

## Chapter 10

# Managing the Patient Service Experience

From drug dosages to treatment regimes, every day physicians and staff make sure that clinical processes conform to established standards of care delivery. Measurable outcomes are considered evidence of quality. But little effort has been made to define and intentionally manage the patient service experience.

It could be argued that busy staff members often “see” their work as a series of tasks focused on fixing chief complaints instead of building relationships with individual patients. In a *Wall Street Journal* article, Dr. Terry Stein, internist at Kaiser Permanente, 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, M., 1998, April 13).

Because it is not defined or intentionally managed, the service experience easily goes unattended or defaults to individual provider and staff assumptions about what is good

service. In effect, a positive service experience ends up being defined differently by everyone. To Mary at the front desk, it may mean smiling and greeting patients by name; to Dr. Jones, it may be doing a thorough workup; and to Connie, the rooming nurse, it may mean staying on time. The outcome? An inconsistent, mediocre service experience. In fact, in millions of encounters each day, the patient lives but the customer dies. However, service is an important driver of patient loyalty (Herzlinger, R., 1997). Patients can't judge clinical quality, but they can and do judge service quality. Research by Press Ganey, a leading firm that tracks satisfaction found that a so-called intimidation factor or acquiescence bias inflates satisfaction scores.

Poor service quality also has financial consequences. Dr. Richard Roberts, JD, and past president of the American Academy of Family Physicians, reports that “when you look at studies of why a patient goes into a lawyer’s office to contemplate a lawsuit, about two-thirds of the time it has to do with the communication and emotional content of their experience more than it does the actual outcome. You hear (plaintiffs say) things like ‘He didn’t seem to respect me’ or ‘She wasn’t interested in listening to me.’” On the other hand, depending on the industry, a 5% increase in customer satisfaction has been shown to increase profits by 25% to 85% (Reichheld, F.F., & Sasser, W.E., 1990).

### ***Patient Versus Provider Perceptions***

The mismatch between patient and provider points of view can result in very different experiences. While serious illness can be an intense, upsetting personal event, the healthcare culture values a logical, objective approach that typically frowns on too much personal involvement with patients.

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. “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.” An enlightened Dr. Bone suggests that the secret for doctors is “to bite your lip for two minutes” so the patient can tell his or her story (Chase, M., 1998, April 13).

During an office visit with my son, the cavernous gap between staff and patient experiences became very personal. After a 40-minute wait to be seen for a minor problem, we were ushered into an exam room slightly larger than a postage stamp. Soon after we sat down, a medical assistant entered and crisply exclaimed, “You’re in my seat!” to my son, who then had to stand. When Eric and I differed slightly regarding the history of his illness, the physician, visibly annoyed, rolled his eyes and asked, “Do you two even live together?” En route to the lab, a staff person bumped into us with an empty wheelchair. When we got to the lab, we had to wait while five staff members reached agreement on accurate directions to the local craft supply store. When I handed a staff

person the lab slip, it had erroneously been marked for a urinalysis instead of a throat culture. Sadly, even in consumer-savvy Boulder, Colorado, outpatient care can be totally devoid of service quality.

For many patients, is it any wonder that the healthcare experience has become a sequence of less-than-pleasant transactions, seemingly devoid of genuine relationships? AHA/Picker Institute researchers found patients experiencing a trend toward care that is cold and impersonal (Gerteis, M., Edgman-Levitan, S., Daley, J., & Delbanco, T., Eds., 1993). Up to one fourth of American households changed physicians in a recent two-year period (Voluntary Hospitals of America, 1999). Patients report problems with access and getting basic information (Medical Quality Management Sourcebook, 1999). *Health & Hospital Networks* magazine noted that the public sees healthcare as “a confusing jumble of seemingly disassociated, impersonal medical professionals and institutions” (Grayson, M., 1997, February 20). Service is lost in the shadow of seemingly more important clinical and administrative priorities. The fact that consumers don’t pay directly for most of their care removes the threat of nonpayment by dissatisfied customers. Finally, physicians judge themselves and their peers on technical not interpersonal skills. Heroic service doesn’t have a CPT code.

Dr. Herbert Benson describes the unfortunate state of affairs in today’s physician-patient relationship in his book *Timeless Healing*. “Too often today, the sacred trust that should be developed between doctor and patient has been replaced by a set of rushed interactions.” Research at Massachusetts General Hospital demonstrates the importance of the doctor-patient bond. The research compared two groups of patients undergoing similar operations. The anesthesiologist visited both groups of patients but interacted with them differently. He made only cursory remarks to patients in one group but treated the other group warmly with sympathetic attention, sitting on the patients’ beds, while detailing the surgical procedure and post-operative pain they might encounter (Benson, H., 1997).

The results? Patients in the group who experienced the more caring relationships got better faster and were discharged from the hospital an average of 2.7 days sooner than those in the other group. The patients treated with genuine caring also experienced less pain, asking for half as much analgesic medication. Placing patient relationships front and center impacts operational and clinical outcomes. Increasingly, progressive leaders like Dr. Berwick of the Institute for Healthcare Improvement who contends that “relationship is the care” are seeing things differently.

### ***Managing Experiences***

Pine and Gilmore identify the elements of an emerging “experience economy” in which businesses of the future will live or die based on how well they design and manage memorable experiences for customers. They describe cues as key in forming impressions:

*It's the cues that make the impressions that create the experience in the customer's mind....Unplanned or inconsistent visual and aural cues can leave a customer confused or lost.... Just as important as positive cues is being vigilant to remove negative cues that can conflict with and contaminate a positive experience (Pine, B., & Gilmore, J., 1998).*

Responsive physical environments that reinforce a familiar sense of meaning and context are important, particularly to seniors. The Center for Health Design contends that “all therapeutic settings should include the positive characteristics that remind people of home” (1997, Summer).

Many office visit cues leave lots of room for improvement. While sick patients appreciate pleasant, comfortable surroundings, they're often greeted with dull, uninspired waiting areas filled with dog-eared magazines, blaring TVs, and staff busily ensconced behind sliding glass windows. In one waiting room, the author recently counted five different styles of mismatched chairs. Disrobing into drafty paper gowns in tiny exam rooms for chilly waits erodes tactile comfort. The overall result is institutional, look-alike places, built around provider priorities that leave patients cold.

Figure 10.1 illustrates contrasting visual cues in two medical office hallways. Office B is utilitarian, with fluorescent lighting and a tiled floor cluttered with equipment including a laundry cart. The visual cues indicate a focus on work tasks that seem to overflow into the hallway. In contrast, Office A's incandescent lighting, carpeted, uncluttered floor, and artwork provide warm visual cues.

Figure 10.2 compares two office waiting areas. Site A's open, low counter enables easy access at check-in for patients; curved soffits and check-in counter panels create an informal instead of an institutional feel. Site B's check-in requires patients to travel to another area of the building. While not visible in the photos, Site A's lively colors and patterns contrast with Site B's browns and grays. Site A's well-defined orange and purple check-in areas are also consistent with each team's color coding. Site A's waiting area is also bathed in natural light, while Site B's area has little natural light.

### ***Learning from Service Leaders***

Disney (1996) and other breakthrough customer service organizations ascribe to the importance of intentionally defining and managing the service experience. By excelling at dimensions of service quality such as courtesy and control, service leaders create predictable, consistently positive experiences that build loyal relationships.

**Figure 10.1 Warm vs. Utilitarian Space****Office A**

Carpeted floor, uncluttered with equipment; artwork on walls; warm lighting.

**Office B**

Fluorescent lighting, tiled floor, cluttered with equipment and laundry cart.

Intentionally defining the service experience enables providers to achieve a standard reference point as well as accountability regarding the patient experience. A service definition for ambulatory care can be developed by matching the dimensions or characteristics of service quality with a provider's values, resources, and processes.

Service leaders build experiences that bring in consumers to be part of their system rather than external to it. Greenfield and others have found that including patients as partners in the care process improves clinical outcomes and satisfaction (Greenfield, S., Kaplan, S., & Ware, J.E., 1985). In a project with several pediatric practices, the Cincinnati Pediatric Research group offered so-called safety net prescriptions in acute otitis media (Siegel, R.M., Kiely, M., Bien, J.P., Joseph, E.C., Davis, J.B., Mendel, S.G., et al., 2003). Parents were given a simple pain control medication (acetaminophen, ibuprofen, or topical anesthetic drops) and an antibiotic prescription. They were advised to fill the antibiotic prescription only if their child's symptoms had not improved within 48 hours. Only 31% of the participants in the study had antibiotic prescriptions filled. About 78% of the parents said that the pain medication alone was enough, and 63% said that they would be willing to follow the same procedure for future episodes of acute otitis media. This approach reduces the cost and dangerous overuse of antibiotics while partnering with patients in care delivery.

**Figure 10.2 Warm vs. Utilitarian Waiting Area**



**Office A**

Open, accessible check-in for each team. Seating promotes conversation. Patterned seats as well as curved soffits and counter panels create relaxed, informal environment.



**Office B**

Institutional seating in front of fire door. Little natural light. Check-in requires travel down the hall.

In the book *Winning the Service Game*, Schneider and Bowen describe how consumer involvement in service delivery can increase a sense of control and satisfaction:

*Perhaps the thought of making customers serve themselves or having them do some of the work themselves seems out of step with these times in which businesses are constantly chided to pamper and delight their customers. Yet customers can obtain delight from serving themselves if it provides them with a greater sense of control over the service production process....Control can be a potent source of esteem maintenance and enhancement for customers....Behavior breeds commitment (Schneider, B., & Bowen, D., 1995).*

Imagine that a family member was just diagnosed with a serious illness. What would you want his or her office visit to include? What would it exclude? Do your expectations change when viewing a visit from the perspective of a family member as opposed to a staff member? If so, do the different expectations have any implications for how you'd manage the patient experience at your office?

**The Perfect State**

What would the perfect service experience look like? It would replace a growing transaction mentality with healing relationships. Waits and delays would be replaced with immediate access. An outdated, compliant patient role would be shed in favor of enabling patients to assume more control of their own care. Finally, a more cost-sensitive system would constantly remove wasteful processes. In short, the perfect state would provide immediate access to healing and enabling relationships in an efficient system. Table 10.1 compares the current versus the perfect state regarding the dimensions of caring, convenience, control, and cost.

**Table 10.1 Current State Versus Perfect State**

<i>Current State</i>	<i>Dimension of Satisfaction</i>	<i>Perfect State</i>
Transaction	←Caring→	Healing relationships
Waits	←Convenience→	Immediate access
Compliant patients	←Control→	Enabled patients
Inefficiencies	←Cost→	Constantly removes waste

Table 10.2, Designing The Service Experience provides a framework to guide service improvement activities related to an organization’s resources, processes, and values. It includes specific strategic and tactical improvements.

Undivided attention and using a patient’s name at least once are process steps that communicate caring during a patient encounter. Rapid service recovery when problems occur is another important process step that’s highly correlated with retaining customers (Schlesinger, L.A., & Heskett, J.L., 1991). A thorough explanation of findings, minimizing patient “gowned time,” as well as reducing waits while in the exam room help return control to patients. Constant removal of waits and delays helps control costs. Ideally, patients would receive immediate access and have enabling relationships in a system that constantly eliminates wasteful processes.

**Table 10.2 Designing The Service Experience©**

<i>Service Characteristics</i>	<i>PROCESS</i>
<b>Caring</b>	<ul style="list-style-type: none"> <li>• Standard greeting When encountering a patient, staff member has first and last utterances and makes sure they're positive. Staff member also establishes eye contact when patient is within 10 feet and greets patient when patient is within 5 feet. Used by some hotels, this tool is also referred to as "five, ten, first, and last."</li> <li>• Staff member uses patient's name at least once during check-in and checkout; undivided attention first 60 seconds</li> <li>• Post results of patient comment cards in common areas to provide simple ongoing feedback to staff and patients</li> <li>• Offer rapid service recovery when problems occur</li> </ul>
<b>Convenience</b>	<ul style="list-style-type: none"> <li>• Bring processes to patients to minimize number of steps and service points during visit (e.g., history taking, obtaining vitals, and checkout )</li> <li>• Provide same-day access to provider of choice</li> </ul>
<b>Control</b>	<ul style="list-style-type: none"> <li>• Provide anticipatory education about procedures and delays</li> <li>• Avoid hand-offs to minimize number of staff involved in episode of service</li> <li>• Facilitate transition to next "service point," informing and guiding patient as needed</li> <li>• Make office processes secondary to patient needs</li> <li>• Offer thorough explanation of findings</li> <li>• Minimize patient "gowned time" and waits in exam room</li> </ul>
<b>Cost</b>	<ul style="list-style-type: none"> <li>• Simply and clearly communicate costs</li> <li>• Constantly remove waits and delays</li> </ul>
<i>Service Characteristics</i>	<i>RESOURCES</i>
<b>Caring</b>	<ul style="list-style-type: none"> <li>• Encourage staff to seek vs. avoid patient contact; to actively manage service experience</li> <li>• Provide signage that anticipates and enables patients to go where they want and know where they are</li> <li>• Create hotel/homelike interiors</li> <li>• Ensure positive symbolism in artwork and décor</li> </ul>
<b>Convenience</b>	<ul style="list-style-type: none"> <li>• Ensure that staffing mix and provider scheduling enable access</li> <li>• Provide as many services as possible at each encounter</li> <li>• Initiate pathways to access care that extend beyond office visit, including phone and e-mail care, group visits, nurse visits</li> <li>• Provide easy, covered access and parking</li> </ul>
<b>Control</b>	<ul style="list-style-type: none"> <li>• Ensure that access and seating accommodate patients with reduced mobility</li> <li>• Encourage shared decision making and self-care</li> <li>• Provide patient handbook to formally orient patients to practice</li> </ul>
<b>Cost</b>	<ul style="list-style-type: none"> <li>• Ensure that staff functions at full professional and legal limits</li> <li>• Encourage that today's work is done today vs. pushing it into the future</li> <li>• Create formal teams to reduce delay between demand and access</li> </ul>
<i>Service Characteristics</i>	<i>VALUES</i>
<b>Caring</b>	<ul style="list-style-type: none"> <li>• Hire and retain staff for attitude</li> <li>• Ensure that friendly tone imbues all patient communications, from signage to brochures</li> <li>• Celebrate service heroes</li> <li>• Ensure that service standards are an integral part of orientation, training, performance evaluations, and daily work flow</li> </ul>

	<ul style="list-style-type: none"> <li>• Ensure that leadership visibly supports service excellence</li> </ul>
Convenience	<ul style="list-style-type: none"> <li>• Encourage culture of teamwork to expand capacity and speed in responding to patient requests</li> </ul>
Control	<ul style="list-style-type: none"> <li>• Ensure that patient concerns are taken seriously and responded to quickly</li> <li>• Encourage active vs. passive patient role, including shared decision making, self-care</li> </ul>
Cost	<ul style="list-style-type: none"> <li>• Provide 24-7 commitment to improvement, removing waste</li> </ul>

Hotel or homelike interiors, positive symbolism in artwork and décor, as well as staff who seek patient contact are excellent steps to ensure that resources build a positive service experience. In addition, a patient handbook provides structured orientation regarding how to access care as well as care management tools.

Hiring and retaining staff for attitude as well as making service standards integral to orientation, performance standards, and daily work flow are values that promote caring. In addition to operational efficiencies, a culture of teamwork expands capacity and speeds up response to patient requests. Building an active rather than a passive patient role reflects the value of putting patients more in control of their care.

As noted earlier, an organization’s values show up in its processes and resources. Some sites begin with simple process improvements to build momentum. But remember, improvements related to a group’s values are essential to sustainability. While process improvements like standardizing the patient greeting may look like great solutions, they’ll fail if they’re inconsistent with a group’s fundamental values and not reinforced by leadership day in and day out.

**Where to Start**

Ensuring a positive patient service experience begins with a number of steps:

1. Assess your current state
2. Select service characteristics
3. Identify practical goals and metrics
4. Get the right people on the bus
5. Walk the talk

**1. Assess Your Current State**

Where does service excellence fall short at your site? Are there recurring sources of patient complaints? Do most problems regard process issues or deeply held values regarding patient relationships? Process issues are easier to fix than those related to

attitudes and values. Frank dialogue among staff and managers regarding the current state of service excellence is a good place to start.

The book *Service America* defines service satisfaction as the collective impact of a so-called moment 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, K., & Zemke, R., 1985). Each encounter with staff during the care process creates a moment of truth for patients. Use of the office visit Access Pathway can help identify common service points or moments of truth during a patient encounter. Consider enlarging an Access Pathway to look at issues related to office visits, applying “sticky” notes to problem service points. Figure 10.3 identifies common issues during an office visit.

## 2. Select Service Characteristics

Service quality characteristics can be identified from site-specific and national satisfaction data as well as from recurring patient complaints. For example, frequent patient requests for self-care information and low satisfaction with wait times suggest that control may be an important dimension of service quality for a given population. Low staff satisfaction ratings or complaints regarding genuine concerns for patient needs suggest the need to improve the caring aspects of service quality. Individual sites can use the four C’s of service quality discussed here or identify their own characteristics.

## 3. Select Practical Goals & Metrics

Goals and metrics provide a structure for tracking service improvement. Patient feedback cards are practical tools that are easy to implement and produce measurable results. (See Figure 10.4.) Frequent sampling using a few questions keeps the process simple. To keep staff engaged in the process, identify specific goals regarding patient responses (e.g., a goal of 95% of patients rating a provider’s listening skills as excellent). A number of sites also post results in staff and even patient common areas. The reason? It communicates in a public way that service quality is taken seriously.

Other metrics to consider are whether patient compliments exceed complaints and whether so-called nonvalue-added wait time for patients exceeds value-added time with the provider or staff. In addition, so-called mystery shoppers can be an inexpensive way to evaluate office visit and patient phone experiences.

How to select which questions to ask on patient feedback cards? Start with current sources of patient complaints as well as the goals of your organization. Include a question about whether a patient would refer your practice to others. Why? Frederick Reichheld, in the *Harvard Business Review*, found that for organizations seeking more customers, one question stood out from the others. Information collected from more than 4,000 customers in a variety of industries found that:

*By substituting a single question for the complex black box of the typical customer satisfaction survey, companies can actually put customer survey results to use.... The best predictor, across all industries can usually be captured in a single survey question: Would you recommend this company to a friend? When customers act as references, they do more than indicate they've received good value from a company; they put their own reputations on the line. And they will risk their own reputations only if they feel intense loyalty. The findings are based on two years of research that tried a variety of questions (Reichheld, F., 2003).*

The first question on the enclosed feedback card measures the patient's satisfaction with his or her provider's listening skills. While providers and staff fear they'll be swamped if they listen until patients complete their list of chief complaints and concerns, research indicates otherwise. In a tertiary referral center study, 335 patients were asked to talk spontaneously about their complaints and indicate when they were finished. Length of spontaneous talking time? An average of 92 seconds and less than two minutes for 78% of patients. Only 2% spoke longer than five minutes. Other studies indicate that doctors jump in and begin asking questions after only 22 seconds (Barclay, L., 2002, September 30).

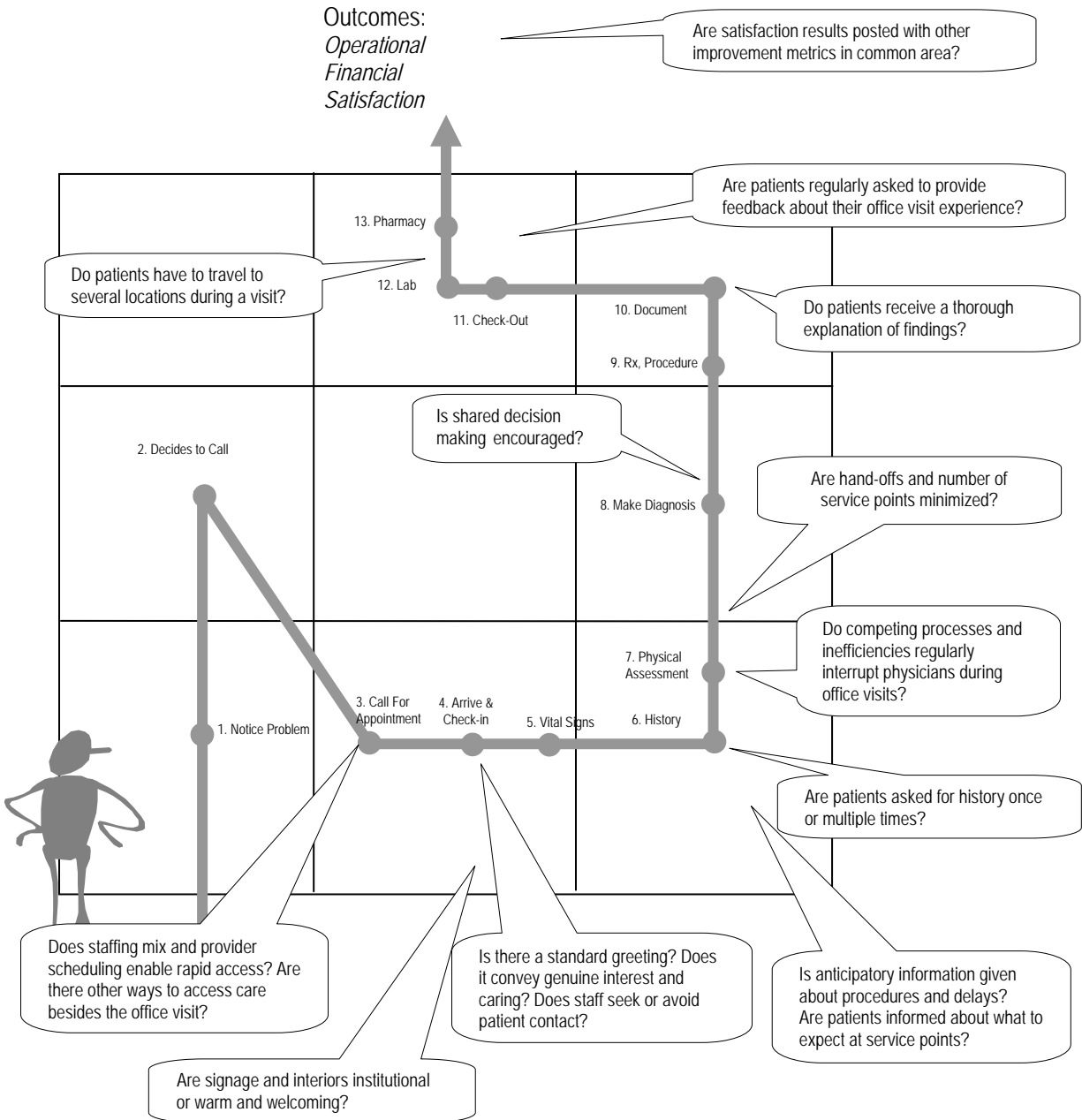
#### **4. Get the Right People on the Bus**

The book *First, Break All the Rules* describes the Gallup organization's quest to find out what it took to attract and keep the most talented employees (Buckingham, M., & Coffman, C., 1999). They posed millions of questions, trying to find "those questions where the most engaged employees—those who were loyal and productive—answered positively and everyone else—the average performers answered neutrally or negatively." The results? The following six questions emerged as the core of a strong workplace:

1. *Do I know what is expected of me at work?*
2. *Do I have the materials and equipment I need to do my work right?*
3. *At work, do I have the opportunity to do what I do best every day?*
4. *In the last seven days, have I received recognition or praise for doing good work?*
5. *Does my supervisor, or someone at work, seem to care about me as a person?*
6. *Is there someone at work who encourages my development?*

Positive answers to questions one, three, four, and five also had a strong positive correlation with customer satisfaction.

Figure 10.3 Common Office Visit Service Issues



Hiring staff that are indifferent to the patient experience doesn't work anymore. The undying commitment of Southwest Airlines' founder Herb Kelleher's to "hire for attitude" became the cornerstone of a culture known for delighting customers.

Even in the best organizations, the inevitable "addition by subtraction" may be needed to improve the patient service experience; some employees need to depart for improvement to proceed. Collins describes the importance of helping the wrong people "get off the bus" and keeping the right people on the bus:

*We expected that good-to-great leaders would begin by setting a new vision and strategy. We found instead that they first got the right people on the bus, the wrong people off the bus, and the right people in the right seats—and then they figured out where to drive it.*

*The old adage "People are your most important asset" turns out to be wrong. People are not your most important asset. The right people are (Collins, J., 2001).*

## 5. Walk the Talk

Service excellence is the new and emerging priority for most healthcare organizations, albeit relatively fragile when compared with other entrenched priorities. To some, it may seem downright strange—extraneous to more important clinical aspects of work. However, the importance of champions who day in and day out relentlessly shepherd service excellence can't be overstated.

A fabled story of Nordstrom's service describes how a preacher was amazed at a saleswoman's seemingly infinite patience with a bag lady's requests to try on dozens of evening gowns, carefully responding to each request. When asked why, the sales woman said, "This is what we're here for, to serve and be kind." If Nordstrom can be known for staff who consistently care about service excellence, why not healthcare organizations?

**Figure 10.4 Patient Feedback Card**

*We're seeking feedback from our patients in order to serve them better. Please let us know how you would rate your visit today. Thank you.*

Provider you saw today: \_\_\_\_\_

1. How would you rate your provider's ability to listen to your individual needs?

Excellent  Very Good  Good  Fair  Poor  Not Sure

2. How would you rate your satisfaction with the wait to get today's appointment?

Excellent  Very Good  Good  Fair  Poor  Not Sure

3. Would you recommend this office to a family member or friend?

Yes  No  Not Sure

4. What do we need to know to improve our customer service?

\_\_\_\_\_

\_\_\_\_\_

Your name (optional): \_\_\_\_\_