical environment will not make up for poor service and communication. Relationships, including relationships with caregivers, family, and friends, must be enabled, and it is important to include opportunities for privacy and quiet conversation. Family dynamics are a component of health, and we must understand and support these complex relationships.

STAFF + CARE + SERVICES + CLEAN = HAPPY MEMBERS

Members and visitors equate medical visits with exposure to germs. There was a lot of conversation around the question of whether wellness and sickness could coexist. Most building occupants do not understand complex design objectives, and often do not even notice, but they all notice and understand convenience, logic, efficiency, and cleanliness.

Design Constructs

At this point in the research translation, design constructs were developed. Whereas the information to this point was always from the member's point of view, these constructs were written from a designer's mindset, and encapsulated the research findings; supported human-centric or somatic design; and were scaleable, feasible, practical, viable, and cost effective so they could be applied to both new and retrofit projects. These constructs define attitudes to be considered in the design of any aspect of a health care facility.

A key finding is that most people have low expectations of the space and share relatively the same needs and emotions when interacting with space. "It's really the service that makes it," is people's general attitude. How do we move beyond these baseline expectations of space?

DESIGN TO SUPPORT EMOTIONAL STATES

"People here are fragile, anxious, and full of emotion."

- Accommodate the special needs of people in different emotional states.
- Different emotions require different spaces.

6. Research Translation, Concepts and Guidelines (continued)

Design Constructs (continued)

REFUGE IS NECESSARY

- Provide special spaces for staff, members, and visitors.
- Health care environments and experiences can be stressful so afford people spaces to "get away."

REDEFINE WAITING AS AN ACTIVE PROCESS OF LIFE

- Provide opportunities for members and family to continue with their life needs, have control over privacy and refuge, and support their emotional needs.
- Accommodate refuge, work, children, mourning, etc. in specific and separated spaces.

ESTABLISH INFORMATION AND INTERACTION HIERARCHIES

- Focus on what is important and necessary — too much information decreases understandability.
- Eliminate excess signage and messaging. If it doesn't have a distinct purpose then it should not be used.
- Provide clear paths for first-time patients and visitors.
- Provide "short cuts" for people who know where to go.
- "Chunk" information to ease understanding and navigation.

REDUCE AND SIMPLIFY

- Kaiser Permanente has a propensity to add, versus subtract, so focus on the least to do the most.

CREATE CONCEPTS TO SOLVE GROUPS OF ISSUES

- Combine, organize, and integrate elements to minimize complexity.

MODULARIZE AND PREFABRICATE

- Create an adaptable kit of parts for planning efficiency.
- Build offsite and install to minimize disruption, time, and cost.
- Use readily available manufacturing capabilities.

INCORPORATE WHIMSY, SURPRISE, AND ENJOYMENT

- Create the unexpected.
- Embrace message and tone of "Thrive."

CONNECT TO NATURE

- Maximize views and opportunities for interaction with nature.
- Create physical and visual connections.

6. Research Translation, Concepts and Guidelines (continued)

Design Constructs (continued)

INCORPORTATE BOLD COLOR

- Use bold color but with restraint to create ambience.
- Use color coding to inform and guide.

INCORPORATE WHIMSY

- Incorporate whimsy, but with restraint to create visual and emotional relief.
- Design to relieve the serious nature of health care.

The Total Health Environment Toolkit

The Total Health Environment initiative was never intended to impose a "cookie cutter" approach to design for all buildings. Instead, it was meant to design a limited number of brand components or signature brand elements that could in time be implemented across a large real estate portfolio in all regions.

The "21 Key Experiences" were developed as a member-centric, experiential structure to translate the research findings into scalable, feasible, practical, viable, and cost-effective design solutions that can be applied to both new and retrofit projects. The design solutions are organized into the key "touch points" that members encounter along their health care journey at Kaiser Permanente. They are designed to be flexible within a framework, allowing all or some of the key experiences to be applied to Kaiser Permanente projects, buildings, or campuses, depending on a specific project scope and budget.

Parallel with the research and design initiative, the Kaiser Permanente team worked to develop a design resources toolkit, which consists of on-brand colors, materials and finishes, furniture, fabrics, lighting, and signage and way-finding. The toolkit integrates an enhanced aesthetic with function, durability, maintenance, sustainability, safety and cost containment. Working in collaboration with the Kaiser Permanente Procurement and Supply Department, the team worked with key manufacturers and vendors to not only develop new products and create national standards, but to leverage Kaiser Permanente's purchasing power to procure those products at significantly reduced prices. Initiatives include:

- On-brand **carpet** patterns, and colors
- Improved public seating and other **furniture** standards
- The Sustainable **Fabric** Alliance
- Sustainable resilient **flooring** standards
- Performance based **lighting** standards
- Enhanced **signage** and way-finding standards

The 21 Key Experiences and the design resources toolkit create a group of tools and resources to infuse the Kaiser Permanente brand —Total Health — into the built environment.

7. Conclusions

As the Total Health Environment standards and design elements roll out across the Kaiser Permanente organization, we will establish a guided and disciplined approach to design that aligns member experience and environments with the brand position.

This will be powerful in many ways. It is in essence a three-dimensional experience for our members, which considerably adds to the expression of the brand that has, until now, been mostly communicated through two-dimensional means. It is a combination of mood, look, and sensory perception created through environmental design and interactions with frontline personnel. It complements advertising, merchandising, Web design, public relations, and generally everything the customer can see, touch or perceive. To some extent, it completes the brand messaging and provides the setting for a care experience consistent with the promise of Total Health.

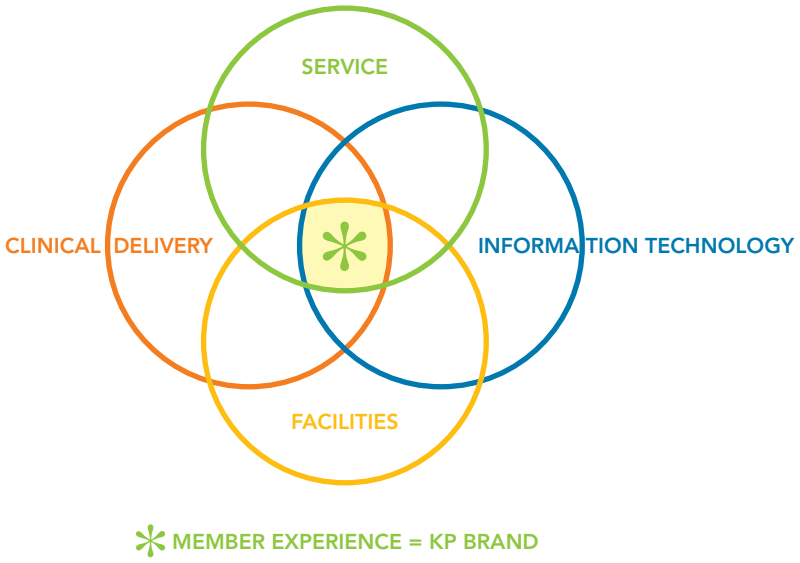
As we stated earlier, the initiative was organized as a systematic and intellectual investigation aimed at discovering, interpreting, and developing knowledge in order to reach new conclusions to inspire and inform design. It is always important to remember that the process to develop this insight, and reach conclusions, was accomplished as a collective activity inclusive of members, customers, designers, and Kaiser Permanente experts. It was not then, nor is it now, a design-centric activity and point of view. By integrating our members in the process of discovery and envisioning the future, we constantly balanced our thoughts as a design team with what we heard members say, what we saw them do, and even, what they made while participating in our design workshops. This makes the design solutions all the more relevant and all the more important to embrace.

Our challenge as ambassadors of this program will be to guide facilities and design experts on how to plan, design, implement, and facilitate Total Health Environments appropriately, and to the highest impact possible considering need, budgets, and timing. The signature elements will not only provide consistency across facilities and regions, but will afford the highest design outcome with the least investment.

7. Conclusions (continued)

Four Key Disciplines Intersect to Affect the Customer Experience

Four key disciplines intersect to affect the customer experience. The key is that an organizational partnership is necessary to fully implement the Total Health Environment initiative throughout Kaiser Permanente. These disciplines include clinical delivery, service and quality, information technology, and facilities. Together, they design and deliver the member experience at Kaiser Permanente.



This partnership is necessary at all levels and includes:

- medical center staff who provide direct care to members and their families;
- those providing services at the medical centers;
- those providing services to the medical center;
- those at the regional offices providing support services to the medical centers; and
- those at Program offices who provide support services to the regions across the country.

Without the synergistic relationships of all involved, the energy and impact of the vision will be compromised.

The Services and Quality group is focusing on collecting data on patient satisfaction scores using the HCAHPS and Avatar programs, and where necessary, on working with regions to design programs to improve these scores. It will remain necessary to continually track the service and quality of the program relative to the core tenets of the program, and the experience of our members.

7. Conclusions (continued)

Information Technology and National Facilities Services are working on the discovery phase of several important initiatives including digital signage and inpatient education and entertainment. We will constantly seek new ways to enhance this program and increase the satisfaction of our members and customers, and to build the brand message into environments and practices.

The Brand team continues to play a key role in Total Health Environment. Just as we included all factions in the development of knowledge and insights, we will continue to involve all of Kaiser Permanente in the implementation, analysis and evaluation, and evolution of the Total Health Environment program. It will always be a goal to consider new ways to better align with the specific needs of regions and facilities.

National Facilities Services has named "implementation leads" in all eight regions who will help the regions and capital project teams implement the 21 Key Experiences into all new construction projects, whether a new large expansion project or a small project in an existing building. The implementation leads meet monthly to share experiences, information, and best practices. To assist with this effort, the Southern California Permanente Medical Group has appointed a "brand champion" who will work with their operations, and Health Plan and Hospitals staff to incorporate the 21 Key Experiences into their existing medical centers.

This new design path will help us bridge the gap between the brand message and intent and the facilities from which we work and provide services.

APPENDIX

TOTAL HEALTH ENVIRONMENT SUMMARY

Great brands evoke emotional experiences. Great brands do not leave details to chance. When our members come to Kaiser Permanente – whether in California or Washington, D.C. – they expect to experience the "total health" promise they see in our Thrive TV commercials. The Total Health Environment project physically builds that promise into our new facilities and during remodel projects over time based on the Total Health Journey.

KAISER PERMANENTE® thrive

Total Health Journey

DISTANCE READ 1

Easy identification of a Kaiser Permanente campus or building from several blocks away; positive presence in the communities we serve.

SITE ENTRY 2

Provide a "Welcome" to the Kaiser Permanente site; create clarity and a sense of arrival; indicate if emergency services are available.

SITE ORIENTATION 3

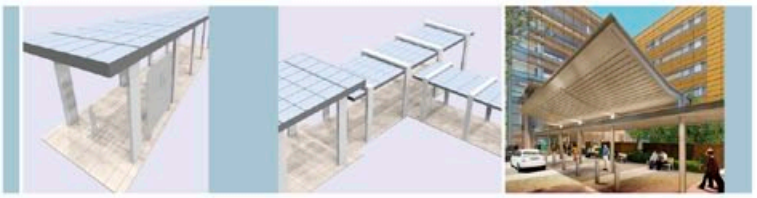
Support intuitive wayfinding; simply and boldly guide members to their destination; reduce visual clutter; provide only required information.

PARKING 4

Provide a convenient parking experience that is pleasant and safe; create environments full of light and fresh air; incorporate whimsy and surprise.

DROP-OFF & PICK-UP 5

Provide safe, comfortable accommodation for easy building access; provide protection from sun and rain.



ENTRY EXTERIOR 6

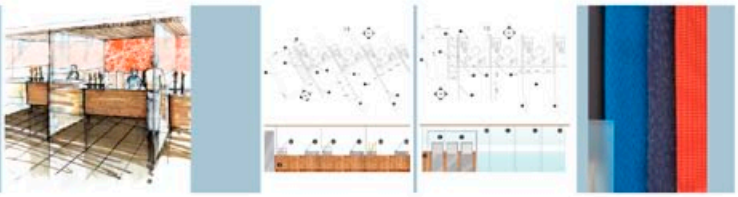
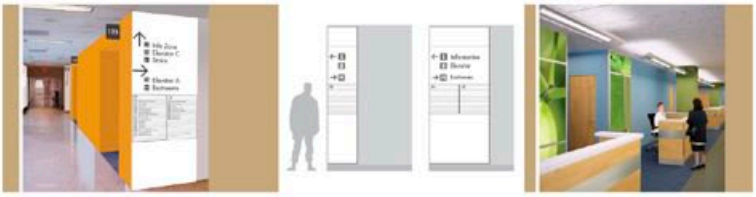
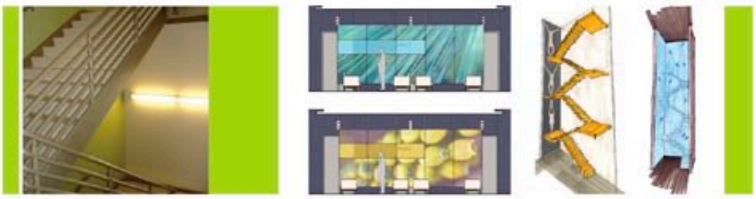
Enhance the outdoor experience and provide a lively, dynamic, and enjoyable journey to the building entry.

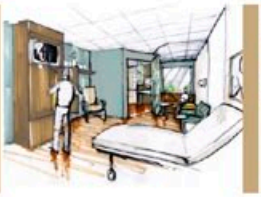
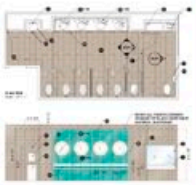
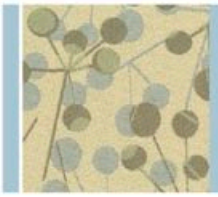
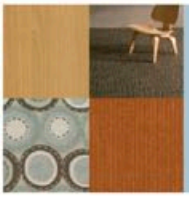
APPROACHING ENTRY 7

Create an experience that welcomes members, and guests.

ENTRY INTERIOR 8

Provide a welcoming experience that orients and informs members and visitors as they continue their journey.

KEY EXPERIENCE	OPPORTUNITY	BRAND COMPONENT
CHECK-IN 9	Create a positive encounter as members begin their personal and private care experience.	
CORRIDORS 10	Redefine corridors to provide information and wayfinding clarity, and calm areas of respite.	
ELEVATORS & STAIRWELLS 11	Inspire people to be active.	
STAFF SPACES 12	Provide respite, recharge, and connection.	F FUTURE DEVELOPMENT
WAITING 13	Redefine waiting as an active process by supporting work, respite, education, or play.	
OUTDOOR SPACES 14	Create environments that provide escape, respite, and inspiration.	
CAFÉ 15	Redefine the cafeteria to a café to support family, communication, connectivity, and escape.	
FARMERS' MARKET 16	Provide a flexible framework for a brand experience.	 F FUTURE DEVELOPMENT

KEY EXPERIENCE	OPPORTUNITY	BRAND COMPONENT
RETAIL & AMENITIES 17	Highlight Kaiser Permanente member resources for Coffee Venues, Gift Shops, Healthy Living, Pharmacy, and Vision Essentials.	 F FUTURE DEVELOPMENT
EXAM ROOM 18	Support the patient-physician encounter by providing comfort, privacy, and personal control in the care environment.	 
GUEST ROOM 19	Create a calm environment that balances emotional and physical patient needs with clinical care.	  
BATHROOMS 20	Go beyond utility to provide an unexpected moment of pause, for peace and quiet, privacy, and to refresh.	  
DOCTOR'S OFFICE 21	Provide respite, recharge, and connection.	 F FUTURE DEVELOPMENT
DESIGN RESOURCES DR	On-brand standards that integrate an enhanced aesthetic appeal with function, durability, maintenance, sustainability, safety, & cost containment.	  

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