"Nothing Is More Powerful than Words:" How Patient Experience Narratives Enable Improvement

Rachel Grob, PhD; Yuna S.H. Lee, MPH, PhD; Dale Shaller, MPA; Emily Warne, BS; Sasmira Matta, MHS; Mark Schlesinger, PhD; Ingrid M. Nembhard, MS, PhD

Background and Objectives: Patient experience narratives (narratives) are an increasingly important element of both measurement approaches and improvement efforts in healthcare. Prior studies show that narratives are considered by both clinicians and staff to be an appealing, meaningful, and credible form of evidence on performance. They also suggest that making concrete use of narratives within organizational settings to improve care can be complex and challenging. Our qualitative study was designed to explore how middle managers working in a health system's outpatient clinics value and use written narratives in their day-to-day work. **Methods:** We conducted qualitative interviews with 20 middle managers working in 8 outpatient clinics. Interviews were fully transcribed, loaded into MAX-QDA software, and coded using thematic analysis techniques. Code reports were extracted and reanalyzed for subthemes related to the objectives of this paper. **Results:** Middle managers across sites described valuing narratives as a tool to: enable better patient experience assessment by augmenting data from patient experience scores; deepen understanding of and relationships with patients; provide insight about operational issues; identify areas for needed improvement and potential solutions; and facilitate strategic work. They reported using narratives for a range of activities related to their roles as supervisors, such as focusing attention on positive practices and needed improvements, promoting deeper group learning, motivating change, reinforcing sense of purpose for staff, recognizing staff strengths and training needs, and inspiring transformational thinking. Finally, interviewees reported numerous specific quality improvement projects (both short- and longer-term) that were informed by narratives—for example, by identifying an issue to be addressed or by suggesting a workable solution. Together, these interviews suggest a collective "narrative about narratives" woven by these organizational actors—a story which illustrates how narratives are highly relevant for how middle managers derive meaning from their work, put organizational values such as responsive service provision into practice, and enact their roles as supervisors. **Conclusions:** Our results add to the nascent literature a detailed description of how narratives can be used both as a tool for middle managers in their leadership and supervisory roles, and as a blueprint for improvement work within outpatient settings. They also illuminate why patient experience scores may improve when narrative data are collected and used. Finally, our results suggest that for middle managers, perhaps "nothing is more powerful than words" because narratives function as both an insight provider and a compelling tool that adds direction and meaning to workplace endeavors.

Key words: measurement, middle managers, patient experience, patient narratives, quality improvement

Author Affiliations: *Qualitative and Health Experiences Research Lab, Department of Family Medicine and Community Health , Center for Patient Partnerships, University of Wisconsin, Madison, Wisconsin; (Dr Grob and Ms Warne) Department of Health Policy and Management, Mailman School of Public Health, Columbia University, New York, New York (Dr Lee); Shaller Consulting Group, Stillwater, Minnesota (Mr Shaller); Health Care Management Department, The Wharton School, University of Pennsylvania, Philadelphia, Pennsylvania (Ms Matta and Dr Nembhard); and Department of Health Policy and Management, School of Public Health, Yale University, New Haven Connecticut (Dr Schlesinger).*

We are grateful to all interviewees for their participation in this research and to the members of the health system that assisted with the identification of possible participants. We also thank Ellie Plahetka for expert assistance in formatting the manuscript.

The authors declare no conflicts of interest.

Q Manage Health Care

Vol. 33, No. 3, pp. 149–159

DOI: 10.1097/QMH.0000000000000477

Patient experience (PE) survey scores and patient narratives—descriptions of care experiences stated in the patient or caregiver's own words—are both elements of PE measurement.[1-4] While scores have become broadly accepted measures, long-standing reservations about the scientific value of qualitative data or "stories"[5] have resulted in slower uptake of narratives as a tool for measurement and improvement. Evidence is now growing, however, that narratives can be a key complement to PE scores because they can provide details needed to guide improvement efforts and contain actionable insights and creative ideas—especially when systematically collected as part of standardized PE surveys.[6-14]

Despite recognition of narratives' actionable content, limited research exists about how they are actually used in organizations. Studies suggest both challenges and promise. An ethnographic study of 6 medical wards in

the United Kingdom found narratives remained underutilized by staff due to lack of confidence about how exactly to use them.[15] Other documented barriers include complexity of narrative data, which can make it less straightforward than survey data to analyze and interpret; lack of in-house expertise to help use narratives for improvement; and inadequate time and resources to build capacity in this evolving area of practice.[16,17] At the same time, studies repeatedly find that both clinicians and staff regard narratives as appealing, meaningful, relevant, and convincing evidence about their practices.[15,16,18,19]

The qualitative interview study we report on here fills an important gap in the literature by assessing whether and if so why middle managers value written patient narratives (hereafter abbreviated as "narratives"), and how they use them both as a resource for improving care and in their roles as supervisors. We focus on "middle managers"—administrative employees who are supervised by top managers within an organization and to whom frontline staff report—because these institutional actors are well positioned in many health care organizations to utilize narratives and play a key role in implementing new practices.[20-22] But they also face challenges deploying narrative feedback with sufficient leverage to induce front-line staff and clinicians to constructively respond to ideas embedded in patient comments.[23]

Our study contributes to the literature on patient narratives by examining their use as a managerial tool for use in tandem with close-ended survey scores and identifying the congruent uses of positive and negative feedback. We further contribute to the organizational literature on the role of stories in professional identification and workplace culture[5,24,25] by documenting the rich meta-narrative our informants weave regarding the importance of narratives in enabling their role as stewards of service-oriented workplace cultures.[22,23]

METHODS

Setting

This study was conducted in a large urban health system that serves a diverse patient population: 35% are not native English speakers, 56% are Medicaid beneficiaries, and approximately 75% are racialized minorities identifying with different groups. All clinics in this system use the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) Narrative Item Set (NIS), a validated tool to elicit rich narratives[14,26,27] alongside standardized CG-CAHPS survey scores. The Office of Patient Experience (PX Office) for this system is actively engaged as an educational and training resource for these clinics, sharing the narrative comments collected with the NIS along with the standardized CG-CAHPS survey scores each week and meeting monthly with clinic staff and leaders to discuss insights from both sources of data, as well as improvement ideas.

Data collection

This study was conducted as part of larger, 5-year project focused on the collection and use of patient narratives, during which we consistently interacted with system leadership, PX Office, and a subset of clinicians and staff working in the system's clinics. Data for this study were collected by conducting semistructured interviews using a exempted by the University of Wisconsin-Madison, Columbia University, and Yale University IRBs.

The PX Office assisted with participant recruitment by contacting practice administrators, supervisors, and "care champions" (the designated leaders for patient-centered care advocacy) at 8 system clinics to request their participation in an hour-long interview during working hours. The clinics were chosen to be representative of the patient population and operations of all network clinics.

Following contact by the PX Office, 1 of 3 interviewers from our team (R.G., Y.S.H.L., D.S.) then followed up to ascertain willingness to proceed and schedule an interview time. Of the 22 individuals contacted, 20 completed interviews; 2 did not due to extended job leave. Table 1 summarizes characteristics of study participants. All interviews were conducted over Zoom between March and May 2022, and lasted between 45 and 75 min.

Interviewers used a semistructured guide, drafted with input from all study authors and incorporating background knowledge of the study setting gleaned from site visits and focus groups we had conducted in connection with the larger project. The interview guide was modified slightly based on insights obtained from the first few interviews. After asking about participants' role and

Table 1. Interviewees by Selected Characteristics

	Characteristics						
	Clinic Type		Tenure in Role		Tenure in Organization		
Role	Primary Care	Specialty Care	New (<3 years)	Established (3 + years)	New (<3 years)	Established (3 + years)	Total
Practice Administrator	5	3	4	4	1	7	8
Supervisor	5	3	6	2	0	8	8
Other[a]	3	1	2	2	0	4	4
TOTAL	**13**	**7**	**12**	**8**	**1**	**19**	**20**

[a]Care Champion or Medical Director.

tenure with the organization, the guide covered a number of interrelated domains of inquiry—each with follow-up probes—including how patient narratives are used by the interviewee and within the practice; what is learned from these data; how roles within the practice facilitate and/or impede ability to use narrative data; how narratives (both positive and negative) are shared with staff; and how such data are used in conjunction with or separate from survey scores, as well as how they may inform recent or on-going improvement initiatives.

Analysis

Interviews were fully transcribed and loaded into MAXQDA2022 software for analysis. The interviewing subteam and E.W. iteratively developed the coding scheme using thematic analysis techniques,[28] building codes both deductively using the interview guide and inductively through open coding of transcripts, group discussion, and code refinement.[29] Once the coding scheme was finalized, R.G. and Y.S.H.L. each coded half of the transcripts, discussing coding questions and disagreements with other coauthors at regular intervals.[30] Code reports relevant to this paper were pulled from MAXQDA and reanalyzed by the lead author for additional subthemes and nuance; coded data and field notes were also reviewed by D.S. and by M.S. (who did not conduct interviews) to ensure the analysis was complete. We present here only those results consistent across clinics.

Table 2. Reasons Middle Managers Value Written Narratives

Enables Better Patient Experience Assessment
▪ Helps explain why survey scores are high or low
▪ Reflects patients' actual experiences most accurately
▪ Highlights specific and detailed aspects of care rather than providing overview assessment
▪ Identifies issues with measurement approach when comments are inconsistent with scores
Deepens Understanding of and Relationships with Patients
▪ Highlights specific experience of subpopulations within the clinic
▪ Identifies how patients feel stigmatized by specific clinic practices and structures
▪ Helps build patients' trust in responsiveness of clinic to their needs
▪ Promotes rapport with staff and patients through shared commitment to improvement
▪ Provides details about patients' expectations
Deepens Operational Knowledge
▪ Provides a view of patients' experiences in the clinic over time
▪ Provides insight about what is happening in clinic that is not directly observable by middle managers
Identifies Areas for Improvement and Potential Solutions
▪ Provides useful information about what needs to be improved (both short and long-term)
▪ Offers ideas for how to improve
▪ Facilitates effective service recovery
▪ Facilitates diffusion of creative and useful practices from outside to inside clinic network
Facilitates Agenda Planning and Execution
▪ Provides validating evidence when advocating with upper management for resources
▪ Informs future longer-term strategy and direction for the clinic

RESULTS

Middle managers across sites consistently described in rich detail *why* they value patient narrative feedback as a form of performance assessment; *how* they work with it within their roles and with other, primarily nonclinical staff, including the specific kinds of utility they derive from both positive and negative feedback; and *what* improvement initiatives they and their staff have undertaken in response.

I. "Seeing the actual comments is very enlightening for us:" why middle managers value narratives

Interviewees were generally quite enthusiastic about the value of narrative data from patients, seeing it as something "important for the operation, important to enhance their care" and important to take "very seriously" (Clinic1B) (see Table 2). Some commented that what patients voice, "what they actually tell us on average, their expectations, and their wants and needs," is the best way to learn what's "really important to them" (Clinic1B). The ideas patients offer for change were also emphasized, with patients acknowledged as "knowing what is going on out there" in other healthcare settings and thus able to encourage diffusion of practices they appreciate (Clinic7A; Clinic6A).

Other strong points of narrative value described by participants include its validating power when advocating with "higher leadership" for resources such as additional staffing or new equipment (Clinic5B; Clinic1B; Clinic8A); the overview of care experiences through time it provides because patients' narratives tend to describe "their experience as a whole since they have been with us" (Clinic4A); and its ability to inform long-term future directions (as well as changes needed in real time) because "it gives you the sense as to, in the future. . . [how to] expedite things to make them more impactful" (Clinic1B). Of particular note is the value interviewees placed on the capacity of narratives to highlight needs and expectations of subpopulations within the clinic by making clear "the difference between. . . the way they see things" (Clinic3B). As one middle manager put it, "the younger population is more into, you know, the technology, the new things, where the older population is more into the older stuff, less complicated, easy to navigate, so you can see the difference in the way they answer certain questions" (Clinic3B). Others talked about how comments from patients of color, or those living with particular stigmatized illnesses, raise specific kinds of questions about

clinic decor and locations (eg, unrenovated or basement spaces), and about being asked if they need translation services based on their appearance.

Interviewees noted that it is part of their workplace culture to encourage patients to provide narrative feedback, and to help them understand that doing so is "not going to be taken as you're complaining, you're a whiner" but rather as "thank you for bringing it to our attention, this helps us improve services not only for you but whoever is coming to our practice" (Clinic1A).

Narratives and survey scores

When participants reflected on the value they place on qualitative data relative to quantitative measures, they consistently emphasized the complementarity of the two data sources, a preference for narratives, or distinct value of each. "A number might say 90," noted one interviewee, "but those words say 150. Do you understand?" (Clinic1B) Another described narratives as an alternative for patients to provide details regarding their expectations and experiences given that "sometimes the [survey] question being asked is not going to give them the chance to explain themselves" (Clinic4B). Interviewees also spoke about how scores and indicators can be difficult to understand or respond to, while comments are "specific to a part of the process," rather than "generic towards to practice"; this renders them more easily actionable, and therefore (to some) preferred (Clinic4B). Respondents also emphasized the value of narratives for understanding why scores are high or low; for "visualiz[ing] what exactly is the problem" so that solutions can be prioritized; and for understanding how scores can be improved. Others focused on how qualitative and quantitative measures work best when used in tandem so as to "drive the staff engagement team work to improve what we are doing" (Clinic4B).

Limitations of written narratives

A few participants voiced a preference for in-person feedback at the point of care over written narratives. Reasons for this include the ability to be in direct dialogue with patients; capacity to respond to issues in real time; and the richer insights that can be obtained through verbal descriptions. Some interviewees also noted that narratives are only useful when they contain sufficient detail to be actionable and do not require much "reading in between the lines" (Clinic1B) or follow-up phone calls to be understood—an issue particularly common with respect to narratives about clinicians.

II. "It's our responsibility as employees to respond:" how middle managers work with narratives

Many participants described working with narrative feedback as central to their identities as managers as well as to their sense of efficacy and meaning at work. As one participant put it, ". . .my focus is to ensure that patients do get the service that they are coming in for but also know that they have a forum, that they could express any concerns. . ." (Clinic1A). In the words of another, taking narratives seriously is "extremely important. . .not only as a supervisor, but as an employee of [the health system]" (Clinic8C).

Our interviewees highlighted two primary foci for using narratives to create change: (1) improving PE and (2) cultivating a service-oriented workplace culture.

Improving care experiences for patients

Middle managers spoke about undertaking a range of formal improvement initiatives informed by narratives (see section III) and using narratives for service recovery whenever patients voluntarily agreed to add names and contact information on their surveys. Phone calls were used to gain detailed information and concrete ideas for improvement. Other times the focus was on communicating to patients who felt upset and unheard that the clinic values them and cares about their experiences (see Figure 1). Follow-up phone contact was also undertaken to de-escalate situations in which frontline staff exhausted efforts appropriate to their role, so middle managers stepped in to help patients with unrealistic expectations to understand "we've done everything we can and what you're asking for, we can't accommodate" (Clinic6A).

Cultivating a service-oriented workplace culture

Interviewees spoke extensively about how they use narratives in their roles as middle managers responsible for supervising clinic staff to cultivate a service-oriented workplace culture that responds to the needs of patients while supporting staff development. Table 3 summarizes primary strategies for using narratives as articulated by interviewees, with supporting quotations.

Participants described using positive comments as a tool for learning as well as for celebrating successes, highlighting practices worthy of further dissemination, keeping momentum, reminding staff of how meaningful their behaviors and actions are for patients, and providing a benchmark from which to elevate. As one respondent summarized, "Everybody likes to hear positive things. . .. That right there releases those happy endorphins" (Clinic7C). Mechanisms for sharing positive comments to achieve these goals include "shout outs" during daily staff huddles; presenting staff with framed certificates with printed comments; sending individualized or group thank you notes; posting narrative exemplars on the bulletin and white boards; and leading team discussions about how practices praised in written narratives can be replicated.

Narratives focused on what did not go well for patients were also used extensively within the clinics. Most interviewees said they welcome this feedback because "it gives you that push to find ways to make it better and involve your team" (Clinic1A). In contrast to positive feedback, negative is most often brought to staff teams in anonymized formats, and to any

FIGURE 1: Example Verbatim Describing Service Recovery

She was very upset. She was very upset because she was calling for an appointment and no one was getting back to her. No one – she wanted to come in. She had an urgency, and no one was getting back to her. So what she wrote was really impactful because it was very negative. I remember she wrote something to the extent that the practice, she would never come back… and she would tell all of her family members not to come to the practice because we don't care for patients. She called us with concerns and nobody is getting back to them and it seems like we're not addressing – we're not valuing and noticing their concerns. So I say, you know what, let me give this patient a call directly. I had just started in my new role, and I remember after the conversation she was very hopeful after speaking to me, I remember her saying, "you have given me hope that things are going to change, and, the reason why I feel this way is not because of what you are saying only but because you actually called me", and it was – I guess it was not the practice before. So I told her that I was actually honored to be speaking to her but most importantly I appreciated the fact that she gave us this feedback, because if we don't have the feedback, there's no way for us to know what's happened. So, I think that was a – that's an interesting story where we can see how we can close the loop for the patient where the comments basically made a difference. – 1B

Figure 1. Example verbatim describing service recovery. She was very upset. She was very upset because she was calling for an appointment and no one was getting back to her. No one—she wanted to come in. She had an urgency, and no one was getting back to her. So what she wrote was really impactful because it was very negative. I remember she wrote something to the extent that the practice, she would never come back. . . and she would tell all of her family members not to come to the practice because we do not care for patients. She called us with concerns and nobody is getting back to them and it seems like we are not addressing—we are not valuing and noticing their concerns. So I say, you know what, let me give this patient a call directly. I had just started in my new role, and I remember after the conversation she was very hopeful after speaking to me, I remember her saying, "you have given me hope that things are going to change, and, the reason why I feel this way is not because of what you are saying only but because you actually called me," and it was—I guess it was not the practice before. So I told her that I was actually honored to be speaking to her but most importantly I appreciated the fact that she gave us this feedback, because if we do not have the feedback, there is no way for us to know what has happened. So, I think that was a—that is an interesting story where we can see how we can close the loop for the patient where the comments basically made a difference. – 1B.

individuals who may be named in the privacy of one-on-one coaching sessions. Middle managers described intentional approaches to the latter function, signaling a strong desire to focus on learning rather than shame or punishment. As one interviewee put it, "You don't want to embarrass them or make them feel that they're doing a bad job or that they're not worthy." (Clinic7C) At the same time, managers noted that because what patients say often "holds more weight" with staff than other kinds of feedback (Clinic5B), bringing it into supervisory conversations can be an effective way to convince staff that identified issues are real, while also helping them feel "okay, alright, I got this. . . it's not so bad, I can fix that" (Clinic7C). Middle managers also use these data to refine work assignments, building on staff's strengths, and to invite group learning and creativity about how to improve.

III. "We're fixing what needs to be fixed:" what improvements middle managers make in response to narratives

A powerful repeating finding is the consistently high level of motivation middle managers described for responding to narrative feedback with improvement initiatives. Some talked about how a single patient narrative impacted practice, motivating changes, for example, in how wrist bands are distributed in waiting areas or how seating for frontline staff is arranged. "[T]he person who took the survey," reported one interviewee while highlighting a cogent example, "said when they sat in the waiting area they felt like they were listening to a bunch of barking dogs." The team huddled to discuss and realized that two frontline staff that day had been speaking with hard-of-hearing patients. This in turn led to a realization about the impact of loud phone conversations on patients, and new recommended practices such as letting patients know "I have someone on the line, I do have to speak up so they can understand what I'm saying or hear me better but please don't take it as I'm yelling" (Clinic4A). Other examples highlighted the way repeating themes in narratives proved catalytic, allowing teams to create improvement projects based on a "mountain of feedback which was the same over and over. . ." (Clinic8A).

Narratives influenced specific improvement projects described by interviewees primarily by identifying issues of importance to patients that were then taken up for discussion and action by middle managers, their teams, and (in some cases) those higher up in the organization. Narratives also suggested solutions and

Table 3. How Middle Managers Use Narratives to Cultivate a Service-Oriented Workplace Culture

	Illustrative Quotations	
How Used	**Positive Narratives**	**Negative Narratives**
Focus Attention on Positive Practices and Improvement Opportunities	**Reinforce positive behaviors**: We also get positive comments and so we use that for reinforcement of the staff in terms of behavior. So for example, if they have been answering the phones more often so now patients are writing hey like I got through the phones, whatever the behaviors that we may have wanted to change and we use that as a positive reinforcement for the staff, you know hey, this is what the patients are writing. . .. – Clinic7B	**Identify behaviors that need to change**: And also it is a way for us to kind of now elicit from the group, what could we have done differently for this particular patient? This is what the patient said. This was not a stellar moment in our practice. What could we have done differently to change, or what can we do differently to change this patient's mindset as to what was exhibited when they were here last. – Clinic5B
Promote Deeper Group Learning	**Allow staff to learn from one another**. embracing the positive because. . ..Once we share that with the staff. . . it helps another co-worker to be able to say, hey, you know what, maybe I should [be]. . . trying doing this too. . . So, and getting that dialogue open with the staff and communicating, hey, you know, how, how was it that, you know, you helped this patient? Like how did that, you know, go about? And people learn off each other. – Clinic8C	**Invite group learning about how to do better.** I use [negative comments] as a learning experience and I. . . take that to mean that, okay. We've faltered somewhere here, and we didn't meet. . . these particular patients expectations. What do we need to do as a team to be able to get to that place where we're meeting those expectations? Right. And so. . . that's one of the reason why I like the comments better than numbers, because the comments really speak to the heart of the matter. The numbers just show like a trajectory that's not going in the right direction. But the comments, you can really sink your teeth into. . . – Clinic5B
Motivate Change	**Keep the momentum for improvement going.** If it's a positive one I can certainly use that as a motivation to not only keep that momentum going and promote that and sort of squeeze the juice out of that good thing that we're doing and make it bigger, but it also gives me an idea as to the path. . . that we want to continue to move forward to. The stuff that they are appreciating. – Clinic1B	**Prompt search for solutions to implement.** Most importantly, in the end. . . we look for what went wrong that definitely we can tweak in real time, meaning if it's something that is technical, was this experience negative for this patient impacted by something technical at the site?. . . Or is it something a little more complex and it has to do with change in behavior among staff members? – Clinic1B
Reinforce Sense of Purpose for Staff	**Encourage a "spark."** I think that some comments can make the difference between setting off that spark in somebody and knowing they made a really big difference in someone's life and here it is in black and white of someone that commented on it. . . – Clinic7B **Highlight importance of daily work.** The patient had just had a miscarriage and so was completely distraught and heartbroken and the level of care and I would say like empathy that the nurse practitioner had with this individual patient, for this patient made the difference between going into like hardcore depression and coming out of there with her head held high saying okay, there's going to be a tomorrow. . .. This may be your 80th patient of the day but to them, this is the only time they're stepping foot into our office and so it's an opportunity to make a lasting impact, it's an opportunity to hear that patient, to understand them, to help them feel that they are being heard, that we're helping them in whatever shape or form. And I felt that that comment really highlighted that aspect. – Clinic7B	**Encourage humility and dedication**. It's not all peaches and cream and that you know what. . . we need to do better. And. . . although we're doing. . . sometimes the best we can, and I say sometimes because sometimes we know that the work that we're doing, we're not giving our entire selves, because you might be, we all have bad days, right? But let's not, the bad days outweigh the good days. Let's let the good days outweigh the bad days. And so, yes. So folks need to know that we're not stellar all the time. We need to work towards it. – Clinic5B
Recognize Staff Strengths and Needs	**Celebrate.** The positive ones obviously we celebrate as a team and there is a lot of commotion and celebration around those. – Clinic1B	**Reassign.** . . . we don't want to like hit [staff] when they're down so we try to give them more of the positive and then look at the negative and see where we can make changes. . . We really try to work on the staff's strengths so if we know that someone is really strong on one thing, we have them focus on that which will make them happier and also give quicker responses to the patients. . . – Clinic6B
Inspire Transformational Thinking	**Provide a benchmark from which to elevate.** Because it tells you, okay, you're doing this, and this is what we probably need more of. But how do we get from here to there?. . . So this is where. . . I would engage the team to say, well, okay. This is what the patient said. How can we. . . use more of this to get to where it is we want to go, right? – Clinic5B	**Invite creativity to improve.** If a patient tells you hey, I love the practice, I love how I was treated, you guys are doing a great job, that's wonderful to hear, that's exactly what we want to hear. But if a patient is telling you that they're not happy or satisfied, then that's when your brain has to work and figure out how we can do better, how we can make the patient experience better next time they come into the practice. – Clinic7A

Table 4. Examples of Improvement Projects Undertaken in Response to Patient Narratives

Improvement Area	Specific Actions Taken to Improve Care	Role of Narratives in Creating Change	Verbatim Regarding Value of Narrative PE Data
Structural Changes			
Preventing Infection Clinics: 8	Improve self check-in process.	Identified issue; Offered ideas for solution	". . . we have like a screening iPad that we give to patients for them to do screening questions. . .. So feedback came to the front desk from patients that they want a stylus, which I understand, because you're touching the screen. . .. So now. . .we're looking into ordering more stylus's. . . these are little, little things that, you know, they make a big difference. . ."
Improving access to care Clinics: 7, 8	Adapt processes for entering virtual visit spaces	Identified issue	Now the big hurdle was IT literacy. . . And that's where we came up with different digital tool solutions, so instead of having them log into Zoom, we would just send them a link to click and then open up the video. . .. But that was only because of patient feedback
Addressing long wait times Clinics: 3	Add signage to clarify mandatory elements of check-in process	Identified issue	Like one comment we got was that a patient. . .registered on his tablet but he didn't come to the front to get a band, so he sat for about 20, 30 min. . . we should have signage that says when you check in on the tablet, come to the front and get a wrist band. So those comments definitely help with things, to make things better for the patient and us
Renovation of space Clinics: 8	Address subjective objections to appearance of physical environment	Identified widely shared perception	So our floors are going to be renovated based off of this mountain of feedback which was the same over and over—it looks like a Medicaid clinic,"I don't want to go to a Medicaid clinic,"it smells like a Medicaid clinic." It's very subjective, I get it, but it is what it is and we have to take into account what our patients are saying. That's not an easy one to hear, for me, but it is something that is real.
Relational Changes			
Improving interactions with staff at point of care Clinics: 2; 3; 5; 6; 8	Counsel staff to acknowledge patients even when otherwise occupied (Rangel 2)	Identified issue; Suggested solution	[The narrative] said "the staff did not acknowledge me". . .And one of the things I've talked with staff about is even if you're busy doing something, just holding up your head and saying. . . "give me a minute". . ..
Clinics: 2	Move internal disagreements to private spaces so patients do not witness them (Eye and Dental)	Identified issue; Used by managers to motivate staff	". . . we used examples of comments that are coming in there to show the staff. . .[patients] observed people interacting in a nonprofessional way then rate us on it, even though it didn't really have to do with the patient itself. . .. We were able to modify some behaviors. . . take it into a room in private. . . So, we've been able to take comments like that to prove to the staff that patients are watching.
Clinics: 8	Institute centralized call center and follow-up with patients after their visits	Identified issue; Demonstrated success (through change in comments over time)	that was a huge pain point for [patients]. . . was. . . I called 10 times, I couldn't get through—so telephone access I think has been a big problem for us. . . [now we. . . and this is something that we did directly to impact patient satisfaction and patient access. . . and it's been really successful and we can see it in the comments. I mean we don't even get comments about telephone access anymore—not in person, not written, not in any way. So that's something that's kind of more global because it's where the hospital is moving towards it as a organization but locally what we've done on just the unit is we restarted reaching out to patients when they do provide their phone number on the surveys.

(*continues*)

Table 4. Examples of Improvement Projects Undertaken in Response to Patient Narratives (*Continued*)

Improvement Area	Specific Actions Taken to Improve Care	Role of Narratives in Creating Change	Verbatim Regarding Value of Narrative PE Data
Providing test results in complete and timely manner Clinics: 6, 4	Improve timeliness of communication; close loop even for lab results with no significant findings	Identified issue; Suggested solution	One particular area that we noticed we were getting comments on was lab results. . . I believe a lot of the practices and providers were under the like no news is good news but for a patient silence may be terrifying so just closing that loop and knowing that based on the comments this is what our patients are looking for—they just want to hear someone say yes, your results are normal, everything is okay. . .
Improving workflow for paperwork completion Clinics: 1	Optimize timely completion of disability forms while reducing burden on patients	Identified issue	One of the things that I used to observe. . . is the complaint about the forms, "my disability forms, I need those papers, I need to get paid.". . . "We can't get the forms back timely." . . . so we decided to take this new project now on where we're like looking at every single component that adds to the practice and making sure that our BFA's or clerks at the front desk they are taking as much information as they can from the patient before the patient leaves to avoid confusion, to minimize the back and forth, making sure that the patient is not repeating information that we should have already had. Then aside from that, we are also meeting with providers to ensure that they are filling out these forms timely and appropriately and we are closing the loop with calling the patients before we mail a form out or even fax it. So, again, little tweaks that might sound minor at the moment, but in reality when we put the whole workflow together we can see the areas of improvement and hopefully create a big impact on our patient experience as well.
Clinics: 8	Keep patients in exam rooms informed regarding wait times		. . .part of the comments that we actually received. . . a patient that was in a room and waited for 30 min; what can we do on our end to improve that, you know?. . . So, you know, part of what we always do with rounding, is also to make sure that we check the rooms. And if the patient is not with the provider, find out with the provider. . . "do you know how long this is gonna take?" so I can at least give the patient some type of wait time?

were used to motivate staff or to understand and document the impact of improvements on subsequent PE. Most improvement initiatives our interviewees highlighted addressed either structural issues (ranging from process or workflow adjustments like new procedures for virtual visits to large capital projects such as renovation), or relational ones (for example, how lab results are communicated, how calls are managed, or how internal disagreements are handled). Table 4 presents examples of narrative-informed improvement initiatives our interviewees described.

DISCUSSION AND CONCLUSION

Our interviews with middle managers in outpatient clinics suggest these stakeholders place a high value on narratives for assessment and ideas. Furthermore, they use narrative data to keep morale and motivation high among staff in their clinics, and to develop and execute improvement initiatives. Finally, the consistency with which participants across 8 clinics embraced absorbing, sharing, and responding to narrative data as an essential job responsibility suggests that a cogent "narrative about narratives" has been woven by these organizational actors—a story which illustrates how this particular form of feedback is highly relevant to how middle managers derive meaning from their work, put organizational values such as responsive service provision into practice, and enact their roles as supervisors.

Figure 2 illustrates how findings from this study can be conceptualized within the context of the clinic sites in which middle managers work each day, providing a model of how patient narratives enable improvement in health care organizations. Narratives (which we found have multi-dimensional value for managers) fuel an active "learning phase" during which middle managers absorb and process new knowledge from qualitative feedback. Over time, they are able to use this knowledge both to cultivate a service-oriented workplace culture, and to catalyze concrete improvement projects. Narratives are central to the ensuing "change phase" via an array of mechanisms ranging from focusing attention on what needs to be changed through inspiring, motivating, and guiding other organizational actors—both down and up the chain from middle managers—to actively participate in meaningful improvement work. The change phase, in turn, sets the stage for improvement in measurable outcomes such as organizational processes and metrics, patient experience, and workforce experience. The line connecting change to improvement is dotted since the data presented here do not explicitly demonstrate altered outcomes; rather, improvements are described by our interview participants in ways fully consistent with earlier findings in this and other study settings.[27,31]

Note: Solid line arrows indicate demonstrated findings; dotted arrow indicates findings described here and partially documented elsewhere.

Our results and derived conceptual model add to the nascent literature a detailed description of how narratives can be used as a tool for middle managers in their leadership and supervisory roles, and as a blueprint for improvement work within outpatient settings. Our results extend earlier findings that middle managers perceive narrative data as useful,[19] by showing how narratives are actually used; and that PE data overall can be utilized to improve staff experience,[15] by specifying how narratives support a workplace culture that aids and develops staff. Our findings also illuminate why scores may improve when narrative data are collected and shared with staff in innovative ways.[27,31]

In contrast to work suggesting it can be difficult to identify what concrete improvements had been made in response to PE data,[16] and that follow-up to measure impact of improvements can be lacking,[16,18] our study offers numerous examples of both specific projects and how comments were used over time to monitor change. Our findings also challenge the notion that when it comes to stories, "people learn more from their mistakes than from their successes[15,25] by documenting extensive use of positive narratives within the clinical setting."

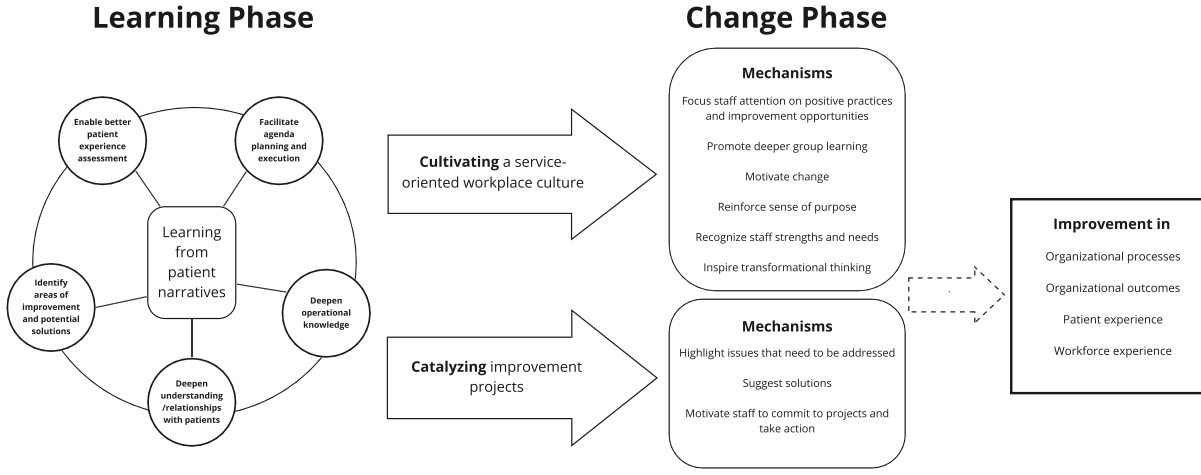

Figure 2. How patient narratives enable improvement: conceptual model derived from middle managers.

Our study was limited in several ways. First, our interviewees were exposed to multiple forms of PE data, including narratives provided by patients in real time at clinic visits or over the phone via complaint lines. While we endeavored in both interviews and analysis to separate out reference to written narratives and excluded data whenever we were unsure, interviewees themselves may confound these sources. Second, because our research team was known to a subset of interviewees in connection with our larger project studying narratives within the health system, participants may have been pre-disposed to focus on positive aspects of narratives. Finally, we interviewed only middle managers and were not able to verify findings through participant observation or formal triangulation via interviews with other institutional actors. Additional empirical work will be necessary to ascertain more about the impact of narratives on people in other critical organizational roles (eg, clinicians, system leaders, and front-line staff) and in other health systems, including whether the change phases and mechanisms we report on here apply more broadly.

Despite these limitations, our study results suggest that for middle managers, perhaps "nothing is more powerful than words" because narratives both convey powerful practical knowledge and can induce added meaning, motivation, and gravitas to workplace endeavors. Their power makes them valuable components and complements of PE measurement and improvement strategies, suggesting that organizations, their staff, and patients are all well served by investment in systems and processes that support greater qualitative PE measurement and use.

REFERENCES

1. Meadows KA, Reaney M. Story completion (SC) - an epistemological approach to the interpretation of patient-reported outcomes? *Expert Rev Pharmacoecon Outcomes Res*. 2024;24 (1):49-56. doi:10.1080/14737167.2023.2268833.
2. Meadows K. Patient-reported outcome measures - A call for more narrative evidence. *J Patient Exp*. 2021;8:23743735211049666. doi:10.1177/23743735211049666.
3. Schlesinger M, Grob R, Shaller D. Using patient-reported information to improve clinical practice. *Health Serv Res*. 2015;50 (S2):2116-2154. doi:10.1111/1475-6773.12420.
4. Guney S, Ghandi TK. Leveraging AI to understand care experiences: Insights into physician communication across racial and ethnic groups. *NEJM Catalyst*. 2022;3(2). doi:10.1056/CAT.21.0480.
5. Rhodes C, Brown AD. Narrative, organizations and research. *Int J Manag Rev*. 2005;7(3):167-188. doi:10.1111/j.1468-2370.2005.00112.x.
6. Tsianakas V, Maben J, Wiseman T, et al. Using patients' experiences to identify priorities for quality improvement in breast cancer care: Patient narratives, surveys or both? *BMC Health Serv Res*. 2012;12(1). doi:10.1186/1472-6963-12-271.
7. Lau H, Litman KC. Saving lives by studying deaths: Using standardized mortality reviews to improve inpatient safety. *Jt Comm J Qual Patient Saf*. 2011;37(9):400-408. doi:10.1016/s1553-7250(11)37050-x.
8. Lee YSH, Grob R, Nembhard IM, Shaller D, Schlesinger M. Leveraging Patients' Creative Ideas for Innovation in Health Care. *Milbank Q*. 2024;102(1):233-269. doi:10.1111/1468-0009.12682.
9. Dohan D, Garrett SB, Rendle KA, Halley M, Abramson C. The Importance of integrating narrative into health care decision making. *Health Aff (Millwood)*. 2016;35(4):720-725. doi:10.1377/hlthaff.2015.1373.
10. Kilaru AS, Meisel ZF, Paciotti B, et al. What do patients say about emergency departments in online reviews? A qualitative study. *BMJ Qual Saf*. 2016;25(1):14-24. doi:10.1136/bmjqs-2015-004035.
11. Kumah E, Osei-Kesse F, Anaba C. Understanding and using patient experience feedback to improve health care quality: systematic review and framework development. *J Patient Cent Res Rev*. 2017;4(1):24-31. doi:10.17294/2330-0698.1416.
12. Lagu T, Goff SL, Hannon NS, Shatz A, Lindenauer PK. A mixed-methods analysis of patient reviews of hospital care in England: implications for public reporting of health care quality data in the United States. *Jt Comm J Qual Patient Saf*. 2013;39 (1):7-15. doi:10.1016/s1553-7250(13)39003-5.
13. Grob R, Schlesinger M, Barre LR, et al. What words convey: The potential for patient narratives to promote high quality, patient-centered medical care. *Millbank Q*. 2019;97(1):176-227. doi:10.1111/1468-0009.12374.
14. Martino SC, Reynolds KA, Grob R, et al. Evaluation of a protocol for eliciting narrative accounts of pediatric inpatient experience of care. *Health Serv Res*. 2023;58(2):271-281. doi:10.1111/1475-6773.14134.
15. Locock L, Montgomery C, Parkin S, et al. How do frontline staff use patient experience data for service improvement? Findings from an ethnographic case study evaluation. *J Health Res Policy*. 2020;25(3):151-161. doi:10.1177/1355819619888675.
16. Gleeson H, Calderon A, Swami V, Deighton J, Wolpert M, Edbrooke-Childs J. Systematic review of approaches to using patient experience data for quality improvement in healthcare settings. *BMJ Open*. 2016;6(8):e011907. doi:10.1136/bmjopen-2016-011907.
17. Flott KM, Graham C, Darzi A, Mayer E. Can we use patient-reported feedback to drive change? The challenges of using patient-reported feedback and how they might be addressed. *BMJ Qual Saf*. 2017;26(6):502-507. doi:10.1136/bmjqs-2016-005223.
18. Lee R, Baeza JI, Fulop NJ. The use of patient feedback by hospital boards of directors: a qualitative study of two NHS hospitals in England. *BMJ Qual Saf*. 2018;27(2):103-109. doi:10.1136/bmjqs-2016-006312.
19. Matta S, Lee Y, Schlesinger M, Nembhard I. Perceived usefulness of patient narrative feedback in primary care settings. *Acad Manage Proc*. 2022;2022(1). doi:10.5465/ambpp.2022.16858abstract.
20. Swordy A, Noble LM, Bourne T, Van Lessen L, Lokugamage AU. Footprints of birth: An innovative educational intervention foregrounding women's voices to improve empathy and reflective practice in maternity care. *J Contin Educ Health Prof*. 2020;40 (3):192-198. doi:10.1097/CEH.0000000000000302.
21. Birken S, Clary A, Tabriz AA, et al. Middle managers' role in implementing evidence-based practices in healthcare: a systematic review. *Implementation Sci*. 2018;13(1):149. doi:10.1186/s13012-018-0843-5.
22. Schneider B, Gunnarson S. Organizational climate and culture: The psychology of the workplace. In: Jones JW, Steffy BD and Bray D, eds. *Applying psychology in business: The manager's handbook*. Lexington, MA: Lexington Books; 1990:542-551.
23. Schneider B, Ehrhart MG, Mayer DM, Saltz JL, Niles-Jolly K. Understanding organization-customer links in service settings. *Acad Manag J*. 2005;48(6):1017-1032. doi:10.5465/amj.2005.19573107.
24. Fischer-Appelt B, Dernbach R. Exploring narrative strategy: the role of narratives in the strategic positioning of organizational change. *Eur J Soc Sci*. 2023;36(1):85-95. doi:10.1080/13511610.2022.2062303.
25. Denning S. Telling tales. *Harv Bus Rev*. 2024;82(5):122-129.
26. Schlesinger M, Grob R, Shaller D, et al. A rigorous approach to large-scale elicitation and analysis of patient narratives. *Med Care Res Rev*. 2020;77(5):416-427. doi:10.1177/1077558718803859.
27. Shaller D, Nembhard I, Matta S, et al. Assessing an innovative method to promote learning from patient narratives: Findings from a field experiment in ambulatory care. *Health Serv Res*. 2024;59(2):e14245. doi:10.1111/1475-6773.14245.

28. Peterson BL. Thematic analysis/interpretive thematic analysis. *Intl Encycl Commun Res Methods*. Published online November 7. 2017:1-9. doi:10.1002/9781118901731.iecrm0249.
29. Hsieh HF, Shannon SE. Three Approaches to Qualitative Content Analysis. *Qual Health Res*. 2005;15(9):1277-1288. doi:10.1177/1049732305276687.
30. Chapple A, Ziebland S. Methodological and practical issues in cross-national qualitative research: Lessons from the literature and a comparative study of the experiences of people receiving a diagnosis of cancer. *Qual Health Res*. 2018;28(5):789-799. doi:10.1177/1049732317736284.
31. Nembhard IM, Matta S, Shaller D, Lee YSH, Grob R, Schlesinger M. Learning from patients: The impact of using patients' narratives on patient experience scores. *Health Care Manage Rev*. 2024;49(1):2-13. doi:10.1097/HMR.0000000000000386.