

# Making it Right:

Healthcare Service Recovery Tools, Techniques, and Best Practices



**PRESS GANEY.**  
THE PRESS GANEY SERIES

# Making it Right:

Healthcare Service Recovery Tools, Techniques, and Best Practices

**PAUL ALEXANDER CLARK, MPA**  
**MARY P. MALONE, MS, JD**



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# ABOUT PRESS GANEY

This book is based on Press Ganey's research and experience. Founded in 1985 by renowned medical anthropologist Dr. Irwin Press and accomplished social research methodologist Dr. Rodney Ganey, Press Ganey has conducted research in the healthcare field that has provided a novel scientific foundation for assessing patient satisfaction with the experience of care. Over the past 20 years, Press Ganey researchers have honed this system through continuous original qualitative and psychometric investigations to arrive at an unrivaled system for measuring, benchmarking, and improving the satisfaction of patients, employees, and physicians—healthcare organizations' key customers. Today, Press Ganey has dozens of researchers and hundreds of consultants who collaborate not only to help our clients improve but also to ascertain best practices among our top improvers and high performers.

As part of Press Ganey's ongoing best practices research, we conducted two separate studies involving our partners. The first is a statistical analysis to determine which healthcare facilities were "most improved" based on the measure "Staff response to your concerns and complaints"—a standard question on most Press Ganey surveys. We conducted methodologically sound qualitative interviews to ascertain the best practices they deployed to achieve their improvements. We then performed a systematic literature review to determine what best practices already existed related to this issue. Service recovery emerged as one of the strongest best practices for improving patient satisfaction.

Second, we held a contest among all of our 6,000 healthcare facilities to find the best service recovery program. We received dozens of detailed entries, which a team of consultants thoroughly evaluated and rated. The best-rated service recovery programs were honored with public recognition and awards.

These world-class programs and their tools, techniques, and best practices featured in this book come from the following Press Ganey clients who have successfully implemented service recovery programs:

- Advocate Healthcare
- Baptist Outpatient Services
- Beebe Medical Center
- Bothwell Regional Health Center

## ABOUT PRESS GANEY

- CaroMont Health
- Carondelet Health Service
- Centra Health
- Columbus Regional Hospital
- Emory Healthcare
- Floyd Medical Center
- Froedtert Memorial Lutheran Hospital & Medical College
- Genesis Health System
- Gottlieb Health Resources Hospital
- Havasu Regional Medical Center
- Henry Ford Wyandotte Hospital
- Holzer Medical Center
- Jefferson Regional Medical Center
- Lexington Medical Center
- Memorial Hospital at Gulfport
- Regional Medical Center/Troyer Clinic, Russell Medical Center
- Saint Luke's Hospital & Health Network
- Saint Vincent's Hospital
- Scott & White Hospital
- SHARP Metropolitan Medical Campus
- Southern Ohio Medical Center
- University of Michigan Hospitals and Health Centers
- Waukesha Memorial Hospital
- Western Maryland Health System
- Women & Infant's Hospital of Rhode Island

This book comes with a CD that includes sample brochures, training programs, service recovery toolkits, and other contributions from Press Ganey partners. It also has a DVD with video clips that illustrate common service recovery situations. Note, however, that these clips don't demonstrate "perfection." There are multiple good ways of handling different situations, and your staff can easily identify different, more effective, or less effective ways of handling these scenarios.

# ABOUT THE EDITORS

## PAUL ALEXANDER CLARK

Paul Alexander Clark, MPA, is senior knowledge manager for Press Ganey. He directs a team of researchers who conduct quantitative and qualitative research to determine best practices for improving patient, employee, and physician satisfaction in healthcare. His team's research supports more than one hundred Press Ganey consultants who actively partner with health-care organizations to help them improve the service they provide to patients, employees, and physicians.

Clark has published articles in such journals as the *Joint Commission Journal on Quality and Safety*, the *Journal for Healthcare Quality*, the *Journal of Nursing Care Quality*, and the *International Journal of Healthcare Quality Assurance*. His research has been presented at the annual conferences of the International Society for Quality in Health Care, International Society for Research in Healthcare Financial Management and the Medical Group Management Association as well as the Press Ganey National Client Conference and Johns Hopkins University Institute for Spirituality & Medicine.

Clark earned his Master of Public Administration in science and technology policy from George Mason University in Fairfax, Virginia, and his bachelor's degree from the University of Pittsburgh. He will soon complete a Master of Arts in Bioethics and Healthcare Policy at the Loyola University in Chicago.

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Mary P. Malone, MS, JD, is president of Malone Advisory Services in South Bend, IN. She has over 20 years of experience in the healthcare industry. Prior to forming her own firm, she worked for Press Ganey Associates for more than 14 years, serving in a variety of senior leadership positions.

Malone writes and speaks often on various aspects of patient satisfaction. Her articles have appeared in such journals as *Joint Commission Journal on Quality and Safety*, *Strategies for Healthcare Excellence*, *Healthcare Financial Management* and *The Satisfaction Monitor*, a client publication of Press Ganey. She has spoken at many national conferences and workshops includ-



## ABOUT THE EDITORS

ing the American College of Healthcare Executives, Forum for Healthcare Strategists, Society for Healthcare Consumer Advocacy, the Institute for Healthcare Improvement and various state hospital associations.

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**Julie Tittle-Plank**, Senior Consultant for Press Ganey Employee Perspectives, delivers enthusiasm, knowledge, and experience to their employee-focused quality improvement initiatives. She earned a bachelor's degree in Spanish and business from Northern Michigan University.

**Barbara Van Holsbeke**, Staff Consultant for Press Ganey, applies her experience in health care to help her clients improve patient satisfaction. Her background is in the legal and healthcare publishing industry. She graduated from Indiana University with a BA in English.

# DEDICATION

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This book is dedicated to all of our partners in all of our client healthcare organizations. The work you do as healthcare professionals inspires us every day. We're honored to serve you. Thank you.

This book is especially dedicated to the healthcare professionals who stood at their posts through the Hurricane Katrina disaster and long recovery. You sacrificed personal need to give in service of others and made everyone proud. We can't say it any better than our President and CEO, Mel Hall, "The daily miracles that continue to be performed by those in the healthcare profession leave me speechless and thankful. We stand in awe of you. We give thanks for you. We hold all of you in our thoughts and prayers."

# FOREWORD

This book touches the heart of healthcare. Service recovery is the ultimate failsafe that can guarantee an outstanding service experience. Service recovery empowers great people to do great things for patients and residents. Empowered with service recovery, care providers can radically transform negative emotions to positive emotions—from fear to calm, anger to contentment, disappointment to pleasant surprise, and negative outcomes to delighted customers. Employees who create and witness these transformations are excited and satisfied by the special, even magical, moments that make patients' lives a little better. Perhaps no greater employee motivator exists than when people who feel the calling to help people see their purpose fulfilled.

Press Ganey consultants visit hundreds of healthcare facilities every year. Through their intense interaction with our customers, the consultants are witness to, and help create, great service. I have the privilege of working with nearly 480 associates at Press Ganey who bring a missionary zeal to their work of helping our customers improve their delivery of care. This book is a representative sample of their expertise and enthusiasm.

We are honored to partner with more than 6,000 healthcare facilities and provide them with information and solutions that help them serve their patients, physicians, and employees. We walk with them on their ongoing journey to continuously improve, and toward our mutual goal of improving the delivery of healthcare.

Melvin F. Hall, Ph.D.  
President & CEO  
Press Ganey Associates, Inc.



# PART I

## **INTRODUCTION**

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## THE HEALTHCARE LANDSCAPE

*Paul Alexander Clark, Matt Davis, Katie Dreves,  
Peggy Fuerbringer, Michelle Gloss, Deborah Spite*

The healthcare marketplace is changing to emphasize, recognize, and include service quality as part of the total quality picture. Clinical quality refers to the quality of patient care and treatment provided by the physicians, nurses, licensed independent practitioners, and other clinicians—and is often assessed by looking at information about structure, process, and outcome. That is, it examines what actually happens to the patient.

Service quality involves everything that relates to providing that patient care. The bottom line is still, in essence, what happens to the patient, but this time we are looking at information such as how long a patient must wait on a gurney for an x-ray, how friendly the meal service provider is, or how clean the halls are. To patients, the most important aspects of service quality involve fundamental issues of communication, respect for personhood, involvement in decision-making, emotional needs, and psychosocial care.

### **Paying for quality**

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Policy experts widely expect that incentives for technical and patient-perceived quality will soon flow from all major payers, including the Centers for Medicare & Medicaid Services (CMS). In the 2006 fiscal year, hospitals participating in the CMS Voluntary Quality Initiative quality data reporting program will receive a payment increase of 3.7%; those not participating will only receive 3.3%. It is only a matter of time before these incentives turn into bonuses for improvement (as has been shown in several pilot programs). It is also only a matter of time before this policy starts to be applied to non-acute healthcare services.

Finally, the Hospital Quality Initiative (HQI) has a patient perspectives component known as Consumer Assessment of Healthcare Providers and Systems (CAHPS). The CMS process



requires that hospitals survey at least 300 patients annually if they wish to publicly report the results for comparative purposes on the CMS website, *www.hospitalcompare.gov*. The intent is to provide consumers with data from which to make decisions about the healthcare facilities they choose to seek care from. This could also intensify competition among healthcare facilities on relative service quality.

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*“Paying for quality may become as important in the next 20 years as paying for case mix has been in the past 20 years.”*

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#### **INCREASING COMPETITION AND MARKET DEMAND FOR SERVICE QUALITY**

Competition has increased in all areas of healthcare. The moratorium on specialty hospitals will expire in 2006 and allow doctors and other entrepreneurs to continue the trend of creating facilities that have a singular focus on the more-profitable, less-complex elective surgeries. In the near future, competition will not be limited to these traditional healthcare players. U.S. consumers already spend upwards of \$47 billion annually on alternative medicine therapies—acupuncture, massage therapists, chiropractors, and other service providers who have a *perceived* greater focus on the quality of service, not just the technical side of medicine.

Healthcare providers will also experience greater competition from traditional business firms. For example, Target Corporation just launched a 60-store pilot dubbed the “One-Minute Clinic.” The clinic does only one thing—strep tests—but you get results in less than one minute. Target plans to cherry-pick the high-margin, technologically simple diagnostic tests that patients traditionally received in the doctor’s office. Now, instead of waiting for an appointment, driving to the office, waiting in a cramped waiting room, waiting again in an exam room to see the doctor, and then waiting for the test results, you can do it while shopping for the comfort foods and cough drops that your strep throat requires. When highly successful service companies with massive customer bases, like Target, start entering the healthcare marketplace, it’s time to watch out.

Underlying all of this is a fundamental shift toward consumer-driven healthcare where patients will pay a greater percent of their healthcare costs out-of-pocket. Health insurers are

laying the foundation for high-deductible, high co-pay insurance plans that afford the patient maximum choice and information to use in order to self-select a healthcare provider. From December 2004 to June 2005, the number of enrollees in health savings accounts—a critical tool for consumer-driven healthcare—has doubled.

All predictions say that patients will be forced to pay more for and actually provide more of their own healthcare. Patients are already becoming more savvy and demanding, and the baby boomers, who have dominated and transformed every institution they have touched, can be expected to do the same in healthcare. As boomers increasingly enter healthcare facilities with illnesses or other healthcare needs, they will expect the service experience in healthcare to be at least as good as other experiences, if not better.

The pressure is on to compete, succeed, and win in a healthcare marketplace increasingly focused on clinical and service quality.

## **The intersection between clinical and service quality**

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Service recovery is about quality of service, not about quality of clinical care. Both should be of the highest quality, but sometimes we only focus on the clinical side of quality. Many healthcare professionals subconsciously think, “Our patients are patients, not customers. People come to our hospital because they’re sick, not because they expect fine dining or six hundred-thread count sheets.” No one will argue that saving lives is the first priority, however, that priority does not preclude providing high-quality service.

## **What’s in a name?: Are they patients or customers?**

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“Patients,” “customers,” “residents,” “clients,” and other terms denoting a person receiving a service are used interchangeably. “Doctor,” “physician,” “nurse,” “clinician,” “staff,” “employee,” “volunteer,” “associate,” “provider,” and other terms denoting a person delivering a service also are used interchangeably.

There is no consensus within the healthcare fields about terminology. Some insist that “patients” be used out of their deep emotional attachment to the word. Others insist that “customer” be used because “patients” are often treated paternalistically and as less than full persons. Also note that, in some instances, physicians can be seen as customers because they too partake of the services of a hospital and could, in most cases, choose to be on the staff of a different hospital.

## *Are they patients or customers?*

Consultants often tell healthcare organizations that the key to service excellence is to “Stop calling them patients and start calling them customers.” Not surprisingly, many healthcare professionals bristle at the suggestion. They may say things like, “Customers are fine at Saks Fifth Avenue, but we’re not a department store,” or “This isn’t Burger King, and you can’t have it your way in the hospital.”

Yet healthcare consumers are, in fact, both patients and customers. Two emergency medicine physicians, Drs. Thomas Mayer and Robert Cates<sup>2</sup>, who have conducted more than 150 healthcare customer service training programs, have found that when they asked their training audiences whether someone would be considered a patient or a customer, the answer depended on several factors.

### **What makes someone seem like a patient?**

Patients were viewed as people who were acutely ill, dependent, and passive. Patients had less choice about being at the hospital, and staff felt that they were in control of the situation. Remember, healthcare professionals in general know how to take care of patients, many of whom are desperately ill and require timely, aggressive, and orderly interventions. Staff are trained to provide those clinical interventions and understand how to approach a patient.

### **What makes someone seem like a customer?**

Customers were viewed as people who were not acutely ill and who were independent. Customers had a choice about being there—in other words, healthcare was a “discretionary purchase.” Staff felt that the customers were in control of the situation. Many healthcare professionals don’t know how to approach a “customer” who still has the technical healthcare needs but has much more power and control over the encounter than does the “patient.” In fact, many people in healthcare may be uncomfortable talking about the “customer side of the equation.”

Thus, a 55-year-old female brought to the emergency department (ED) by paramedics with an electrocardiogram and all other clinical indicators clearly showing that she is having myocardial infarction was always identified as a patient. However, a three-year-old child brought to the ED by his parents at 11:45 p.m. with a temperature of 99.2°, who were concerned because earlier that day their pediatrician diagnosed the boy with left otitis media, started him on antibiotics, and said to keep his fever down, was always identified as a customer (or, rather, the parents were seen as customers).

## *Are they patients or customers? (cont.)*

### A simple rule

Mayer and Cates created a rule to describe their observations. The more horizontal they are, the more they are a patient; the more vertical they are, the more they are a customer. Furthermore, this rating changes daily. For example, as the woman with the heart attack improves and becomes more “vertical,” the staff may begin to realize that there are substantial customer features emerging through the course of her healthcare.

### Who has higher expectations?

When Mayer and Cates ask their training audiences who had higher expectations, the woman with the heart attack or the parents of the child, the audience always says the parents—who were customers—would have higher expectations.

However, when asked what the woman with the heart attack wants, the audience always answers, “To live.” When asked what the parents and child want, they answer, “Reassurance.” Stated in this way, healthcare professionals begin to see that it’s definitely odd to feel that someone who wants to live has *lower* expectations than someone who is just seeking reassurance.

This disconnect comes from the assumption that customers have high expectations, often because we don’t know how to meet them when we haven’t been explicitly trained how to do so. Conversely, acutely ill patients’ expectations are rated low because the life-saving interventions are what the healthcare professional clearly knows how to deliver—and do so with pleasure and enthusiasm. Recognize and understand this tension in rating the expectations of the patient and the customer.

### Both patient and customer, all the time

Staff need to understand that they have their own internal barometer of how they rate patients (and their families) on a daily basis. Many recognize that their internal rating system has been in effect for them forever. Rather than having the customer service training define for them what constitutes a patient or customer, the staff define it for themselves in a stunningly consistent fashion.

Thus, improving customer service is not a transition from patient to customer, which is often viewed as insulting or demeaning of healthcare professionals. Instead, it is a recognition that they are always both. Once healthcare organizations help their staff understand this dynamic, they have a substantial foundation for an excellent customer

We believe that the term used is less significant than showing affection and respect for everyone involved in the healthcare enterprise. We deeply respect all humans giving the profound gift of healthcare and have deep affection for all humans touched by illness. Please keep an open mind and apply the terms according to your own situation.

Clinical and service quality certainly overlap: Patients who get infections are less satisfied. We'd like to believe that making the right diagnoses, cutting in the right spots, delivering the right medicines, and calling it a day is all we need to do to get good clinical outcomes, but it isn't true. *How* we deliver that care matters almost as much as what we deliver. For example:

- When we discuss medication or therapy regimens with patients, we can simply say what needs to be said. Or we can package the education in ways that enhance patient understanding and recall, thereby increasing the likelihood of adherence.
- We can simply stick patients with IVs or insert catheters. Or we can introduce ourselves, talk in a reassuring manner, and answer questions while we do so.
- We can ignore patients' and families' distress. Or we can inquire about and address their emotional needs, thereby reducing stress and increasing their comfort.
- We can cut through patients' long explanations of their minor physical ailments and get to the point. Or, remembering that in the average patient-physician encounter doctors only allow patients 17 seconds before they interrupt, we can listen actively for the patient to fully describe their concerns before speaking.

Thus, although clinical quality is a necessary, minimum criterion, it is insufficient on its own. Patients want and deserve more.

The market is now providing the monetary incentives and opportunities to do more. But we can't simply tell staff to do more or try harder. Rather, we need to create systems that support staff in their efforts and set them up for success.

## **The mission**

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### **YOUR MISSION**

Your mission is to contribute to the creation and execution of systems and processes that meet the goals of all your stakeholders: trustees/owners, employees, physicians, patients, and

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*“Inferior care results when health professionals lack full mastery of their clinical areas or cannot communicate effectively and compassionately.”*

—Kathleen N. Lohr<sup>3</sup>

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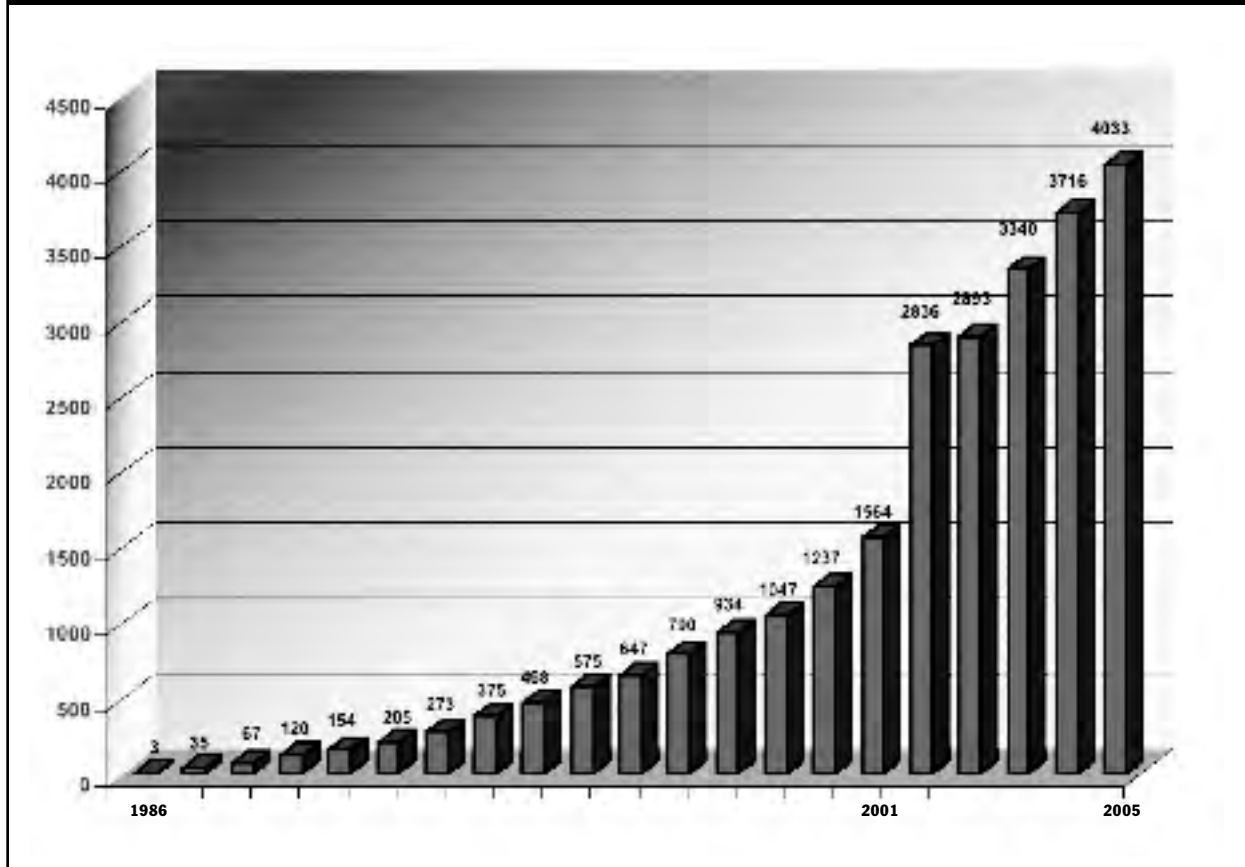
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the community. Although these constituents may have slightly different goals, all agree that we want a healthcare institution that survives and thrives by doing the good work of healing patients and families, creating healthier communities, providing genuinely fulfilling opportunities and a good work environment for employees, and creating a place for physicians to practice medicine to the fullest of their abilities.

Service recovery systems are established within the context of other systems used to reach these goals, typically a global service excellence or patient satisfaction strategic initiative. Of course, saying that something is of strategic importance does not necessarily mean that it is actually treated as if it's strategically important: Do as I say, not as I do, typically fails to create behavior change in any situation. Even in healthcare organizations, staff will imitate behaviors—especially those of leaders, managers, and supervisors. If they show that it is on their “radar,” other staff will know it is important to the organization.

### **THE PRESS GANEY MISSION**

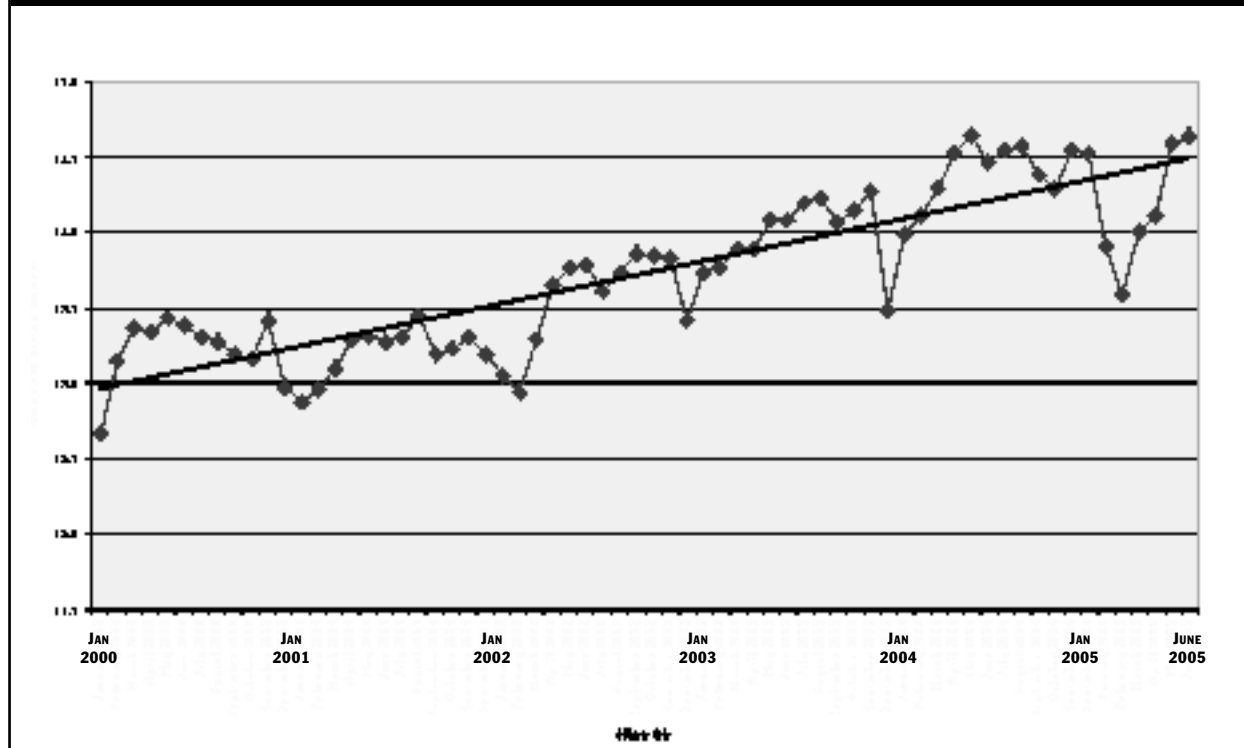
Press Ganey can help you answer all of those questions. Our mission is to “partner with our clients in defining, assessing, and improving the quality of service to their customers.” We're experts in applying rigorous psychometrics to measure what many consider unquantifiable. Each year, we survey more than nine million patients and help healthcare facilities use their customer data to improve their healthcare services. (The CD accompanying this book contains examples of Press Ganey patient satisfaction surveys and an explanation of our measurement scale.) Over the past five years, the customer revolution finally kicked in: The number of healthcare providers partnering with Press Ganey to measure satisfaction continuously has dramatically increased, from 1,564 in 2001 to more than 4,000 in 2005 (See Figure 1.1).

**Figure 11****Number of healthcare facilities partnering with Press Ganey**

Facilities that have partnered with Press Ganey for the past five years have seen their overall patient satisfaction scores rise from 82.68 to 84.64 (as shown in Figure 1.2; note that the variation is consistent with normal seasonal variation). Note the contrast with the national average for hospitals, which the American Consumer Satisfaction Index found to have dropped to 70.8 in the first quarter of 2005 (from 76.0 in the first quarter of 2004). Similarly, the Kaiser Family Foundation, in conjunction with Harvard University and the Agency for Healthcare Research and Quality, conducted a nationwide phone survey published in late 2004 in which 55% of those surveyed said that they were dissatisfied with the quality of healthcare, up from 44% in 2000—and 40% said the quality of care had gotten worse in the past five years.

Figure 1.2

## Overall mean score by discharge month



Healthcare organizations partnering with Press Ganey also dominate healthcare quality awards and rankings, such as Solucient's Top 100 hospitals, *Fortune* magazine's best employers, Consumer Choice awards, Magnet hospitals, and Malcolm Baldrige National Quality award.

Because we provide a systematic performance measurement and management system for satisfaction, we enable our partners to focus on improvement instead of on the nitty-gritty details of managing the measurement, reporting, and feedback processes. A recent study found that having such a system is predictive of high performance in healthcare quality improvement:

We identified some key characteristics that separated the high performing from the low performing groups . . . Groups that encouraged formal involvement in quality improvement, such as implementing a systematic method of measuring patient satisfaction and a requirement to report quality results to outside bodies, were more likely to rank in the top 25 percent of almost all performance measures.<sup>4</sup>



## Endnotes

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1. Kevin Quinn, “Dividing a trillion-dollar pie,” *Healthcare Financial Management* 58, no. 4 (April 2004): 60.
2. Thomas A. Mayer and Robert J. Cates, “Are they patients or are they customers?,” *The Satisfaction Monitor* (July/Aug 1998).
3. Kathleen N. Lohr, “How do we measure quality?,” *Health Affairs* 16, no. 3 (May/June 1997): 7–21.
4. Stephen M. Shortell, Julie Schmittiel, Margaret C. Wang, et al, “An empirical assessment of high-performing medical groups: Results from a national study,” *Medical Care Research and Review* 62, no. 4 (Aug 1 2005): 407–434.