MEDICAL UNIVERSITY OF SOUTH CAROLINA VALUE INSTITUTE
Evidence-Based Practice Brief
Effective Customer Service Tactics to Improve Patient Experience

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ASK THE QUESTION

Question: What customer service components are effective in improving the patient experience in the academic medical center setting (i.e., patient satisfaction scores)?

SEARCH FOR EVIDENCE

Databases: PubMed, CINAHL


CINAHL search: (customer service OR MH "Guest Relations") AND (MH "Patient Satisfaction" OR satisfaction OR "patient experience" OR "Hospital Consumer Assessment of Healthcare Providers and System" OR hcahps) AND (bundle* OR program*)

Filters: English, Published last 10 years

CRITICALLY ANALYZE THE EVIDENCE

Four primary research articles (Eales-Reynolds and Clarke, 2012; O’Neill et al., 2012; Tajeu et al., 2015; Van Fleet and Peterson, 2016) were found addressing customer service tactics to improve patient experience in the academic medical center setting. None of the studies directly link changes in the customer service framework to HCAHPS scores directly.

Eales-Reynolds and Clarke (2012) explored the effectiveness of a training program developed to encouraging a culture of customer service at a Health Trust in the UK. The workshop showed an impact on customer care-related skills including: the ability to challenge poor performance in the workplace, understanding the importance of taking a proactive approach, recognizing the values and beliefs of others and recognizing the impact each individual can make. O’Neill et al. (2012) evaluated a program developed to improve both the experience of calling for an appointment and access to physicians in ambulatory care at an academic medical center. As part of the study, “mystery shoppers” called to schedule appointments then evaluated access and quality of phone service. As a result of this evaluation: 1) telephone scheduling services were updated to include specialized schedulers, which markedly decreased the number of unanswered calls, 2) telephone schedulers were better trained to meet customer service needs, 3) physicians were incentivized to expand their clinic hours, and 4) additional physicians were hired to meet the growing scheduling demand. Ultimately, these changes resulted in an increase in the net margin for specialty
clinics from $16.9 million before implementation to $19.2 million afterward. Tajeu et al. (2015) completed focus groups with African American and European American participants (n=92) to assess patients’ perceptions of discrimination and patient satisfaction in the health care setting by non-physician staff. Participant comments revealed that both verbal and non-verbal communication contributed to perceptions of discrimination, with race and socioeconomic status being the main themes for feeling discrimination in the health care setting. Participants’ recommendations to reduce perceived discrimination included: smiling, patience and listening, general pleasantries (e.g., “good morning, how are you?”) and taking time to “walk a mile in someone else’s shoes.” Van Fleet and Peterson (2016) performed a qualitative analysis of feedback from 376 students in graduate business programs who had seen a doctor in the last three months to assess for effective and ineffective behaviors exhibited by health care staff. Findings from the three most prevalent providers (general practice, dentists, RNs) were thematically analyzed based on 11 specific criteria (described below). They found that when consumers believed they were being treated ineffectively, the providers’ integrity and ethics were often called into question (56% of general practitioners, 24% of dentists, 19% of RNs). Additionally, the top 10 consumer complaints in the study were:

- dishonesty or unfairness
- treating consumers disrespectfully
- broken promises
- no desire to solve basic problems
- long waits
- impersonal “non-service”
- lack of communication
- unwilling to permit questions
- not taking time to answer questions
- visiting with one another while the consumer waits

While not considered primary research, there were three additional articles (Merlino and Raman, 2013; Rangachari et al, 2011; Weigand, 2013) that provided useful information regarding customer service tactics to improve patient experience in the hospital setting. Merlino and Raman (2013) described “lessons learned” by the Cleveland Clinic in creating a superior experience for health care customers, as they recognized that “patients were coming to us for the clinical excellence, but they did not like us very much.” Changes at the Cleveland Clinic fell into three distinct categories:

- Develop a deep understanding of patient needs
  - Goal is to provide reassurance that the people taking care of them understand what it is like to be a patient
    - Prompted increases in care coordination and better communication about what was going on
    - Understanding of patients using proxy ratings (i.e., dirty room = poor care, happy employee = patient more satisfied with appropriateness of care)
  - Develop and implement processes, create metrics and monitor performance for continuous improvement
    - Coordinated by the Office of Patient Experience
    - All employees randomly assembled for half-day customer service training
      - Smiling
      - Identification (name, role, what to expect)
      - Active listening
      - Building rapport
      - Saying thank you
    - Creation of electronic dashboards for customer service metrics
    - Implementation of a “Caregiver celebration” incentive program
    - Mandatory manager training and annual planning to improve engagement and satisfaction in the people they manage
• Communicate intensively with prospective patients to set realistic expectations
  o Changes to how appointments are scheduled
    ▪ Cleveland Clinic was the first organization to offer same-day appointment options
  o Improvements in multidisciplinary communication regarding hospitalized patients (including a case-by-case root cause analysis)
    ▪ Hinged on regularly scheduled interdisciplinary huddles
    ▪ Implementation of hourly nursing rounding on patients
  o Formalized way of setting expectations for inpatient stays before admission regarding factors like sleep disturbances and nurse call system prioritization

Rangachari et al. (2011) used the theoretical Service Quality Model (aka “customer service framework”) to describe how to successfully implement patient- and family-centered care (PFCC) in the health care setting. The authors describe how the customer service framework helps “to support the case for universal adoption of patient involvement.” Additionally, they offer suggestions for how the customer service framework can be used to create action steps to minimize gaps between service quality specifications and actual service delivery to improve service quality from the customers’ standpoint. They make suggestions for:
  • New communication processes at the point of entry (i.e., clear signage and way-finding materials, staff training on recognizing and responding to people with language and literacy barriers)
  • New communication processes during the care encounter (i.e., use of plain language, probing for understanding using “teach back” and “show back” methods, staff access to patient-centered resources)
  • New communication processes during care transitions (i.e., detailed hand-off operations, patient-centered medication reconciliation)

Weigand (2013) describes the nursing bundle created for patient satisfaction which includes: bedside shift report, communication, hourly rounding with the use of whiteboards and post-discharge phone calls. The article describes the reason and evidence behind the inclusion of each of the four components.
  • Bedside shift report
    o Promotes the expectation that the patient is involved in the plan of care
    o Promotes accountability and teamwork
    o Sets expectation for the patient that a nurse will return within an hour to answer any further questions
  • Communication
    o Acknowledges that the quality of the initial nurse to patient interaction establishes the foundation for overall patient satisfaction
    o Promotes setting realistic expectations with the patient and family and timeliness of providing information to the patient
  • Hourly rounding and whiteboards
    o Addresses the 4“P”s of comfort: pain, personal needs, position, and placement (disposition)
    o Uses whiteboards to promote communication between patients and health care providers with a focus on the patient’s individualized care
  • Post-discharge phone calls
    o Confirms patient’s understanding of home care instructions and clarifies any questions the patient might have

All seven of these studies provide insight into the various tactics that have been effective in improving customer satisfaction in other organizations through systematic, organizational implementation.

<table>
<thead>
<tr>
<th>Author/Date/ Journal</th>
<th>Purpose of Study</th>
<th>Study Type</th>
<th>Population &amp; Setting</th>
<th>Outcomes</th>
<th>Study Design Limitations</th>
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<tbody>
<tr>
<td>Eales-Reynolds, L. and Clarke,</td>
<td>To explore the effectiveness of a novel</td>
<td>Descriptive (pre-post survey; semi-)</td>
<td>373 health care workers participating in a training program at Portsmouth Hospitals Trust in the</td>
<td>Workshop’s impact on customer care-related skills: -ability to challenge poor performance in the</td>
<td>Study Limitations = None. Non-Experimental/Observational</td>
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| C., 2012, *International Journal of Health Care Quality Assurance* | approach to training health services workers to meet the aims of raising awareness of their customer care framework and encouraging a culture of customer service | structured interviews) | UK regarding a new customer care framework -86 RNs, 50 support staff, 38 allied health, and 2 doctors -145 admin and support staff -52 managerial staff

Designed to improve customer care through highly interactive workshop, supporting materials and follow-up contacts to reinforce messages in the workplace

Perceptions of customer care before and after workshop
Online questionnaires
Semi-structured interviews with 17 randomly selected participants to determine if learning had resulted in changes in practice (pre-training n=5; post-training n=10; 3 months n=5)

Workplace (43% well, 27% very well)
-identify the importance of behavior and communications (32% well, 62% very well)
-understand importance of taking a proactive approach (43% well, 46% very well)
-be aware of own values and beliefs (40% well, 49% very well)
-recognize the values and beliefs of others (40% well, 49% very well)
-recognize the impact each individual can make (24% well, 68% very well)

Participants asked to set goals to enhance customer care, but recollection of these goals was inconsistent immediately after, 1 month after and 3 months after

O’Neill et al., 2012, *Academic Medicine* | To evaluate a program developed to improve both the experience of calling for an appointment and access to physicians in ambulatory care at an academic medical center | Prospective observational | Beth Israel Deaconess Medical Center in Boston, MA pre and post implementation of a customer service program (2005-2007)

Measuring access and quality of phone service:
-“mystery shoppers” to measure scheduler effectiveness and quality
-quantifying cost (mystery shoppers) and benefits (improved access)
-# of business days between call and 1st appointment offered (scheduler identifying reliably available slots; physician devoting more time to ambulatory care)

Telephone scheduling service:
-moved from academic secretaries scheduling appointments to specialized schedulers with standardized templates for each clinic
-marked reduction in # of unanswered calls; courtesy and registration skills have improved markedly (above 90% on multiple surveys)

Appointment access time:
-training with schedulers
-presented transparent profit/loss statements to physicians quarterly
-created physician incentive plans to increase interest
-established coverage systems for vacation
-hired additional physicians

Growth and cost: Total # of ambulatory visits

| Studies (case-control, cohort, cross sectional, longitudinal, descriptive, epidemiologic, case study/series, survey) |
| Insufficient sample size |
| Sample not representative of patients in the population as a whole |
| Variables (confounders, exposures, predictors) were not described |
| Outcome criteria not objective or were not applied in blind fashion |
| Insufficient follow-up, if applicable |
| For prognostic study, sample not defined at common point in course of disease/condition |
| For diagnostic study, gold standard not applied to all patients |
| For diagnostic study, no independent, blind comparison between index test and gold standard |

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### Tajeu et al., 2015, American Journal of Public Health

To assess patients' perceptions of discrimination and patient satisfaction in the healthcare setting specific to interactions with non-physician healthcare staff

- **Descriptive (focus groups)**
- 12 focus groups with African American (AA) and European American (EA) adults stratified by race and gender (92 participants; 55 AA and 37 EA)
- University of Alabama, Birmingham
- Goal to identify factors contributing to perceived discrimination by healthcare staff (6 questions)
  - answers stratified by theme
  - 22% AA had Medicare/Medicaid; 5.4% EA had Medicare/Medicaid
  - Self-selected to participate and given $20 gift card

Feelings of discrimination associated with 2 main characteristics: insurance or socioeconomic status (SES) and race
- Differences between how patients with and without insurance were treated by staff
- Differential treatment based on racial differences between staff and patient

Non-verbal communication: both AA and EA participants reported feeling disrespected and discriminated against based on staff behaviors
- Lack of staff smiling
- Lack of eye contact, "not looking up at all"
- Negative attitudes: multitasking while being spoken to; "look you up and down"

Verbal communication: both AA and EA participants reported feeling disrespected and discriminated against based on verbal communication and tone of voice
- "Talking down" to people based on race or SES
- Shortness and tone of voice

**Recommendations to Reduce Perceived Discrimination:**
- Smiling
- Patience and listening
- General pleasantries like "good morning, how are you?" - "Walking a mile in someone else's shoes"

### Van Fleet, D and Peterson, T., 2016, International Journal of Health Care Quality Assurance

To develop an awareness of healthcare behaviors, with a view toward improving customer satisfaction with healthcare services and

- **Descriptive (qualitative)**
- 376 students in graduate business programs at 3 US universities who had seen a healthcare practitioner within 3 months
- Critical incident technique: asked to identify 2 incidents of behavior (1 effective, 1 ineffective) by anyone employed within the practice (690 responses)

- Larger # of ineffective incidents raises the question of whether people recall ineffective incidents more readily

**Effective:**
- Excellence: confident, self-assured, "followed correct procedures" (general practice: 53%, RN 64%)
- Respect: friendly, concerned, "took time with me" (general practice: 59%, RN 93%)
- Joy: RNs seem to have "time or ability to uplift

Study Limitations = None

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provide evidence to distinguish between effective and ineffective behaviors

| practice, dentist, pediatrician, specialists | the human spirit and add to the consumers' perception they are being treated effectively (79%) |
| - "test" for criticality by a second group of subjects (n=23) on a 5-point Likert scale; only those above 4 or below 2 retained | Ineffective: |
| -420 responses (181 effective and 239 ineffective) remained | Top 10 consumer complaints: |
| Thematic analysis of 3 most prevalent providers (general practice, dentists, RNs) | - dishonesty or unfairness |
| - Berry 1999: 7 common core values for building a trust-based relationship (excellence, innovation, joy, teamwork, respect, integrity, social profit) | - treating consumers disrespectfully |
| - National Quality Strategy foci: patient safety, effective treatment, care coordination, person-centered care | - broken promises |
| Value of integrity: when consumers believe they are being treated ineffectively, integrity and ethics are often called into question (56% of general practitioners, 24% of dentists, 19% of RNs) | - no desire to solve basic problems |
| Person-centered care was often mentioned in terms of ineffective behavior for general practitioners (21%) and RNs (18%) | - long waits |
| | - impersonal "non-service" |
| | - lack of communication |
| | - unwilling to permit questions |
| | - not taking time to answer questions |
| | - visiting with one another while the consumer waits |

REFERENCES