Why The Patient Lives & The Customer Dies In Healthcare And What To Do About It

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Service provider success in America's consumer oriented society is driven by loyal clientele from Motel 6 to Ritz Carlton. But very few healthcare providers can boast large cadres of raving fans. In fact, service that delights is almost non-existent in healthcare, considered by many providers to be secondary and even inferior to fixing patient chief complaints. As discussed below, basic differences in patient and provider perceptions regarding an episode of care help to explain why hundreds of thousands of times a day in ambulatory care settings, the patient lives but the customer dies.

Other causes include the fact that third party reimbursement in effect makes insurers not patients the primary customer for providers. Patients can and do leave providers that ignore service quality, but the fact that healthcare consumers have not historically paid directly for most of their care has largely removed the threat of non-payment for poor service.

The traditional passive role of patients expected to comply with provider directives has also blunted the potential for market driven service quality. In addition, the fact that healthcare is a service may be a factor. Lovelock (1984) found that, "Because consumers participate to a greater extent in the definition and production of services than products, they may feel more responsible for their dissatisfaction when they purchase services."

Spending on ambulatory hospital care soared 16.3 percent in 2001, the fastest growing component of overall health care spending, according to a study released by the Center For Studying Health System Change (Strunk, Ginsburg, and Gabel, 2002). Double digit jumps in premiums are forcing many employers to shift insurance costs and ambulatory care co-payments to employees, a move not likely to please patients. Patient dissatisfaction with increasing costs and access to care may fundamentally change consumer roles in the healthcare equation. Patients who pay more may demand and get better service quality.

American Hospital Association research indicates that, "when describing their experiences patients are deeply frustrated with lack of access to care and higher out-of-pocket costs." (American Hospital Association, 1998) Access to care is the number one reason that 20 % of enrollees switch health plans annually. (Journal of Health Care Marketing, 1996) The AHA research also found, "an increasing trend toward care that is cold and impersonal. They don't feel things are being done in their best interest." (American Hospital Association, 1998)

Although they serve as an essential tool in measuring patient perceptions, in 1996 Press Ganey reported a so-called intimidation factor or acquiescence bias characterizing patient satisfaction surveys because people are intimidated by caregivers. (The Executive Report on Managed Care, 1995) The bias was much higher for telephone vs. anonymous mail surveys possibly due to the less directly interactive, more removed nature of mail surveys.

Different Perceptions

Differing perceptions regarding what patients vs. providers "see" during an ambulatory care encounter may help to identify key issues and possible solutions. In industrial terms, the raw materials of an ambulatory encounter from which an outcome is produced could be defined as the patient experience and his or her "chief complaint." While patients are likely seeking an overall positive experience from an ambulatory care visit, providers are likely to see a chief complaint or array of symptoms that require numerous logical, technical tasks to fix or at least control.

Pine & Gilmore (1998) detailed the elements of an emerging "experience economy" in which businesses of the future will live or die based on how well they design and implement memorable experiences for customers. Ambulatory care providers show little awareness of such an experience economy, instead choosing to take control and fix chief complaints. In a Wall Street Journal article, Dr. Terry Stein, internist and director of clinical-patient communication for Kaiser in Northern California noted that many doctors come into a patient encounter with a list of tasks in mind "and proceed in a controlling way. It's a conversation about an ailment. Often the patient gets left out." (Chase, 1998) The unsatisfying result for patients is a fragmented, impersonal experience that often leaves them cold. As the writer and television commentator Bill Moyers (1993) commented after an episode of care, "I felt like I had to leave myself at home."

Ambulatory care outcomes are also valued differently among providers and patients. Good clinical outcomes that fix or at least control the chief complaint and reasonable reimbursement are paramount to providers. Traditional payment mechanisms have reinforced this view. Patients on the other hand want to feel that they are cared for and respected as individuals. The current state finds providers in control, costs rising and a patient experience that's unmanaged and often devoid of genuine caring.

Some might argue that a provider's focus should be on fixing chief complaints vs. designing "Disneyesque" experiences that delight. While entertainment may not be the goal, meaningful interaction that genuinely satisfies is an essential part of the care process. As improvement leader and CEO of the Institute for Healthcare Improvement, Dr. Donald Berwick comments, "Interaction is not the vehicle, it is the care." (Berwick, 2000)

In fact, provider accountability for patient experiences that genuinely satisfy is likely to increase. Six of California's biggest HMOs have committed up to $150 million in bonuses for top-performing physician groups, starting in 2003. (Silber, 2002) Patient satisfaction with care will get top billing in how groups will be evaluated, accounting for 50 percent of the cumulative score. Clinical data will count for 40 percent and information technology will get 10 percent. The policy group, Integrated Healthcare Association of Walnut Creek, California that came up with the program intends to publish the data for consumers to help them choose their doctors.

Table 1. The Healthcare Equation

Patient	+	Ambulatory Care Provider	=	Outcomes
Raw materials	+	Production system	=	Product
Patient experience and chief complaint	+	Resources Processes Values	=	Satisfaction Financial Operational

The Healthcare Equation© in Table 1 maps the raw materials, interaction and results of a patient encounter with the values, resources and processes of an ambulatory care provider. Outcomes include financial, satisfaction and operational results or "products" of an episode of care.

Beyond Fixing Chief Complaints To Genuine Caring

Dr. Robert Bone, a head-and-neck surgeon at Scripps Clinic was puzzled by a patient who became increasingly hostile despite a successful recovery from jaw cancer. A life threatening illness had been controlled, even conquered. However, the patient was not satisfied. "When I finally sat down with him and asked why, it turned out he was out of money, in discomfort, couldn't work, and his disfigured face made it hard for his family to be around him. I should have been more in touch with that." (Chase, 1998)

Patient cues regarding their need for genuine caring from providers often go unnoticed. A recent study of 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons found that physicians responded positively to patient emotional cues in only 38% of surgery and 21% of primary care cases. (Levinson, W., Gorawara-Bhar, Rita., & Lamb, 2000)

Surprisingly, the same study found that shorter visit lengths when physicians provided positive responses to patient cues for emotional support.

Satisfying patients impacts compliance as well as financial and clinical outcomes. A meta-analysis of 191 studies found improved surgical outcomes including fewer complications and lower costs associated with interventions based on what patients value. (Devine, 1992) Francis, Korsch, and Morris (1969) found that key factors in non compliance with prescription regimens included lack of physician warmth, not having visit expectations met and the lack of an explanation of the cause of a child's illness.

Poor physician communication can be costly when dissatisfied patients decide to go elsewhere. Research indicates that 47 percent of females and 40 percent of males would switch physicians because of poor so-called 'bedside manner'. Age plays a factor too. While only 32 percent of those 65 and older would switch for this reason, 53 percent of those aged 25 to 34 and 48 percent of those aged 35-44 would switch. (Prince, 1997)

Levinson (1997) found that patient satisfaction and physician style were important predictors of the likelihood of malpractice claims against physicians. The number of utterances, including asking questions and giving information, were significantly higher for physicians with no claims.

An Unmanaged Service Experience

The book *Service America* defines service satisfaction as the collective impact of so-called moments of truth, "an episode in which a customer comes into contact with any aspect of the service provider, and has an opportunity to form an impression."(Albrecht & Zemke, 1985)

Each encounter with staff during the care process creates a moment of truth for patients. The sum of these moments creates an overall outpatient experience that is either satisfying or not. Fragmented administrative processes including multiple registrations and bills, as well as redundant requests for demographic and insurance information yield an unpleasant experience for patients. Compared to the hotel check-in experience, multiple ambulatory care registrations even in separate buildings do not satisfy. Sadly, "when moments of truth go unmanaged, the quality of service regresses to mediocrity." (Albrecht & Zemke, 1985)

As discussed earlier, in their pursuit of excellence, ambulatory care providers closely control the clinical aspects of care but often don't actively manage or even "see" service quality moments of truth. American Hospital Association research found that the public sees health care as "a confusing jumble of seemingly disassociated, impersonal medical professionals and institutions." (American Hospital Association, 1998)

Costly Inefficiencies

Costly system inefficiencies from reimbursement incentives to outmoded office operations also hinder service quality. While rising costs continue shifting to wary patients, reimbursement mechanisms confine providers to outmoded ways to deliver care or what Dr. Donald Berwick, founder of the Institute for Healthcare Improvement (IHI) calls the "tyranny of the office visit." (Berwick, 2000)

For busy consumers, an office visit is not necessarily seen as adding value. Executives at PacifiCare Health Systems report that Americans want minor health problems responded to quickly, even if they're resolved with a phone consultation. (Lessin , Taylor, 1996.)

Technology and innovation have also opened up alternative avenues of delivering care and satisfying patients that go beyond the traditional office visit at less cost. These include e-mail as well as phone and group visits. Yet most insurers refuse to reimburse for these alternatives and in-fact incentivize providers to maximize the amount of care provided.

But the benefits of innovations like group physician visits are clear. A two year randomized clinical trial of 400 chronically ill older patients enrolled in Kaiser Permanente in Colorado, found that compared to controls, group visit patient hospitalizations dropped from 39% to 27%. In addition, there were fewer calls to physicians, an increase in the number of calls to nurses, and a drop in annual per patient ED visits rates from 53% to 35%. Kaiser also found a reduction in same day visits to primary care as well as patients leaving the plan, a key satisfaction indicator. (Beck, Scott, Williams, 1997)

Another factor impacting satisfaction is pervasive inefficiency in ambulatory care processes, generating long waits for appointments that increase costs and no-show rates. A study of patient visits by at Denver Health and Hospital Authority by Dr. Tom Mackenzie (Mackenzie, 2001) found significant increases in no-show rates for patient appointments made beyond two weeks into the future. Appointment no-shows are expensive. They generate huge amounts of waste and rework as charts are

pulled, reminder phone calls done, paper work prepared, and follow-up notices sent to patients who don't show up. Numerous appointment types and lengths confuse staff and create long queues of patients waiting to be seen.

Unnecessary handoffs, delays and redundancy of work are also common. At one client site, when a patient called to make an initial appointment, he was told to call back when a specific volunteer would be in the office. When asked why the patient had to call back instead of being given an appointment immediately, the clerk responded that she did not know. When she subsequently asked her supervisor the reason for the policy, she was told, "Because we don't have time" to make initial appointments. Policies like this create unnecessary, redundant effort and costs for patients and staff as well as a fragmented vs. cohesive service experience.

Increasingly however, frustrated patients are expecting greater promptness. In 1995, 73% of patients expected to be seen by their doctors within 15 minutes of their appointed times. In 1989, only 68% demanded that degree of promptness. And patients aren't cutting physicians much slack beyond the 15 minute mark: only 19 percent consider a wait of more than 20 minutes reasonable and only 2 percent consider a wait of more than 30 minutes reasonable. More than half of patients reported that they usually see their doctors within 14 minutes of their appointed times. That's just slightly better than in past years. (Price, Mayberry, & Frank, 1997).

Defining Service Quality

By intentionally defining and operationalizing patient service quality, standards can be identified and measured. Accountability can be established. In effect, training staff to "see" a patient's experience as well as his or her chief complaint moves customer service from an amorphous good idea that means something different to everyone to a predictable, measurable "deliverable" in an episode of care. In addition, by defining the service experience, staff will clearly understand what is expected of them. Despite potential intimidation bias, patient satisfaction surveys as well as complaints are essential building blocks for looking outward in defining the service experience.

Disney and other breakthrough customer service organizations also ascribe to the importance of "defining the service experience." (Disney, 1996, Bennis, 1995) A service definition for the ambulatory care visit can be developed matching the dimensions of service quality with the provider's delivery system: its values, resources and processes. The so-called dimensions of service quality for a site's patient population can be identified by categorizing key issues from site-specific and national satisfaction data as well as recurring patient complaints. For example, a consistently strong preference for structured self-care instruction and low satisfaction with wait times suggest that control may be an important dimension of service quality for a given patient population. Low satisfaction ratings or complaints regarding genuine concern among staff for patient needs suggest the need to develop a caring dimension of service quality.

Active support from formal and informal leaders is essential to successfully improving service quality. At a minimum, a top manager who commits time and resources plus a key physician willing to participate in the development and implementation of service improvement initiatives are required. Without active support from these two sources, sustainable service improvement is unlikely.

The Ambulatory Care Service Matrix© in Table 2 defines a patient service experience framework. We've used three dimensions of ambulatory care service quality discussed earlier, the so-called "three Cs" of Caring, Control and Costs to develop a sample service matrix.

Organizations encountering problems in implementing a service matrix should assess whether their core values are clearly identified and actively supported by key leaders. Frustration with implementing a patient service model may be symptomatic of insufficient resources, while confusion may reflect inadequate staff information or training.

Table 2. Ambulatory Care Service Matrix©

	Delivery System Components		
	Values	Resources	Processes
Personalized Caring			
Control			
Costs			

Table 3 illustrates common service experience issues. It represents a cross section of recurring actual issues observed at hundreds of large and small ambulatory care sites and physician practices nationwide with whom the author has worked. Current State examples were gleaned from a variety of staff and patient surveys as well as informal discussions with key leaders at a variety of sites.

Common issues included leaders who were inconsistent in their actions regarding service quality with little or no accountability. Satisfaction surveys were conducted once a year, the results tabulated, shared, and stored with no change in staff behaviors. Some staff actually avoided patient contact. Authoritarian signage included a waiting room sign that read, "Parents, please control your children!"

A review of hiring practices at one site indicated that staff was usually hired for clinical skills and experience. Prospective staff commitment to service quality was a low priority in hiring. Detailed medical information regarding differential diagnosis and treatment was often shared with patients only on request. Waits for appointments of 2 months or more were common for routine visits with some no-show rates exceeding 30%. Patient attrition rates often exceed 15%.

Table 4 outlines the dimensions of the ideal ambulatory care service experience. It has served as a provider planning tool for defining an optimal patient service experience. Establishing measurable service goals enables staff to measure progress. Examples of ambulatory care service goals include reducing average visit cycle to 40 minutes, having 95% of patients report that they would recommend the site to a family or friend, or same day access to one's own provider. One site which had 50 pages of appointment protocols that included 60 appointment types and 8 lengths reduced all appointments to two types and 20 minutes in duration.

Ambulatory care providers have used the Service Matrix by first assessing their values regarding service, starting with their current state, then defining an ideal state and taking needed action. Why start with values? In our experience, from an organization's values, their resources and processes flow or "show up" for patients and staff. Once the desired ideal state that reflects an organization's values is defined, appropriate resources and processes can be identified to implement those values. A medical director leading the implementation of a service guarantee and

celebrating customer service heroes, actively waived co-pays for waits exceeding fifteen minutes and enabled time off for support staff who are customer service heroes.

The physician CEO at one client site started with a blank slate Service Matrix (Table 2) asking management, providers and staff to define the organization's current values regarding service quality. Management then proceeded to explore how the site's processes and resources reflected those values. Next, specific goals were set regarding the organization's desired ideal state. These included reducing appointment no-show rates by 40%, making all staff accountable for satisfaction results, completion and distribution at all sites within 3 months of a patient handbook, and increasing patient satisfaction with waits for appointment from 56-90%. We also assisted the site in exploring alternatives to the office visit with group visits.

At another site the matrix helped staff to identify long waits for appointments as a key service issue which contributed to a costly 30% no-show rate. The site also scored low on patient satisfaction with access to their own primary care provider. Efforts to improve access resulted in patient satisfaction with getting an appointment with their own PCP to rise 14.7%, and wait to get an appointment to increase 29%. Key to success in improving service satisfaction at all the sites with which we have worked has been strong leadership willing to act consistently regarding needed change.

A number of sites have found that service guarantees strengthen satisfaction. Hospitals and Health Networks reports that Blue Cross/Blue Shield of Massachusetts increased patient satisfaction ratings from 89% to 96% when its health centers offered a service guarantee if any member was not completely satisfied with care. Patients are paid for any premium contribution made the following month and receive a pledge to correct the problem. (Kelliher, 1995)

Results at sites making a strong commitment to service improvement with which we've worked have included over 20% improvement in patient satisfaction with overall access and ability to see their provider of choice. In addition, appointment no-show rates have dropped 50% at some sites, which in turn, have improved provider productivity up to 25% as unclogged schedules open up capacity.

Conclusion

Improving customer service has emerged and then receded in the past as in important issue for ambulatory care providers. Whether it will have staying power this time remains to be seen. But just training staff in service quality doesn't help if patients are still waiting two months for an appointment. Longstanding, costly inefficiencies that reduce patient access and create delays must also be addressed. Increasing patient out-of-pocket costs and demands for better access may provide the impetus for sustainable change. Patients who assume more direct financial responsibility for care are likely to be less willing to wait.

A fabled story of service at Nordstrom's department store describes how a San Francisco preacher was shocked and amazed at a saleswoman's infinite patience with a homeless woman's requests to try on dozens of evening gowns. When asked about her boundless graciousness, the sales woman replied, "This is what we're here for, to serve and be kind." (Bennis, 1995). If Nordstrom can achieve breakthrough service, why not healthcare?

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Table 3. Ambulatory Service Matrix©
Current State

	Values	Resources	Processes
Caring	-Inconsistent leadership activity regarding service quality -No accountability for satisfaction results	-Some staff avoid patient contact -Signage authoritarian -Staff hired for clinical and technical skills, service quality secondary or not considered -No artwork, institutional decor -No structured customer service training or feedback -Generic look-alike interior	-Focus on chief complaint vs. service quality -Staff commonly multi-task while talking with patients -Occasional eye contact with patients -No structured service recovery -No structured use of patient name -Close ended questions, little active listening, patient input not actively sought -No structured service scripts
Control	-Patients passive in care process -Patient processes secondary to provider tasks/+ -Medical information shared on request	-Signage identifies location only vs. point direction -Seating accommodates able bodied patients -No structured self care or health information -Long delays in patient flow cycle time -Patients must find own way to next "service point"	-Patients move to where services are located -Patient does not receive copy of visit note -No posting of satisfaction metrics -Patients travel up to 4 places in building during visit -Numerous, check-in processes take up to 6 min -Numerous patient handoffs
Costs	-No service guarantee -High no-show rates -Alternatives to office visit model unknown to providers	-Inefficient staffing mix results in bottlenecks reducing access -Physicians and nurses frequently perform clerical tasks	- No refund for long waits -Two month waits for routine appointments -52 pages of appointment types and lengths -Office visit only delivery model -15-20% patient attrition rates

Table 4. Ambulatory Service Matrix©
Ideal State

	Values	Resources	Processes
Personalized Caring	- leadership consistently acts to improve satisfaction -All staff accountable for satisfaction results -Celebrate and reward customer service "heroes"	-Seek vs. avoid patient contact -Signage welcoming vs. authoritarian -Hire for service attitude -Positive symbolism in artwork and décor -Time and money committed to training and feedback -Hotel homelike interiors	-Actively manage patient experience -Establish eye contact -Immediate service recovery -Use patients name at least once -Open ended questions and active listening -Scripts comfort and reassure
Control	-Patients respected as active partners in care -Provider processes secondary to patient needs and wants -Medical information freely shared	-Signage anticipates patient needs -Seating accommodates patients with reduced mobility -Structured self care and health information -Vigilantly maintain the "primacy of patient flow" -Cycle time averages <30 minutes -Facilitate transition to next point of service	-Bring services to patients -Patient leaves with copy of visit note -Stop other activity when patient approaches, give undivided attention for at least 60 seconds -Regular posting of satisfaction metrics -Minimize patient travel within building -Minimize check-in processes -Minimize patient handoffs
Costs	-Service guarantee -Commit to reduce patient waits and delays -Test alternatives to office visit	-Staffing mix minimizes bottlenecks and enables access -Staff work at highest level of professional and legal competency	- No co-pay for waits exceeding 15 minutes -Same day access to own provider -Two appointment types and appointments standardized to 20 minutes -Group doctor visits for chronic illness and geriatric patients