CHAPTER 1

Getting Started: Why Worry About Customer Service in Healthcare?

One of the most intriguing and troubling questions facing healthcare leaders is, *How do I create a meaningful and lasting culture of customer service in my institution?* Improving customer service and patient satisfaction is a critical issue in administrative offices and hospital boardrooms across the United States.

THE IMPORTANCE OF HEALTHCARE CUSTOMER SERVICE: AN INTRODUCTION

More than a hundred books have been written on the application of customer service to healthcare. Many, if not most, healthcare leaders' core goals and objectives for the hospital (and their bonuses) are tied at least in part to attaining improved service excellence ratings. The problem, of course, is that while there is plenty of legitimate and genuine concern in the executive suite, too little practical guidance is provided in the patient care areas, where clinical care and customer service are offered. In other words, the *intention* is almost universally good, but the *execution* is often lacking. Despite posting eloquent mission statements, paying substantial fees to consultants, developing training materials and building sophisticated websites, and delivering appropriately passionate statements at management team meetings to exhort the troops, for many healthcare institutions, when it comes to customer service, the words and the music don't match.

Consider this example: Your organization has a first-rate service excellence road map, fully supported by fiercely passionate members of your leadership team. You've done the "tent revival" rollout, brought in the best motivational speakers,

put up all the right posters and slogans in all the right places, and built accountability into the compensation plans of the entire management team. There's only one problem—the needle isn't moving up on the customer service gauge. As a matter of fact, it shows a disturbing downward trend.

Unfortunately, this is an increasingly common scenario, and one that has a single root cause: For many healthcare providers, the *why* of service excellence is much less clear than the *how*. But without a clear sense of why things are being done, the specific methods constituting the "how" get lost in the shuffle.

Nietzsche, in *Beyond Good and Evil*, made the point concisely:

> He who has a strong enough "Why" can bear almost any "How."

> Between the idea
> And the reality
> Between the motion
> And the act
> Falls the shadow.
> —T. S. Eliot, *The Hollow Men*

Why is there such a long shadow between the *idea* of service excellence and the *reality* required to bring it to fruition? Why is there such a gap between the proclaimed commitment to and the actual delivery of customer service in healthcare institutions? Noted scholar of organizational behavior Chris Argyris (1993) comments, "For many institutions, the fundamental problem is the dissonance between the espoused strategy and the enacted strategy."

Part of the reason for the dissonance between the carefully espoused strategies of customer service and the enacted strategies seen in the patient care areas is that the staff members, charged with providing the service and enacting the strategy, can clearly understand why it is important to the CEO but not why it is important to *them*. As the old story goes (adapted from Belasco and Stayer 1993),

> The CEO of a large regional healthcare system took one of her key managers to the top of a hill overlooking the city. Pointing down at a ridge just below them, she said, "Imagine a beautiful house sitting atop that ridge, overlooking the city. Can you see it?" "Oh yes, I can see it," said the manager. She continued, "Imagine there is a swimming pool just behind the house. Can you see it in your mind?" "Yes, yes I can!" said the manager, getting more excited. "Imagine there is something off to the right of the house—it's a tennis court! Can you see it?" "Yes," said the manager, "I can see it!" The CEO continued, "If this customer service initiative is successful and we continue to increase our market share, someday all of that will be . . . mine."

This concept can be illustrated in another way, through the lens of "owners" versus "renters." Owners are fully engaged in the organization's success; deeply passionate about its mission, vision, and values; and grateful for the opportunity to serve patients and their families. Renters? Well, they just show up, expecting a paycheck (and eventually a promotion) for their "time served." In a study of companies that were able to sustain their success, Jim Collins (2010) put it this way:

> One notable difference between wrong people and right people is that the former see themselves as having "jobs," while the latter see themselves as having "responsibilities."

Throughout this book, we show you how to make the distinction between owners and renters and those with jobs versus responsibilities clear and actionable in your organization. It starts with acknowledging a simple, yet often overlooked, consideration: Patients have come to expect *both* clinical quality and service quality, not one or the other. Thus, clinical excellence and service excellence cannot be separated—they are inextricably linked. When it comes to service and clinical quality, the framework through which it is achieved must always be based on "both/and," never "either/or" (discussed in detail later in the book).

This book is written for healthcare leaders operating at every level of the organization, with the understanding that transformation to a culture of service excellence requires not just the *intention* of the leadership but also the constant *attention* of doctors, nurses, radiology technicians, laboratory technicians, registrars, housekeepers, and so on across the organization. For this reason, our intent is to give *you* direction on how to give *them* direction to accomplish high-level customer service.

Toward this end, we present an approach that leaders can use to address those staff who provide service. We give you plenty of clinical examples of what you need to do to not only demonstrate your commitment to service excellence but also show clinicians *how* to apply highly successful strategies. Our greatest hope is that you will finish this book, hand it to your leadership team, and say, "Put this into action!" If you do, you *will* transform your organization.

Many in healthcare feel they are "at the ramparts," evoking images of a besieged, embattled industry facing declining revenues, increasing demands, an aging population, healthcare personnel shortages, emergency department crowding and diversion, and the reality that key providers of service—physicians—are typically neither employed nor controlled by the healthcare system. Into the midst of such difficulties comes the demand for improved customer service and patient satisfaction. Add

to this the challenges of moving from volume-based to value-based purchasing and of adopting, adapting, and implementing different structures to comply with the Affordable Care Act, and healthcare providers may legitimately ask themselves, Is this *really* the time to be focusing on customer service in healthcare?

This honest and straightforward question deserves a frank and direct answer—"Yes!"—but for a reason that is not necessarily obvious, since it focuses more on the healthcare professional than on the patient. Having taught the customer service training course (Patient Care Survival Skills™) on which this book is based to more than 200,000 healthcare professionals for 20 years at more than 2,000 healthcare institutions, we have found that the most significant challenge to creating a culture of customer service is providing healthcare leaders and the healthcare team a clear and practical understanding of why customer service and patient satisfaction should be important to them. (We know it's important to you—indeed, your job may depend on it.) To do so, we pose to them—and you—a simple exercise. First, take a moment to consider the following statement.

The number one reason to get customer service right in healthcare is _____.

If you are like the many healthcare providers to whom we have given this exercise, your answers generally fall under the following classifications:

- It's better for the patient.
- It's better for the family.
- It's better for quality care.
- It's better for the medical staff.
- It's better for market share.
- It's better for risk management.
- It's better for reimbursement.
- It's better for patient safety.

The most commonly heard answer is that excellent customer service is good for the patient or the family. We also typically hear that it is good for risk reduction—those providers who are good at service are sued for malpractice at much lower rates than those who do not excel in that area, a fact that has been repeatedly demonstrated by Dr. Gerald Hickson (2009) and his colleagues at Vanderbilt University Medical Center.

All of these are great reasons to get customer service right in healthcare, but who primarily benefits—the individuals providing the services, or those who lead and manage the organization? As suggested by the first point in the right-hand column of the above list, market share improves when customer service improves. Sounds great—but what if I'm a nurse in a busy, overcrowded emergency department? The reward for good customer service is . . . *more patients*? That doesn't sound like a reward to us, nor will it to the nurses.

GETTING THE "WHY" RIGHT BEFORE ATTEMPTING THE "HOW"

Health leaders have spent an enormous amount of time, energy, and effort emphasizing and training for the "how to do it" questions of customer service while neglecting the "why do it in the first place" motivation, which is where we must always start.

Any customer service initiative that answers, "Why are we doing this?" with, "Because the boss says so" or "It's good for market share" is doomed to failure. In fact, such a response is precisely why most customer service initiatives in healthcare either fail or are not sustainable. The paradox is that, while all of the above responses are certainly true—and in themselves excellent reasons for getting customer service right—they miss the fundamental point:

The number one reason to get customer service right in healthcare is that ***it makes the job easier.***

Effecting change in service behaviors in the healthcare environment is nearly impossible unless the people providing the care understand this truth. *Anything* that is described as customer service should make the job easier. Make no mistake—providing clinical care at the bedside is a difficult job that seems to get more difficult each day. If we now say, "Oh, and by the way, get your customer service scores up, too," we should never be surprised if our staff members are not only not on board but ready to revolt. For that reason, there are two simple litmus tests for whether to launch a customer service initiative and the programs comprising them:

It's called customer service, but

1. *does* it make the job easier? If so,
2. *how* does it make the job easier?

If any initiative that is described as customer service fails either test, the staff providing the care know that it is not a true customer service–oriented effort. Further, they understand that things that come labeled as customer service but that do not make their jobs easier actually create *more work* for them. The translation of this knowledge to the work of healthcare delivery is one of the reasons so many service excellence initiatives in healthcare either fall short of their goals or produce temporary results rather than lasting cultural changes.

Rather than a vague management plan, service excellence is an *evidence-based discipline* designed to make the difficult job of patient care easier. Each of the ten elements of the A-Team Tool Kit, which are discussed in detail in Part III of the book, are not "rah-rah" cheerleading concepts or exhortations to raise scores. They are evidence-based solutions that were born of and proven over time to effect change by *making the job easier.*

How do we (1) communicate this solution-based approach to service excellence in a way that resonates with those who provide care and service to patients on a daily basis and (2) illustrate that excellent customer service makes their job easier? Without a way to create a widely shared understanding that service excellence works for them—as well as the patient—meaningful and lasting change is unlikely to occur.

How *Not* to Communicate the Initiative

We have all seen signs posted at the grocery store or on light poles asking for help in finding lost pets. But you might have missed this one:

Lost!

Small brown dog
Partially blind
One leg missing
Tail has been broken three times and hangs at an unusual angle
Recently neutered
Answers to the name "Lucky"

When you introduce customer service programs that do not clearly make your staff's job easier, they don't feel lucky—they feel *like* "Lucky"—they can't see, their tail has been broken, and they have been surgically altered. And they will want to know why they have to change. For highly trained professionals in particular, for whom asking "Why?" is an ingrained characteristic, "Because I said so" won't cut it. On the other hand, "Because this is an evidence-based discipline to make your job easier" works because there is a scientific base to support it.

A-TEAM MEMBERS VERSUS B-TEAM MEMBERS

The simplest way to communicate the belief that customer service behaviors actually make the job easier is to pose a single question to your healthcare providers: *Do we offer good customer service?*

Not surprisingly, typical answers include "Yes!" from some; an affirmative but less emphatic "yes"; and even the occasional "No, unfortunately, we don't offer consistently good customer service." In addition, a predictably large group will answer neither affirmatively nor negatively. They believe that the answer to the question is, "It depends." The next question, of course, is, "Upon *what* does it depend?" What are the factors that determine whether we offer good customer service? Again, a simple exercise serves us well in making this determination. Pose the following question to a healthcare team:

Do you sometimes look at the people you are working with and think to yourself, "Bring it on! Whatever we've got to do today, this team of people can make it happen!"?

Those individuals who proclaim "Yes!" are known as the A-Team. If you were to ask these folks to describe A-Team attributes and attitudes, their responses would likely include the following terms:

- Positive
- Proactive
- Confident
- Competent
- Trustworthy
- A teacher
- Does whatever it takes
- Compassionate
- A communicator
- A team player
- Has a sense of humor

This list summarizes the responses from the thousands of healthcare providers we've questioned about the attributes of the A-Team. Regardless of where they work in the healthcare system, the phenomenon of the A-Team is well known. This is a team we'd all like to work with—and join. These people make the hard work of providing patient care not only bearable but enjoyable. When you use this exercise, it is important to remember that you don't need to tell them what the A-Team attributes are (top down)—they already know and will tell you willingly (bottom up).

However, there is a second part to the above exercise that is equally, if not more, important. You now must ask the staff this question:

Do you sometimes look at the people you are working with and think to yourself, "Shoot me, shoot me now! I can't work with him! Who in the world makes the schedule around here?!"?

Those staff who make you think, "That's exactly how I feel" are B-Team players—also a well-known phenomenon among healthcare providers. B-Team members can be described in the following terms:

- Negative
- Reactive
- Confused
- A poor communicator
- Lazy
- Late
- Has a victim mentality
- Administrator Scrooge
- A constant complainer
- Can't do
- Always surprised
- Nurse Ratched
- Dr. Torquemada

Almost every institution has a Nurse Ratched, the quintessentially dour and negative nurse of Ken Kesey's *One Flew over the Cuckoo's Nest*. Many of you are also painfully aware that most institutions have their Dr. Torquemada, the Grand Inquisitor of the Spanish Inquisition. Nurses know that one B-Team doctor can extract more pain from the staff with his negative attitude in an eight-hour shift than Tomas Torquemada did in eight years of the Inquisition because doctors typically set the tone on the "attitude meter" by their actions. Unfortunately, your staff may also think you have an Administrator Scrooge on your management team. An important insight is to recognize that not only do all of you know who the Nurse Ratcheds, Dr. Torquemadas, and Administrator Scrooges are in your institutions but you also know their negative behaviors and faults in infinite detail.

In our seminars, we hear about a curious but predictable phenomenon whereby staff enjoy articulating the attributes that typify the A-Team but they truly delight in delineating the B-Team behaviors, often shouting them out, laughing as they do so. Regardless of the location where the service is provided, all members of a particular team understand on a fundamental level the phenomenon of the A-Team and the B-Team in their daily work. They also understand the toxic nature of the B-Team behaviors, as evidenced by their response to the question, "How many B-Team members does it take to destroy an entire shift?" Without exception, every audience shouts the same response—"One!"

How can this possibly be? Can a single person destroy the morale of your entire staff in a busy, clinical environment? You bet—and he or she does so daily and predictably in your hospital or healthcare institution. You know it, and, far more

importantly, your staff know it—they know who these people are, precisely how they act, and the details of their toxic behavior.

Why Are B-Teams Problematic?

As one nursing director on a busy clinical unit in an academic medical center told us, "I don't really mind taking care of the patients; they're the reason I went into nursing and management in the first place. It's taking care of the B-Team members that wears me out. I don't know how much longer I can do it."

The fundamental problem with B-Team members is not that their behaviors create customer dissatisfaction (although they clearly and predictably do) or that they are harming patients (often, they know precisely where the line is between getting fired for patient negligence or malpractice and getting away with delivering poor customer service). The problem is that their actions and attitudes systematically demoralize the remainder of the healthcare team. A nursing director of a neurological unit, for example, tartly observed that "B-Team members are like space-occupying lesions—they take up space and drain energy." B-Team members foment discontent and nurture it in others. Thinking of the B-Team from the neurological perspective, the overall impact of its members on others is not neutral—it's not just that they lack the A-Team skills but also that they suck energy out of the system routinely.

If for no other reason, eliminating B-Team behaviors is essential to ensuring that employee satisfaction and morale are maintained at the highest possible level under the admittedly difficult circumstances faced in hospitals and healthcare systems.

Many B-Team members seem to be negative, reactive people who begin their day unhappy—and get unhappier by the minute, dragging the morale of patients and staff down with them. Why does this happen? How can people go to work, day after day, year after year, under such circumstances? Quite simply, *the B-Team members are doing a job that isn't their job to do.*

By this we mean that the B-Team members have, through multiple pathways and circumstances, ended up doing something for which they are not basically suited; they simply do not have the skills and abilities (largely from an interpersonal standpoint) required to do their job.

One of us (TM) is the father of three young men and, while the analogies between child rearing and leadership and management can certainly be overdrawn, this story is pertinent to both. Each morning when I dropped my sons off at school when they were younger, they heard the same thing from Dad: *One more step in the journey of discovering where your deep joy intersects the world's deep needs.*

(Understandably, they preferred to take the bus.) Nonetheless, the consistent message is to begin with "your deep joy" as opposed to the "world's deep needs," since all of us must discover what it is we enjoy doing, where it is we enjoy doing it, the kinds of people we enjoy doing it with, and the circumstances under which all of this occurs.

For people to become a doctor or nurse or healthcare executive because "the world needs them" is not a great idea. To become a doctor or a nurse or a healthcare executive to fulfill the fundamental joy they derive from serving people in need is a better match of the deep joy/deep need ratio. Many B-Team members have signed on for a job that is simply not their job to do. They would be better suited either in some other area of healthcare or in an altogether different area of the workforce.

For B-Team members, somehow the world is always a surprise to them—they are surprised that there are patients to be taken care of; they are surprised that these patients have needs and expectations that often do not match their own; they are surprised that available resources are taxed to provide such care; they are surprised by . . . *everything*. One emergency department medical director summed it up nicely:

> I don't understand how these people can be surprised. Many of them have been working in our emergency department for ten years. We see 75,000 visits in a space designed for 40,000, so it is a crazy place. These people have come to work every day for ten years and yet continue to ask, "Where in the world do all these people come from?" I always tell them, "I need to explain something to you. There is a big red sign above our door that says EMERGENCY, and it has an arrow pointing right at us. I think maybe that's where these people came from."

In this respect, B-Team members remind us of bobblehead dolls—they just stand there with a vacuous stare, their heads nodding vacantly to any question asked of them. However, A-Team members are rarely surprised, since they have a clear expectation and essential knowledge of where their deep joy intersects the world's deep needs. And even when they are surprised, they adapt to the unanticipated situation remarkably well, expressing the feelings of one A-Team member: "What's my job description? It's to do whatever I have to do to get through the day, to help my patients, to help the people with whom I work. My job description? I guess it's 'Do whatever it takes.'" This is someone we want to work with!

In addition to the negativity and unhappiness B-Team members bring to the workplace, however, is an even deeper and more basic reason to address problems introduced by their presence: Everyone in every area of your institution knows

who the Nurse Ratcheds and Dr. Torquemadas are—except, of course, for Nurse Ratched and Dr. Torquemada—and if you consistently fail to deal with those B-Teamers, as dictated by the law of unintended consequences, you are demonstrating to your staff that you are dishonest as a leader. Why? Because you allow a system to operate in which there are two sets of rules: one set for the A-Team members and a separate set for Nurse Ratched and Dr. Torquemada. Perhaps the best indicator of this situation is if you hear staff members say some variant of the following:

"Oh, that's Dr. Smith—you have to learn how to deal with him."

"One more thing—when you work with Mr. Jones, he is always 'loaded for bear.' "

"Listen, Christine is a good nurse, but she can be really prickly."

All of these comments are signs that a dishonest double standard is in place, and your reputation will pay the price for it if you don't aggressively and visibly correct the problems related to the B-Team.

We offer several detailed strategies on how to deal with the B-Team in Chapter 9. For now, suffice to note that one of the most important outcomes of a successful customer service program that addresses and eliminates B-Team behaviors is that A-Team members who have tolerated B-Team members' behavior for years will understand that leadership and management are *finally* serious about systematically addressing the problem. If you deal with your Nurse Ratched and Dr. Torquemada, your staff will understand that something is different about *this* customer service program—that people will be held accountable for service *and* disservice.

A-Team behaviors =
good customer service . . .
and employee satisfaction

B-Team behaviors =
bad customer service . . .
and employee dissatisfaction

They're Still Here?

It's not hard to see the damage that B-Teams do to the delivery of healthcare and the healing environment. So why haven't we gotten rid of the B-Team members? Again, posing a simple query to the staff helps gain insight into this issue:

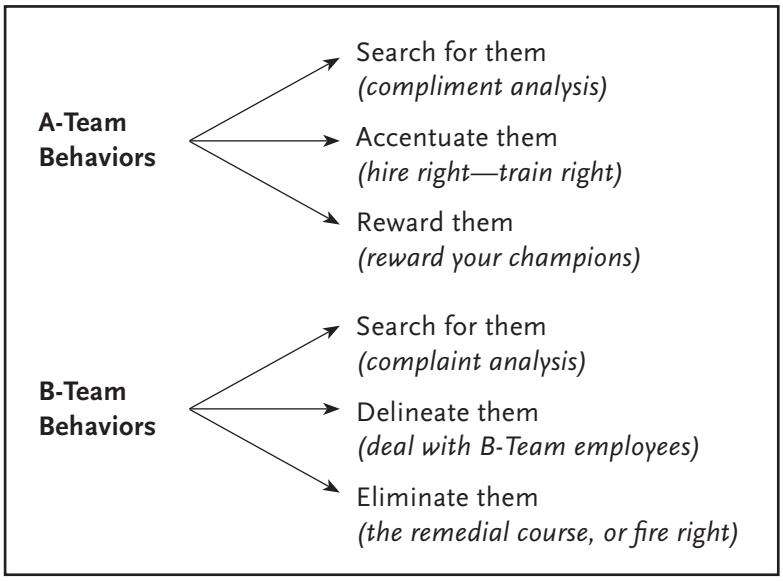
Are you an A-Team member?

Most people to whom this question is posed answer, "Of course, darn right, I am an A-Team member and very proud of it!" (It is a curious comment on human nature that few people ever admit, "I am a B-Team member with 20 years of providing miserable service.")

When A-Team members look in the mirror, what do they see? They see an A-Team member, since these people tend to be self-aware and have a clear understanding of what works and what doesn't work, both in the workplace and in their private lives. They know what their A-Team behaviors are and how to apply them, even if that understanding is, to a certain extent, on the subconscious level.

When B-Team members look in the mirror, what do they see? B-Team members see an A-Team member in the reflection, since they do not recognize that their attitudes and behaviors have a poisonous effect on those around them. (B-Team members are worse than vampires—vampires don't see *any* reflection, whereas B-Team members see the *opposite* of reality.) For B-Team members, their behaviors and attitudes work—for them.

One role of leadership and management is, with the assistance of the A-Team, to *hold the mirror up to the B-Team members,* letting them see the impact that their behavior has on patients, families, and other members of the healthcare team.



CHANGING BEHAVIOR: INTRINSIC VERSUS EXTRINSIC CHANGE

One basic truth of the human condition is that

All meaningful and lasting change is intrinsically motivated.

While extrinsic change may produce immediate results, those results plateau quickly before decaying steadily over time. Natural diffusion of change—intrinsically generated—takes longer to result in a positive alteration of behavior, but it is more sustainable and exceeds the impact of extrinsic motivation, as seen in Exhibit 1.1.

Effecting intrinsic change ("It makes your job easier") instead of extrinsic change ("Get your scores up because I am the boss and I said so!") results in shifting the effectiveness of change dramatically to the left of the scale shown in Exhibit 1.1, both accelerating the pace of change and sustaining its effectiveness over time, as seen in Exhibit 1.2.

To be sure, extrinsic motivation is seductive. It draws us in by appealing to our desire to mandate immediate change. Watch George C. Scott's mesmerizing and Oscar-winning performance in *Patton,* and you will see a good example of how some bosses act—storming around giving commands. But the real George S. Patton was a far more complex and effective leader, one who understood the importance of being at the front lines so the troops knew their leader was with them—an early version of rounding (discussed in detail in Chapter 11). He also made the connection between motivation and execution (Blumenson 1996):

Exhibit 1.1: Extrinsic Change Versus Natural Change

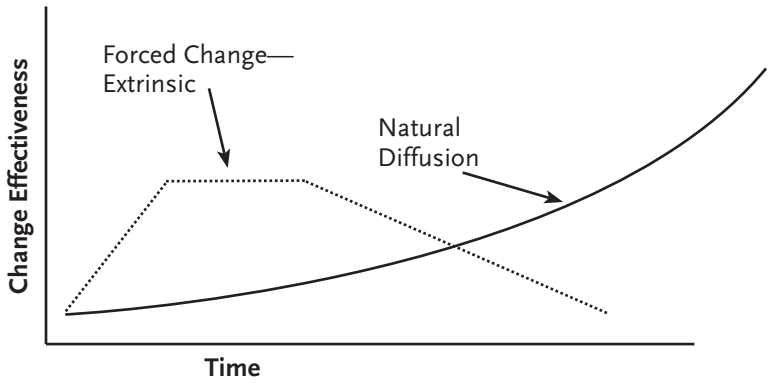
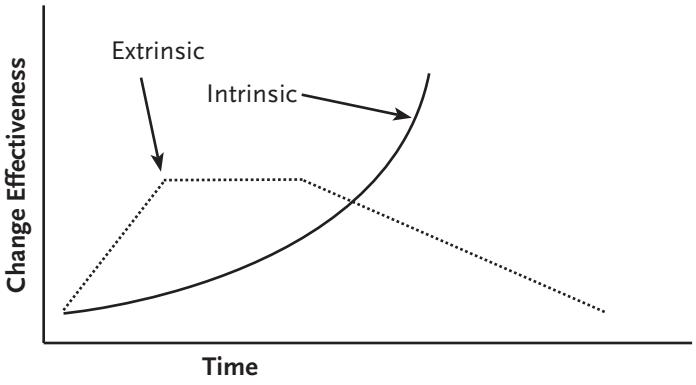


Exhibit 1.2: Extrinsic Change Versus Intrinsic Change



> It comes down to using intrinsic motivation to drive execution. *Without the ability to execute, all other attributes of leadership become hollow and meaningless.* (Emphasis added.)

Execution is also discussed in chapters 6 and 8. For now, suffice to say that execution requires the *specificity* of clear goals and objectives, widely known and shared throughout the organization, as well as the *sensitivity* of using intrinsic motivation to achieve self-motivation in professionals to move toward change—particularly nonincremental change.

INTRODUCTION TO THE SURVIVAL SKILLS

The biggest difference between this book and others on patient satisfaction is its basic tenet: *The number one reason to get customer service right is that it makes the job easier.* As illustrated by the A-Team and B-Team exercises, healthcare providers can clearly see that A-Team behaviors are also high-value customer service behaviors that improve not only patient and family satisfaction but also employee satisfaction.

We call these behaviors our *Survival Skills*. Why do we call them that? Because the skill set that supports A-Team behavior is essential to our survival in the complex, complicated, and confusing world of healthcare. Training in these skills—or A-Team behaviors—is an investment in the most precious resource in all of healthcare: the providers of care. Herb Kelleher, the colorful and highly successful cofounder and former CEO of Southwest Airlines, was once asked the question, "If you had to choose, would you invest in the employee or in the customer?" His

answer came instantly: "In the employee! Because if you take care of the employees, they'll take care of the customers" (Frieberg and Frieberg 1996).

In the remainder of this book, we discuss the importance of understanding expectations (Chapter 2), define the patient–customer axis (Chapter 3), share our Survival Skills (chapters 4–6), and break down the tools in the A-Team Tool Kit and how to apply them (chapters 7–17).

CONCLUSION

Peter Drucker (2010) notes that all service businesses require the voluntary contribution of the provider to choose the type of service that will be created in the interaction with the customer. Therefore, according to Drucker, all service workers are "volunteers." You cannot force your employees—much less the physicians with whom you work—to be nice, professional, friendly, and caring. However, you can show them that all efforts to provide excellent customer service make their job easier, and all successful customer service initiatives recognize this fundamental truth and put it to work effectively.

SURVIVAL SKILLS SUMMARY

While the CEO's and senior management's commitment to customer service is essential, your staff has to understand the following:

- The number one reason to get customer service right is that it makes the job easier.
- The customer service litmus test is that if an action or a decision doesn't make the job easier for your staff, it isn't *really* customer service.
- The A-Team is a group of people who are admired and respected because their behaviors and attributes make life easier, not just for the patient but also for those with whom they work.
- Discover who the A-Team members are in your organization and learn what they are doing.
- Use the A-Team/B-Team exercise to demonstrate to your staff that A-Team behaviors are simply good customer service that will make their jobs easier.
- The B-Team members' attitudes and attributes make life miserable for the patient and your staff. Discovering who the B-Team members are is, strangely, much easier than identifying the A-Team members.

- How many B-Team members does it take to destroy an entire shift? One!
- Identify A-Team members and the skills they use—then accentuate them, insist on them, and reward them.
- Identify B-Team members and behaviors—then eliminate either the behaviors or the people. No less than your integrity is at stake.
- Identify your Nurse Ratched, Dr. Torquemada, and Administrator Scrooge—let them know it's time to get with the program or get gone.
  - Use a combination of specificity and sensitivity—intrinsic motivation—to drive execution.

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