

Special Article – Quality Improvement

Improving Healthcare Service Quality: Listen to the Patient and Take a Comprehensive Approach

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Abstract

With healthcare reform legislation and the spread of value-based payment models, traditional healthcare quality measures have evolved to include patient perception of the experience of care. Citing concern that many factors outside the organization's control could arbitrarily influence patient perception, many healthcare leaders have opposed Medicare's weighting of patient satisfaction data in its value-based purchasing formula. We contend that the patient's perceptions of various dimensions of service quality are integral to its improvement. The aim of this article is to share Mayo Clinic Arizona's (MCA) "7-prong" model for service quality improvement, as well as key lessons learned with its implementation in our Family Medicine Department. The model incorporates these service quality principles: (1) multiple data sources to drive improvement; (2) accountability; (3) service consultation and improvement tools; (4) service values and behaviors; (5) education and training; (6) ongoing monitoring and control; and (7) recognition and reward. The model is driven by service-related data and a culture of accountability. A few key lessons, learned over the past several years, are shared to help other healthcare organizations on their service quality improvement journeys.

Keywords: Healthcare quality; Service quality; Patient experience; Quality improvement

Introduction

For decades, healthcare leaders have used industrial methods, such as total quality management, lean, and Six Sigma, to improve process quality and organizational performance. Value-based payment models, which combine clinical and service quality measures to determine medical care reimbursement, have placed more emphasis on improving service quality and the patient experience. This shift has given healthcare leaders an opportunity to re-examine and improve their organizations' patient-centered focus.

Patient perception of quality of care is subjective. Some healthcare groups have opposed the weighting of patient satisfaction data in Medicare's value-based purchasing formula, citing regional and patient-related factors that could randomly influence perception [1,2]. Most healthcare and service quality leaders would agree that only a minority of patients (e.g. those with clinical training) have the technical expertise to judge quality of care. The remainder use service dimensions (e.g. interpersonal skills and facility cleanliness) as proxies [3,4]. As customers of service giants such as Amazon, Starbucks, and Southwest Airlines, patients *know* quality service when they experience it. Patients interact closely with front-line staff throughout the organization, giving them a unique perspective on the staff's empathy, service attitude, and friendliness, as well as the provider's communication skills and the efficiency of operations. Given their vast customer service experience outside healthcare and their close proximity to the front-line staff, there is no better way to evaluate the impact of service quality on the patient experience than to *ask the patient*.

A service experience consists of countless points of contact with an organization and its front-line staff. Service breakdowns are inevitable at any of these touch points [5], especially in highly complex systems. Healthcare organizations should monitor patient feedback to anticipate service breakdowns and adopt a comprehensive approach to service quality improvement. The aim of this article is to share Mayo Clinic Arizona's (MCA) "7-prong" model for service quality improvement, as well as key lessons learned with its implementation in our Family Medicine Department. The model (Figure 1) is driven by service-related data and accountability and has demonstrated efficacy

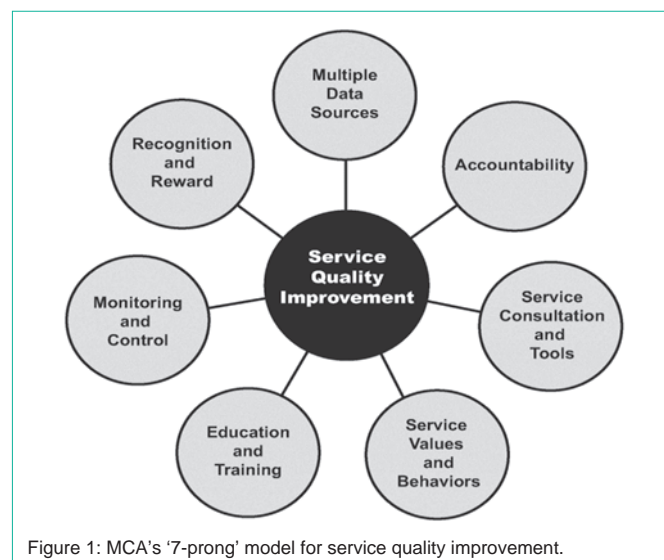


Figure 1: MCA's '7-prong' model for service quality improvement.

in specialty [6] and primary care [7] settings. The model incorporates seven widely accepted service quality principles: 1-multiple data sources to drive improvement; 2-accountability for service quality; 3-availability of service consultation and improvement tools; 4-service values and service performance standards; 5-service education and training; 6-ongoing monitoring and control of service quality; and 7-recognition and reward.

The Model and Tools for Improvement

1-Multiple data sources to drive improvement

Service-related data, including patient and employee satisfaction, call center metrics, and complaint rates, were monitored regularly and reviewed with providers and allied health staff. Custom patient satisfaction reports were created and automatically emailed from the vendor's online system to providers, nurses, and call center/receptionists. A form was sent with the patient's pre-visit paperwork to capture data on reasons for scheduling the appointment [8]. This form familiarized the provider with the patient's expectations of the visit, helping to minimize the "customer gap" [9] and enhance perception of the experience. The voice of the patient, gathered through multiple channels, helped guide service quality improvement [10].

2-Accountability for service quality

Family Medicine improved service quality by implementing small changes; administering short, point-of-service patient surveys; evaluating post-improvement data for desired results; and displaying trends in work areas so staff could monitor progress. Overarching this departmental data review was a quarterly review by MCA's clinical quality oversight committee. This group requests action plans and 90-day progress reports from leaders of departments performing below goal. Accountability for service quality is maintained through formal monitoring by influential organizational leaders and a continuous improvement cycle.

3-Availability of service consultation and improvement tools

MCA's service administrator provided service consultation, including data analysis, service quality audits [11], and service education and training, to Family Medicine for several months. A final report of improvement opportunities, recommendations, tools, and resources helped department leadership prioritize opportunities and develop the improvement plan.

4-Service values and performance standards

MCA's service values and performance standards were incorporated into departmental service education and training. "SERVE" was customized for specific Family Medicine roles.

- Solutions-focused (Solve problems when and where they occur.)
- Empathetic (Treat everyone as you wish you or your family to be treated.)
- Reliable (Own the work; if you don't have the answer, find it.)
- Valuing others (Protect patient and employee confidentiality.)

- Exceed patient expectations (Contribute to an unparalleled experience.)

5-Service education and training

Educational sessions were customized with Family Medicine's service-related data. Content was designed to enhance staff understanding of basic service quality principles (e.g. service challenges, satisfaction surveying, common complaints, and service recovery) and how their behaviors influence patient perception. Department leadership participated in the educational sessions to communicate their importance.

6-Ongoing monitoring and control of service quality

In addition to ongoing monitoring of service quality data, periodic "secret assessment" of service performance was conducted by the service administrator and Family Medicine staff themselves. Also, with the nurses' input, nursing service standards and a performance monitoring tool were developed to promote consistent evaluation of performance against standards and to encourage nurse accountability. The nursing staff's service quality assessments of their peers tended to be more critical than the administrator's, which affirmed their understanding of the service performance standards.

7-Recognition and reward of service achievement

Two years after implementation of the model, Family Medicine was recognized with its first "five-star" award for exceeding the 90th percentile goal for patient perception of overall quality. Other forms of recognition included "thank you grams," used by staff to express gratitude to each other, and movie tickets, used by leadership to recognize individuals for outstanding service performance. Positive patient comments were shared via group emails, and employees identified by patients were recognized for providing excellent service.

Lessons Learned

Our seven-year journey to improve service quality has taught us the following:

Implement the model in its entirety

The prongs in the model are interconnected, so all prongs must be implemented for best results [6]. Improving behaviors and processes that move the metrics requires a comprehensive approach. When all seven prongs of the service model were systematically applied (with constant vigilance of the department administrator), increases in patient satisfaction were achieved in several service dimensions [7].

Leadership endorsement and visible support

Leaders must demonstrate a genuine commitment to service excellence. Executive and clinical practice leadership endorses the "7-prong" service model and, from its inception, has given legitimacy to the PX leader's actions. One example is using the practice management structure to hold department leaders accountable for improvement. Another is the CEO's repeated differentiation of PX leaders' (subject matter experts and consultants) and practice leaders' (accountable process owners) roles. In addition, it is vital to include Human Resources personnel in the process. There may be disgruntled employees who, when being held to service performance standards, are unwilling to adapt and change their behaviors to a more customer-centric approach.

Share satisfaction survey questions, patient ratings and comments

With front-line staff, especially with providers, who are the strongest drivers of perception of overall quality [6].

Hire the right qualifications to lead PX initiatives

With no authority over people, processes, or resources, the PX lead serves as an internal consultant to management [12]. Desirable skills include: subject matter expertise, highly developed analytic and communication skills, a systems thinker with knowledge of healthcare operations, superior presentation skills, and the ability to teach abstract service quality concepts as opportunities to improve a department.

Conclusion

Patient satisfaction with U.S. hospital, clinic, and emergency room service is at its lowest point in nearly a decade [13]. As healthcare consumers are asked to personally pay more for medical services, they will have higher expectations, shop for services more discriminately, be less tolerant of poor service, and more quickly leave providers who don't satisfy their needs. It is not enough to simply make cosmetic enhancements to a facility; healthcare organizations must actually improve the patient experience. Doing so requires a comprehensive model, a systematic approach for collecting and acting on patient satisfaction data, and an accountable culture. Improving service is the right thing to do for the patient and, in a value-based payment model, helps to sustain an organization into the future.

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