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INSIDE

FEBRUARY 1999

VOL. 7, NO. 2 (pages 13-24)

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Service recovery doesn't mean showering unhappy patients with gifts

Here's a system for recognizing, handling problems

You can't please everyone all the time. Nowhere is that adage more true than in health care. Despite all your customer service initiatives, staff training, and incentives, someone, somewhere, sometime will become displeased. And that unhappy customer will tell his or her story to at least nine others.

You can actually turn those dissatisfied customers into your best advertisers — if you have a sound service recovery program in place, says **Terry Williams**, MBA, senior consultant at LUMEN, a health care consulting firm in Atlanta.

Service recovery is damage control

A service recovery program, he explains, is a mechanism by which all levels of employees know what to do when to quickly "recover" the customer's trust. For example, employees are empowered to send flowers or small gifts as an apology to show customers that their needs are important.

"A service recovery program not only helps you mitigate those unexpected occurrences when a patient or family member is dissatisfied, but it also helps employees discover where process improvements need to be made," Williams says.

In these days of aging baby boomers who expect and demand top-notch customer service, a recovery program can also be one of your facility's biggest competitive advantages, he adds.

"As service rises to the forefront in the health care industry, such programs will become the tie breaker among competing systems," Williams predicts.

However, your service recovery initiative must be more than a "train them to smile program," he warns.

"If you don't set a system in place that allows employees to determine a triage methodology for recognizing and handling dissatisfied customers, the program will turn into an indiscriminate — and ultimately ineffective — giving of gifts," he says. "When it comes to service

recovery programs, one size does not fit all."

Kevin Moffitt, FACHE, MHA, agrees. "Not every situation calls for flowers," says the administrative coordinator of re-engineering at Blessing Hospital in Quincy, IL.

Moffitt uses a service recovery strategy developed at the Disney Institute in Orlando, FL, in which employees are trained how to make on-the-spot responses based on two factors: severity and fault.

The strategy includes the following points:

1. Empathize with the customer.

A situation fitting in the lower left-hand quadrant would be categorized as "low fault, low severity: the situation is not our fault and the complaint is not serious," Moffitt explains. (The assessment of seriousness is a judgment call of the complaint recipient.)

Suppose a patient approaches the emergency department (ED) registration counter and complains that he has been waiting for two hours even though the ED does not look busy.

"This is a case where you need to concentrate more on offering information and empathy, rather than sending flowers," explains Moffitt.

He suggests following the guidelines:

• **Listen and acknowledge the customer concern.**

• **Empathize, but don't get personally involved in the situation.** "Do not take on the customer's emotion," he explains. "Empathy is different from sympathy."

When dealing with an angry customer, for example, don't show anger yourself.

"Acknowledge how they feel and start to build a relationship. Most angry customers must have their emotions dealt with first before you can jump to logic, explanations, etc.," he explains.

• **Accept responsibility for taking action.** "Reset your expectations," he says.

For example, in the case of the busy ED, most people may expect to wait no more than 20 to 30 minutes. "You may have to reset their expectations by explaining that the ED is very busy and the wait may be longer," Moffitt says.

In addition, use the approach of "underpromise and overdeliver," he stresses. "When resetting expectations, if the wait is 45 minutes, tell them it will be an hour," he says. "Then, when they are seen in 45 minutes, you have exceeded their new set of expectations."

• **Communicate, communicate, communicate.** "Explain why, although it appears to be a slow period out front, you are really busy in the back. Perhaps there are several critical cases who arrived at once," he says.

Don't just stop with the explanation. "Take the extra step by asking if there is anything you can get to make them comfortable, such as a drink of water or access to a phone," he recommends.

In this quadrant, he says, "The main thing the customer wants is to be heard."

2. Meet the customer's needs.

A situation that falls under this quadrant — low severity, high fault — is "not serious, but it is your fault." For example, a family member complains because an ICU nurse spoke rudely to her or a patient has to wait because someone forgot to order a lab test.

"Whatever you do, don't affix the blame to another department or person," Moffitt stresses. "Don't say, 'Oh, that lab is always late' or 'that ICU nurse is rude.'

Instead, take responsibility for action and serve as the contact person for the customer. Ask them: What can I do right now?

"Do what you can within the limits of your job description to meet the customer's needs; if that's not possible, get your supervisor or someone who can," Moffitt advises.

Not only should you respond quickly, but assure customers you will personally see that your supervisor gets back to them within a certain period of time.

Then, within 24 hours, do something extra. "Depending on the situation, this may range from

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Ten reasons to implement a service recovery program

Who in their right mind wants a patient to complain?

If you don't, you should, says **Kevin Moffitt**, FACHE, MHA, administrative coordinator of re-engineering at Blessing Hospital in Quincy, IL.

"I tell staff to consider each patient as one of our advertisers because he or she will have a story to tell after discharge," he explains. "Even if they have a bad experience; if we can catch it in time and turn it around, these people then become our best advertisers — even better than those who had no incident and are satisfied!"

Moffitt shares with *Patient Focused Care* other facts he uses during staff training to illustrate why a customer service recovery program is vital:

1. Ninety-six percent of unhappy customers never complain about the rude or discourteous treatment they received.

2. Ninety percent or more of customers who are dissatisfied with the service they received will not come back.

3. Each unhappy customer will tell his or her story to at least nine others.

4. Sixty-eight percent of customers who stop doing business with an organization leave because of indifferent attitudes.

5. It is five times more expensive to attract new customers than to keep an old one.

6. Seven out of 10 customers will do business with an organization again if a complaint is resolved in their favor.

7. Ninety-five percent of dissatisfied customers will do business with an organization again if a problem is resolved right on the spot.

8. If the complaint is eventually resolved, 56% to 70% will do business again.

9. If the complaint is resolved quickly, 95% will do business again.

10. Customers whose complaints were resolved tell five to six people. ■

Source: Blessing Hospital, Quincy, IL.

writing off some of the bill, to assuring the customer that the situation will be dealt with," he says. "If a customer was treated rudely, most often he or she will be satisfied if they feel someone in authority will take the complaint to the [offending] person and deal with that incident."

Do what is most useful to the customer, not what is easiest, Moffitt adds. "For example, you may take off a portion of the bill relating to the incident, but the customer will still pay for the original visit."

Don't forget to follow up, he advises. "Not every incident requires a follow-up, but for those that do, we explain what we are doing to correct the problem so it won't happen again. Or we update them with the situation and what they can expect if they need to come back."

You should also tell them about any improvements that have been made as a result of their complaint, he adds. "Thank them again for bringing it to your attention."

3. Be a hero.

Situations of low fault and high severity are not your fault at all, but in the patient's eyes, they are severe, Moffitt explains. For example, a patient is discharged and has no transportation home.

"Then it's time to be a hero; you can meet their needs personally or you can connect them to resources who can," he says.

In this scenario, you might offer to take the patient home yourself if your shift is about to end or you might give him or her a voucher for a cab.

"Sometimes a situation in this quadrant needs follow-up action and sometimes it doesn't," he says. "Use common sense."

4. Roll out the red carpet.

This quadrant is reserved for high-fault, high-severity situations. (Think incident reports.) Suppose a patient falls off the table during a radiological procedure and is injured.

"You don't want to try and rectify the situation after the patient has left and get the incident report in inter-office mail," he stresses. "Deal with it on the spot."

At Blessing, employees call their supervisor immediately, who contacts the risk management department. "A representative is available 24 hours a day," he says.

In addition to assessing the injury, the risk management representative can instruct you in a service recovery action. For example, the facility may write off the bill or not charge for a return visit.

"Don't make promises without running them by risk management first," Moffitt says. ■

ED managers can reduce legal risks of complaints

Emergency department managers can do a lot to reduce liability risks presented by patient complaints, says **Michelle Regan-Donovan**, RN, CEN, principal of Millennium Strategies, in Charlottesville, VA, and Ambulatory Care Advisory Group in Chicago.

"A comprehensive complaint management system for most EDs is highly time- and resource-consumptive. However, if complaints are well-managed, that may ward off any number of liability concerns," says Regan-Donovan.

If a patient's complaint is not properly managed, the patient may report the problem to other bodies, such as the Office of Quality Monitoring at the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or their state Peer Review Organization, warns **Sue Dill Calloway**, RN, MSN, JD, director of risk management for the Ohio Hospital Association in Columbus.

"Many organizations now post toll-free numbers for patients to voice any concerns or comments," notes Dill Calloway. "Hospitals in our state have recently seen a significant increase in the past year of unannounced surveys by HCFA [Health Care Financing Administration], which occurred after the patient lodged a complaint."

Hospitals have also had visits from the Office of the Inspector General when patients lodge complaints of fraud and abuse, notes Dill Calloway.

"Articles covered in the newspaper could have a negative effect on the hospital and compromise patient trust in the facility," she says.

Four steps to lessen legal risks

Here are ways to reduce legal risks posed by complaints:

• **Listen to patients.** Proper handling of patient complaints can reduce or prevent lawsuits, says Dill Calloway. "Patients who are disgruntled often file lawsuits. When I defended nurses and physicians who had been named in medical malpractice lawsuits, we were able to settle about 78% of all the claims for this company without one penny of payment. These were considered to be nonmeritorious claims."

However, in taking the depositions of these plaintiffs, it became clear why the suits were filed, says Dill Calloway.

"Patients usually filed the lawsuits because they had complaints that fell on deaf ears," she explains. "Simply listening to the patient's concern and complaints may have been all that would have been needed to deter a lawsuit."

• **Keep a paper trail.** Legal counsel should be pursued after meetings of the medical director, nursing director, and hospital administration, or as a direct result of an alleged lawsuit or maloccurence, Regan-Donovan notes.

"A paper trail of some sort (even if only a file) is recommended to show that indeed there is a system for tracking and following up on various types of patient complaints."

• **Know which complaints to refer to risk management.** "Any allegation which meets the JCAHO's definition of [a] sentinel event should be reported, because the facility only has 45 days to complete a thorough and credible root-cause analysis," says Dill Calloway. "Also, any complaints alleging serious criminal activity, fraud and abuse, potential litigation, or violations of federal or state statutes and regulations should all be reported to risk management."

Risk managers should always be advised of any threat (formal or telephoned) that intimates lawsuit, misdiagnosis, or bad outcome, as soon as possible, stresses Regan-Donovan.

"A short memo to the directors (medical, nursing) and the director of the department is sufficient," she says. "This should not negate the return call to the patient, however, since much crisis intervention might be achieved with the phone call and empathetic conversation."

• **Don't acknowledge error.** "Written or phone responses to a complaint should always be documented, and admission of error or libel never acknowledged to the complainant until legal counsel is notified, even if it is known to be true," stresses Regan-Donovan.

Always indicate that the management team will be doing everything in their power to correct the situation, without suggesting or promising any disciplinary action or an ongoing problem, Regan-Donovan says. "Instead, thank them for identifying a very important issue, and suggest that you will be addressing this with others as appropriate," she advises. ■

Can 'shapes' improve staff relationships?

Use science of psychogeometrics

Common sense and a healthy dose of experience may tell you the temperament and aptitude of individual members may make or break a team's ability to work together. The theory of psychogeometrics, based on the science of understanding people and the art of influencing them, can help you build stronger teams that can then solve more difficult problems, says **Patty Williams,** RN, director of educational services at Blessing Hospital in Quincy, IL.

Discover strength in diversity

The theory explains strength in diversity of personality, Williams explains. "By discovering how they process information and approach situations, staff members can recognize the value of each team members' contribution."

Williams teaches this theory in 90-minute workshops throughout the facility to minimize conflict and maximize communication for both internal and external customer groups. Although the program was originally designed to enhance relationships among co-workers, it has become an integral piece of the patient delivery and customer service training pie. For example, Williams adapted the concept for the emergency department staff who used it to better communicate with their patients' family members.

According to the theory, everyone has five tendencies or "shapes," but one "shape" will be more dominant than the others:

1. Boxes.

As logical, linear thinkers, this "shape" is the most organized of all patterns. Hard workers by nature, "boxes" stay focused on the task at hand until the job is done. Their motto might be, "If you want it done right, do it yourself."

"They like rules, policies, procedures, schedules, paperwork, and data," Williams says. "They are the data collectors and like to analyze the data slowly before making decisions."

A box would appreciate a staff member making an appointment, being organized, focused, and sticking to an agenda. "You need to be serious and equipped with data," Williams recommends. "Give plenty of details, allow the box time to prepare and not expect immediate changes."

2. Triangles.

As natural leaders, these people are typically very ambitious, strong, self-confident risk takers who are comfortable with politics and power.

"They are intelligent people who can process information very fast and consequently make very quick decisions," she explains. "Because they have a tendency to tell others what to do, they have no tolerance for 'wishy-washy' people."

Triangles also like to do things their own way, so it's best not to disagree with them in public. Their motto might be "when I want your opinion, I'll give it to you" or "Don't bring me problems, bring me solutions."

When dealing with a triangle, speak fast, firm, and get to the bottom line quickly without a lot of details. "Be decisive and maintain emotional control. Keep all communication succinct and make sure it is well presented," she says.

3. Rectangles.

This shape is temporary because it represents people who are in a state of transition such as adolescence, midlife, or retirement.

"They are at a time of change in their lives when they begin to question who they are," Williams explains. "It is a time of growth and introspection."

Realize a triangle may be unpredictable in the response. Be prepared to offer support, patience, and understanding. "For rectangles, present a sure front and insist on a discussion," she says. "Keep it focused and away from emotions."

4. Circles.

As people pleasers, nurturers, and caretakers, these shapes are concerned with others' happiness. "They are typically trusted by many because they are genuine, caring, and good listeners," Williams says. "Harmony is important to these people, and they are uncomfortable with conflict."

Circles are better than any other shapes at reading the non-verbal communication of people, and empathetic and sensitive to the needs of others.

A circle needs to see that you are genuine and needs to trust you. "However, do not allow the circle to accommodate you," she says.

You need to initiate the confrontation and/or discussion, and keep it focused. "Be prepared for hurt feelings and show how a solution will help others," she says.

5. Squiggles.

This shape is best described as sensual, creative, innovative, bright, spontaneous, and impulsive,

Williams explains. "They continually have ideas and are experimental. They have a high energy level and talk very fast," she says. "They are direct and honest in their communication.

Squiggles like change and see it as a challenge; consequently, they hate rules, paperwork, and deadlines.

The communication style of a squiggle is often dramatic and emotional, she adds. "They frequently do not feel they fit in, as they truly march to the beat of a different drummer," she says. "Or, they feel as if they fit in; but do not like the way things are, and are consequently working to change them."

Therefore, if your team member is a squiggle, remain calm, yet show enthusiasm and a desire to understand. "Be prepared with your side of the issue because they are very persuasive. Remember they like to have it their way, so explain why their ideas cannot be implemented," she adds. ■

New dictation system cuts report turnaround for ED

Decreases reimbursement errors

The reputation of speech recognition systems usually ranks next to physicians' handwriting: They both produce illegible results.

However, Lawrence Memorial (MA) Hospital's emergency department is piloting a new integrated dictation and transcription system that provides articulate, efficient — and legible — information almost instantly, says **Steven Sbardella**, MD, chief of the emergency department. (The system's radiological counterpart is already being used at Duke University Medical Center, Emory University Healthcare, and Cornell Medical Center.)

Less errors saves money

The PowerScribe EM, manufactured by fonix Corp. in Salt Lake City, not only reduced report turnaround time to almost nil, but also significantly cut billing and coding errors, leading to higher reimbursement.

"From a billing perspective, emergency room (ER) procedures that are documented but illegible result in a loss of money for the hospital. Patients cannot be charged for an undefined procedure," he says.

As a result, many hospitals end up eating the cost of procedures that cannot be translated from handwritten patient charts.

"We've done about 85% less handwriting than before, and patient reports are considerably more legible," Sbardella says. "Plus, we can dictate much more in three minutes than we could when were writing it. The quality and quantity of information has increased."

Staff had doubts about automation

Last April, Sbardella's four colleagues weren't at all convinced that automation of patients' charts in the complex and chaotic workflow of an emergency room was possible.

"It was a hard sell because all their experiences with voice transcription in the past were negative ones," he says. "They weren't thrilled about trying this one."

He explains that old voice recognition technology was not user-friendly, nor particularly reliable.

"It required extensive training because you had to use a template on the menu and speak those entries specifically," he remembers. "A lot of what was on those systems was not applicable to emergency medicine. Not to mention the fact that one would have to practice cookbook medicine to be able to use the old technology."

High error rates and lack of real time transcription also frustrated early users of voice recognition software.

Fortunately, this system, which only has a one- or two-second delay from dictation to transcription, has won the favor of hurried ER docs.

"When they saw it only took about 20 minutes to train, and what it could do for them in such a short amount of time, they agreed to try it," he says.

With the fonix system, explains Sbardella, physicians aren't burdened by intrusive or rigid templates. "Basically, you just sit back and speak naturally into the microphone; the barriers to use disappear."

Natural language technology enabled physicians to dictate clinical notes in a continuous, free-form manner without having to pause unnecessarily between words.

"Recognition accuracy is about 98%," he says.

The computer "learns as it goes. It takes the physician's speech and compares it to their corrections. For example, the first-run through was 85% to 90% accurate; we turned on the adaptation and saw a dramatic increase in recognition."

It also permits multiple dictation sessions on the same chart. "This is vital for an ER, because we may see five or six patients at a time, dictate notes, return to the patients, and come back to the dictation again," Sbardella points out. "The system remembers where we were and we can pick up immediately from there."

System is easily accessed

Located at the nurses' station, the PowerScribe is within easy reach of ER physicians and their staff. "We put the single PC station at the desk where the physician sits because it had to be convenient," Sbardella says, explaining that in a single-coverage emergency department, the system must be accessible at all times.

"We have to be able to sit down, use it quickly, and then move on," he says.

Within seconds after dictating, physicians can quickly edit the report because of the high recognition rate. "On a Level 5 service [the most complex one] we make only about 10 corrections," he notes.

It also helps physicians to meet the demanding documentation requirements of the Health Care Financing Administration by providing real-time feedback as to how well their reports meet its stringent Evaluation and Management codes.

Instant charts satisfy doctors

After editing, the physician can approve and sign the report within minutes. They can be automatically stored in the PowerScribe's own data repository or uploaded into the hospital's information system and distributed to the intensive care unit, surgeons, or primary care physicians.

"Having legible charts instantly also expedites admission and improves quality of patient care," he adds.

The system has also increased the satisfaction levels of community physicians. "We did a survey of the physicians, who indicated the most important thing we could do was to get them legible charts in a timely fashion," Sbardella says.

By implementing a faxing system, the emergency department can fax the reports almost instantly. "It goes right to the doctors' offices. They get it when we get it," he says.

Sbardella estimates payback time to be about six months. ■

Know benefits, pitfalls of satisfaction measures

This month, ***John Guaspari*** *shares his views about the uses and misuses of customer satisfaction measurements. Recently named one of the "New Quality Gurus" by* Quality Digest *magazine, Guaspari has been one of the business world's leaders for the past decade on issues of customer value and how to use the customer's voice to energize organizational change. With a background in aerospace engineering, he held a variety of engineering, marketing, sales, and customer service positions. Since 1986, he has helped clients from many industries "make the customer come alive" for their employees. He is a senior associate with Rath & Strong, a Lexington, MA, consulting firm.*

Q. You've written about the problems of using satisfaction ratings as a quality improvement strategy.[1] Will you elaborate on those?

A. There is nothing wrong with using customer satisfaction readings as one strategy. I like to think of satisfaction as the extent to which you meet the customers' expectations — in this case, your patients' expectations. That's a good thing, and attention must be paid to it. The problem is that it tends to trip up organizations. This is true whether it's in health care or manufacturing or retail or financial services. What trips up people is not a lack of information; satisfaction surveys will give you information. The problem is a lack of organizational energy and alignment to affect positive change with the information.

The reasons, I think, are several:

1. Measuring customer satisfaction is inherently a negative thing to do. That might sound odd, since satisfaction sounds positive. But, when you're measuring customer satisfaction, what you're really measuring is the absence of dissatisfaction. While you don't want your patients dissatisfied, you want to go further. You want to create positive results.

2. Paradoxically, measuring customer satisfaction is a self-absorbed thing to do. You're probably saying, "Wait a minute! We're talking to patients, how is that self-absorbed?" I think it's self-absorbed in this way: You are asking patients to focus on you. You are basically saying, "Of those things we did for you, how did we do?"

That's important to ask, but recognize that it will only get you one category of information

about how you did. It says nothing about what you could be doing. It says nothing about an opportunity that you might have overlooked. Also, organizations start to feel self-righteous in saying, "We've taken care of our external focus stuff by doing a satisfaction survey," when, in fact, the measurement of satisfaction is just asking others to focus on you.

3. Satisfaction surveys define the box — in other words, standard elements of health service — when you really want people to get outside of the box. Satisfaction is a function of customer expectations. And those expectations are formed by what customers typically experience. While you need to know how you are doing on that stuff, satisfaction measures are silent on the question of, "What could we be doing that we are not doing today?"

Getting people focused on that is creative and very energizing. Organizations usually have difficulty getting people energized to effect change and there is an opportunity to address that by focusing on something bigger than satisfaction — something externally focused, outside the box. When people focus on creating value, they can step outside the box. Value is very much related to, but by no means synonymous with, satisfying customers.

Q. Could you give an example of how a health care facility could create value through an external focus on its patients?

A. I don't claim to be an expert in the health care industry, but in a general way, I can speak to how an organization can find out what its customers value.

Step One is getting everybody in the organization single-mindedly focused on what is of value to customers. The way you find that out is not by simply asking customers, "How did we do?" but by institutionally asking customers a different sort of question like, "Tell me about you. I want to understand you. Let's not talk about the processes you may have experienced at a health care facility. I want to understand who you are, your frame of mind when you are here. What's important to you?" A smart way of putting this is, instead of asking, "How did we do?" ask, "How are you doing?" Then the focus is on the patient rather than the institution.

Second step is to get everybody in the organization focusing on customer or patient value. What tends to happen is that there are people who have a lot of day-to-day contact with the customer, or the patient. But oftentimes those who don't have as much direct contact have a very big effect on what the experience is like for the patient.

The goal is to get everybody engaged with customers and maybe even directly involved in conversations with customers. So they get it not only as an intellectual proposition, but as a visceral proposition.

The third piece is to engage everybody in actively and explicitly finding ways to create more customer value. I know it sounds very simple to condense it into three steps, and implementation is more complicated than that, but I think that is where the focus should go.

Q. Typical questions on our patient satisfaction surveys often include, "How much time did you have to spend in the waiting room?" or "Were you satisfied with the way your provider answered your questions?" Are these surveys going to improve the quality of the health care experience?

A. Doing those kinds of surveys and gathering that information is a very good thing. And, if some kind of action is behind it, it could lead to improved quality results. Again, just as customer satisfaction is really the absence of dissatisfaction, I think quality is really the absence of defects.

Obviously, not screwing up is a good thing to do, but that ought not to be your goal. It's not good enough for your patients. It's also not good enough for the people of an organization. For example, when I go to work in the morning, I don't want to say, "My goal for today is to just make sure I don't mess up." I would rather work to a higher purpose than that. Similarly, I think that measuring time spent in a waiting room is very important, and you ought to reduce it, but it's not the goal. It's the foundation on which you then build value.

Q. Are there tools we should use to discover these value-building ideas from patients, or should we just sit down and talk with them?

A. A formal satisfaction survey is a very good thing to do, but we like to engage our clients in what we call "value conversations." We set up ways for large numbers of people from all departments in an organization to have direct contact with customers and engage them in conversation, so they get more than knowledge. They get a better

feel for what's important to customers. There is a rational complement to this; there is also an evocative complement to it.

Organizations often overlook the fact that everybody who works there has a lifetime of experience in being a customer, regardless of function, work experience, or age. They know that little things can have an enormously negative impact on them as customers. At the same time, they know exactly how some little simple thing that didn't seem like that big a deal could leave them with an enormously positive effect.

When organizations understand how to come up with those little things, they can add enormous value for the patient. If you can get everybody in the organization, in every function, focusing and trying to understand the patient, you are more likely to find those types of things.

Q. Are you suggesting that gathering a group of health care consumers together with a group of hospital people and getting them to talk to each other could lead to added value for the patients?

A. Right! You can have meetings with patients or former patients. Or you can do it through focus groups of patients or former patients and their families. There may be ways to add value for the patient by addressing the needs of the family, for example. You can videotape the focus groups and have staff workshops around them. You'd be surprised at how people will come up with ideas to add value for patients.

Another excellent way for health care people to understand patients is to walk through the steps patients go through at their hospital or clinic; from the time they walk in the door, to the time they receive the bill for services. You could also sit down in a room and say, "Let's imagine we are customers of this organization. What are all the steps we go through?" You visualize what the patient sees, who is there to help the patient.

The objective of all this is to help people make those connections of understanding how that patient feels. I'm not talking about feelings in the clinical sense, but rather in an emotional sense. I've seen people who work in an office but never have contact with customers. When they go through exercises like these, the understanding hits them between the eyes like a two-by-four! They recognize that some little thing they are doing causes enormous headaches for the customer.

Q. From your experience, what sort of impact would these kinds of exercises have on health care costs?

A. I like to use a simple definition of value that touches on that issue: What the customer "got," divided by what it cost the customer. "Got" means a product, plus a service, and a whole host of intangibles.

Cost is money, plus time, plus a long list of intangibles. By focusing on value, you are necessarily focusing on cost. That definition of value forces you to recognize that cost is in the equation. So you say, "We could give the customer or patient this service, but the commensurate costs would be enormous; so, it does not add value, in fact, it subtracts value." The ratio goes foul.

Focus on the intangibles

Where a lot of the benefit comes in, however, is in the intangibles. People too often leap to the hard product-related or direct service-related things that you give the customer and those do have a high-dollar cost attached to them.

If you focus on the intangibles, a lot of times you can do things which cost very little — in some cases, literally nothing. Like asking someone in an organization to behave in a slightly different way. There's no additional cost to the organization, but there's significant benefit to the customers in terms of the overall experience they have.

I do not have a quick fix or easy answers to the dramatically changing economics of the health care industry. I am saying, though, that a focus on value necessarily keeps you thinking about costs.

Q. Have you seen examples of this in other industries where greater customer value can actually help contain costs?

A. Yes, let me give you an example from the hotel industry. A few months ago, I was meeting with clients in a hotel meeting room. I showed up in the meeting room at 8:00 and began to set up for the 8:30 meeting. At about 8:15, in walks the hotel function manager and asks me if everything was OK. I said everything looked fine.

He asked, "Do you know about our gold switch?" I didn't, so he showed me what looked to be a light switch on the wall with a gold plate around it. He said, "If you need anything at any point during your meeting, just flip that switch.

SOURCE

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A light will go on in my office, and someone will come down and take care of your problem."

During the meeting, someone said they were going to run to the front desk to make copies. I told them to just flip that switch and see what happened. Thirty seconds later, somebody walked in, asked how they could help, and made the copies.

It was great to know that if something went wrong for me, I didn't have to run around the building and chase somebody down. That confidence added value for me. It was great for the hotel, too, because the front desk did not have to find someone to solve my problem. They had one person manning the gold switch who could respond instantaneously.

Reference

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Visual triggers promote continuity in care

Staff have patient information at a glance

Faced with the challenge of providing continuity of care around the clock, the rehabilitation department at Kernan Hospital in Baltimore came up with visual triggers at the bedside, on the wheelchair, and at the receptionist's desk so each staff member can know instantly what the patient needs.

The tools were developed as a way to enhance communication among all levels of employees on all shifts and make sure that everything a staff member does helps reinforce the patient goals set by the team, says **Linda Hutchinson-Troyer**, MGA, CRTS, patient therapy manager of the brain injury unit.

"We take the approach that staff need to share and reinforce what patients are learning at all hours of the day and night, whether it's bowel and bladder training, the special diet they are on, or the splinting schedule. Everybody has to understand what each patient needs," she says.

When staff go into patient rooms, they automatically glance at the Quick Bedside Evaluation (QBE), a legal-size sheet of paper posted in the room that gives staff capsulized information about the patient. Included is information on swallowing, diet, cardiac precautions, fall prevention precautions, transfer status, orthopedic issues, activities of daily living status in terms of independence, and a section for "other" which includes any information the team needs to share that isn't listed on the chart.

Posting in room heads off problems

Anyone coming into the room has immediate information about the patient without having to track down the nurse. For instance, if a patient care associate (PCA) answers a call bell light and the patient has to go to the bathroom, the PCA can glance at the QBE and know immediately how to transfer the patient.

Recently, Hutchinson-Troyer happened on a situation in which a family member brought in pizza for a patient and offered a slice to the patient's roommate. The roommate was on a restricted diet and couldn't eat pizza. The family member wasn't aware of the diet restriction. Hutchinson-Troyer glanced at the QBE and explained why the roommate couldn't eat it.

The QBE is useful when staff such as the PCAs flex between units. Even when they enter the rooms of patients they've never seen before, PCAs know by glancing at the charts what the patients can and can't do.

When appropriate, the brain injury unit uses sitters for patients who are highly agitated and not easily directed. If the sitters are agency staff and unfamiliar with the patients, the QBE gives instant information at bedside. "The sitters receive orientation, but this is more information posted right in the room," she says.

The staff update any changes as they occur and review the QBE every week. The therapy staff also use the QBE as a quality improvement monitor by tracking the accuracy and completeness of the tool. This tracking is done on a weekly basis.

The QBE contains only the patient's first name and last initial to retain confidentiality.

"The fact that we use only the first name and post the QBE in the room, not in the hallway in public view, addresses the issue of maintaining confidentiality," Hutchinson-Troyer says.

Color-coded belts tell patient status

Another visual cue to communicate patient status among staff are color-coded wheelchair seat belts to communicate patient status. A red seat belt means, "Stop. Don't let this patient beyond your grasp." A yellow seat belt denotes a patient can be supervised from a greater distance. A green seat belt indicates an independent patient who needs a staffperson on hand because of impulsiveness.

"The color-coded seat belts are a small precaution, but they are effective in letting staff know the patient status," she explains. The intershift communication tools were made as part of the merger between Montebello Hospital and Kernan Hospital into a new organization. Both hospitals had been part of the University of Maryland Medical System, but were located across town from each other.

An interdisciplinary transition team of staff from both hospitals wanted to make sure there were easy written and visual communication triggers so every staff member knows what each patient needs. "When we merged the staff of the two hospitals, we looked at it as a time to sort things out. We didn't necessarily want to adopt procedures from one side of town to another, but to use those we identified as most appropriate to what is going on in the health care environment," Hutchinson-Troyer says. ■

Creativity catches on with ED staff

Triage, bedside admissions increase satisfaction

Bradley Memorial Hospital in Cleveland, TN, and Baptist Health in Little Rock, AR, used to have something in common that they'd rather not mention. Both hospitals' emergency departments (ED) had low patient satisfaction scores: 40th and 52nd percentiles, respectively, on the Press, Ganey Associates patient satisfaction survey.

After a year of concerted efforts to raise those scores, the two hospitals again have something in common: They're now at the top. Bradley is up to the 90th percentile, and Baptist is in the 92nd. Last year, both hospitals won honorable mentions in the South Bend, IN-based patient satisfaction measurement firm's client competition.

The reason for drastic change

At Bradley Memorial, the ED problem was getting bad enough that hospital administrators and board members were receiving periodic complaints, and public perception was so poor that some local residents were driving 45 minutes to a larger hospital for treatment, says **Brenda Wynkoop**, process improvement director.

Quality improvement teams failed to get staff buy-in until they hit upon the idea of a staff-driven task force called the "PIT Crew." PIT stands for performance improvement team. It's a multidisciplinary group, and staff must apply for membership. Each PIT Crew member is responsible for getting input from other ED staff.

Patient-Focused Care and Satisfaction (ISSN # 1097-9530) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient-Focused Care and Satisfaction**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (custserv@ahcpub.com). Hours: Monday-Thursday 8:30 a.m.-6:30 p.m.; Friday 8:30 a.m.-4:30 p.m., EST.

Subscription rates: U.S.A., one year (12 issues), $419; three years, $717. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $209 per year; 10 or more additional copies, $125 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $41 each. (GST registration number R128870672.)

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The PIT Crew began by doing a flowchart of the path a patient takes from arrival to discharge and found a potential of 30 waiting points for the patient, Wynkoop says.

The project was divided into three phases: triage / registration process, treatment, and discharge.

In the initial phase, the crew decreased the potential waiting points from six to one. Now, when patients arrive, a "guest service ambassador" does a mini-registration, getting name, date of birth, and complaint.

The ambassador generates a chart and notifies the triage nurse, who evaluates the patient. Portable two-way radios are used to notify the team leader, and a room is assigned.

When all 23 rooms are filled, patients are taken to a glass-enclosed inner waiting area where treatment can begin even before a room is ready. The total patient waiting time has decreased by 44 minutes to 137 minutes.

"Patients can also be monitored or wait for test results in the inner waiting room after they've seen the physician, which frees up treatment rooms for other patients," says **Connie Martin**, administrative director of the emergency center. "Patients are not tied to that exam room."

Military-style communication ensures success

Martin says the key to the successful changes was communication among the staff. The emergency staff had an all-day session with a consultant where they were allowed to air grievances, and they learned how to reach decisions by consensus. Education sessions were also held, and a departmental newsletter was created to inform the staff of the PIT Crew's plans.

Baptist Health also took a creative approach to get the staff motivated to improve the ED. Patient satisfaction scores had at one point been as low as the 33rd percentile, and the situation had come to a head with the hospital administration.

Sandy Pryor, BSN, supervisor of emergency services, says the basic message was that the staff would improve the scores or their replacements would.

Pryor decided to draw on her Air Force experience to create a military-themed campaign to improve patient satisfaction. She went to staff meetings dressed in combat fatigues, brought an American flag as a prop, and played the theme music to the movie *Patton* as a backdrop for her presentation titled "D-Day: Don't Drop or Die."

The plan was presented in military terms, as follows:

- **Problem No. 1 — "Unsynchronized deployment of personnel."**

Because of a confusing entrance to the ED, patients were getting lost. They weren't sure where to park, and some needed help getting to the door. The simple solution: Place a security officer in the parking lot to assist patients.

- **Problem No. 2 — "Delay in staging area."**

Because there were no standing orders from physicians for common problems, waiting times could be lengthy. The ED developed protocols for such complaints as abdominal pain so nurses could initiate routine tests before the physician sees the patient.

Another improvement is bedside admissions, which allows patients to be taken to a room immediately. It might not get them to the physician any quicker, but it gives them privacy and the chance to lie down.

"They're more comfortable, and that changes their whole perspective," Pryor says. "Some of this is pretty basic stuff. It just takes thinking it through." ■