Quality Improvement Primers

# Voice of the Customer

Ontario

Health Quality Ontario

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## INTRODUCTION

Customer satisfaction has long been measured and analyzed by businesses to better understand the opinions of customers and in turn improve the ability of the company to sell their products. In health care, the 'customer' perspective has historically been gathered mainly as a risk management or public affairs activity to reduce the possibility of costly litigation or negative media exposure. This focus on mitigating negative patient feedback began to evolve as the quality improvement (QI) movement took hold in the early 2000's. For more detailed information on the QI movement, please see Health Quality Ontario's *Quality Improvement* primer.

Quality Improvement science has evolved the concept of customer satisfaction to a more holistic view, often called the 'Voice of the Customer' (VOC). The VOC is the idea that the wants and needs of the customer are central to any business or service. This concept can be seen in several QI science models and methodologies such as Lean and Six Sigma. Six Sigma illustrates how customer input should be gathered and utilized in every business transaction and is 'part of its intrinsic function' to satisfy customer needs. In Lean methodology, anything done by an organization that does not provide value to the customer is waste and should be minimized or eliminated. Regardless of the type of QI science utilized, a truly QI focused organization has a strong, fundamental link to the VOC.

## CUSTOMERS IN CANADIAN HEALTH CARE

A customer is anyone who interacts with a product or service, from its design and development all the way to the end-user. In Canada, since health care is publicly funded, there is no direct exchange of money for the majority of health care services. In fact, inherent in the Canadian model of publicly funded health care is the idea that no one should pay for medically necessary, evidence-based health care. The Canada Health Act states that 'the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.'[1] Therefore, the use of the word 'customer' is not the norm in health care. Indeed, its use can lead to debate over whether a person using a service provided by the public has the right to 'dictate' the terms of that service.

Instead of using the word customer, the different sectors of the health care system have developed their own terms to describe their "customers", i.e., the 'residents' of long-term care homes, the 'clients' of home care services, and the 'patients' of hospitals. At the heart of this differing terminology is the desire to promote greater respect for the 'customers' that are using health care services. For example, since the customers of long-term care homes actually live in the health care setting, they are called 'residents.'

For simplicity we will use the term 'customer' when referring to QI science and 'patient' when describing the consumers of health services.

Regardless of the term used to describe the customer, quality focused health care organizations continually work toward achieving more person/patient centered care. Through the adoption of QI principles such as the VOC, health care organizations have begun engaging their patients in the design and improvement of services. This engagement can be seen in hospitals, long-term care homes and community health care services through the inclusion of patient advisory committees and community/patient membership on quality committees. Many organizations have listened to the opinions of their patients and embedded them into overarching mission and goal statements. Patient-centred care as defined by the Institute of Medicine is: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."[2]

### *Internal and External Customers*

The saying "the customer is always right" is as true today as it ever was. However, too many people consider only the voices of external customers (in health care, the external customer is the patient). To design something that is truly patient-friendly, designers must take into consideration **all of the customers, both internal and external.** In health care, this means creating processes that take the needs of the patients and their loved ones, housekeepers, nurses, physicians, and lab technicians into consideration.

Considering the needs of internal customers can also mean involving people in the Quality Improvement (QI) initiative or 'redesign' that are not normally involved in direct health care delivery. These internal customers should be included as they are passionate about the care and services they provide and are up to date on new ideas in their fields. These individuals may play a significant role in creating new and innovative solutions to QI concerns.

Incorporating the voice of these innovative internal customers moves QI beyond just meeting current customer expectations and the prevention of problems to truly customer focused service delivery.[3]

## CAPTURING THE VOC

In addition to being integral to a QI-focused organization, the term VOC is also used to describe a process/action. The Malcolm Baldrige National Quality Award defines the VOC as the "process for capturing patient- and stakeholder-related information. Voice-of-the-customer processes are intended to be proactive to continuously capture stated, unstated, and anticipated patient and stakeholder requirements, expectations, and desires."[4]

### Internal and External Customer Service – Example

*The registration process for elective surgery has been redesigned so there is no wait to register and there is a person available at the hospital to help patients and their loved ones go through the necessary steps prior to surgery. However, this redesign did not consider internal customers. The redesign did not consider the infection control steps that the housekeepers must follow to clean the cots that are used to transfer customers from registration to the surgery suites. As a result of not consulting all the internal customers, the cots are not cleaned regularly. The end result could be that more staff and patients end up contracting viruses. Considering only the patient in the redesign of a process could lead to processes that negatively influence all customers.*

*For example, in the QI initiative described above to redesign the registration process, the QI team may include an information technology (IT) internal customer that is passionate about health care IT. This individual may know of some new technology that could make the registration process more effective for both patients and internal customers like housekeeping.*

Many methods of capturing the VOC focus on obtaining feedback from the customer after they have finished their experience with a business or service. These methods capture the VOC by gathering and integrating:

- Focus group findings
- Survey data
- Interview information
- Complaint feedback or data

*More detail on the above methods and forms of data can be found in Appendix A.*

The VOC can also be obtained by "going to gemba." Gemba is a Japanese term used in Lean which means "going to the real place." This is usually understood to mean the place where care is delivered, support processes are performed, or more simply, where the work gets done. Using gemba as a means of hearing the VOC is to put the saying "walk a mile in their shoes" into action. Certain health care organizations have taken this idea and instituted processes to reflect the VOC in their delivery of service. For example, the Institute for Healthcare Improvement uses a method/tool to capture the VOC that they have termed the patient "Walk-through Tool".[5] Observing firsthand how a customer interacts with and experiences health care processes can reveal previously unknown perspectives, unintended consequences and challenges, as well as illuminate potential areas for improvement.

### *Customer Co-Design*

The most collaborative method of obtaining the VOC is *Customer Co-Design*. Using this method, organizations actively engage the customer in the entire quality improvement process - not just pre/post change. This involvement is usually in addition to the other methods of garnering the VOC, such as surveys or interviews.

Once the VOC is obtained, this information can be categorized into themes. There are many techniques to categorize the themes, such as the use of an affinity diagram to help the organization focus on which customer needs require immediate attention or would benefit from improvement.

Involving the customer throughout the QI process makes it possible to deal with issues that directly impact customer experience as they come up, rather than allowing a final product to be completed and then finding that it must be reworked. When internal (i.e., health care professionals) and external customers (i.e., people seeking health care) co-design a new or improved process, they take ownership and are more likely to accept the changes and promote them to other customers and stakeholders. In this way, the new process is made for the customer by the customer. This, ultimately, is a priceless by-product. The promotion of a product or process by both internal and external customers can lead to widespread acceptance, spread and long-term sustainability.

### *Experience Based Design (EBD)*

Experience Based Design (EBD) is a field of study and a method of obtaining the VOC by capturing the 'emotions' the customer experiences while moving through the health care system. Experience Based Design is considered a form of customer co-design. Most of the research and theory on EBD comes from the National Health Service (NHS) in the United Kingdom.[6]

Experience Based Design uses the patient's perception of their experience to gain insight which assists in the identification of opportunities for improvement. Experience Based Design methodology utilizes a tool known as 'emotional mapping' to capture the patient's experience and their corresponding emotions as they travel through the 'touch points' in the health care system. The 'touch points' technique focuses on the patient's actual emotional experiences not attitudes or opinions about the care they received. It moves the quality improvement journey beyond simple patient satisfaction measurement to a process of honest patient engagement. The focus is on the relational aspects of care which impact thoughts, feelings and experiences. The NHS now builds EBD into all the services and programs that it offers.

### *What are the key activities in EBD?*

**1. Capture the experience**

- Survey, Experience Questionnaire
- Focus groups, interviews to further understand the customer experience

**2. Understand the experience**

- Identify the emotions
- Find the touch points in the health care delivery process. Clearly identify when the patient is engaged in process vs functions that occur without patient involvement
- Map high and low emotions to touch points

**3. Improve the experience**

- Patient and staff engagement day
- Identify problem
- Idea generation to address problem
- Don't let staff "take-over"
- Use HQO QI Framework to develop and test changes to improve the process and experience
- Develop a next steps plan, "what will we test?"

**4. Measure the improvement**

- See step 1 to measure the change
- Measure both baseline and after the change

**INTRODUCTION TO THE TOOLS**
Roles and structures
Tools to help raise awareness

**Capture the experience**
Tools to help people tell their stories

**Understand the experience**
Tools for understanding patient and staff experiences

**Improve the experience**
Tools to turn experience into action

**Measure the improvement**
Tools for evaluating and measuring the improvement

## CONCLUSION

To truly create high-quality, focused health care that is meaningful to patients, we must ask patients (external customers) what it feels like to seek and receive health care and related services. We have to ask health care providers (internal customers) what it feels like to provide health care services. We must engage all health care customers in the quality improvement process to improve health care delivery. Establishing a formal connection to the VOC by actively engaging customers in ongoing quality committees or patient advisory groups ensures there is a constant flow of information both to and from the customer. Only by listening to customers can we hope to meet their needs.

## OTHER RESOURCES

To learn more about engaging the customer in Quality Improvement, you may wish to read:

National Health Service (2013). Experience Based Design. Retrieved from http://www.institute.nhs.uk/quality_and_value/experienced_based_design/the_ebd_approach_%28experience_based_design%29.html

Patient and Family Centered Care Innovation Center (2013). Retrieved from http://www.pfcc.org/

Pyzdek, T & Keller, P. (2010). *The Six Sigma Handbook.* Columbus: McGraw-Hill Professional

## 1. Focus groups

A focus group brings together a group of customers for an in-depth conversation about their views and expectations of the product or service they are using. In QI initiatives, the focus group should include a representative from each of the customer groups (for example, a group of patients who have undergone a total hip-replacement surgery). This method promotes the exchange of ideas and provides feedback about how to improve the customer experience through service/ process redesign. It also allows individuals to build on the ideas and creativity of others when developing suggestions for improvement.

This method is beneficial as it: “does not discriminate against people who cannot read or write and they (the facilitators of the group) can encourage participation from people reluctant to be interviewed on their own or who feel they have nothing to say.”[7]

The drawback of focus groups is that they take time and effort to arrange, they may obtain the voice of only those willing to be in a face-to-face group setting, and it may be difficult or costly to obtain the assistance of an individual with experience in properly facilitating focus groups.

There are many reference materials available online to assist in establishing and running focus groups. One such source, which includes many guidance concepts, is “Focus Groups in Health Services Research,” which was produced in 1999 by the Institute for Clinical Evaluative Sciences.

*For example, if the improvement is focused on the registration process for patients undergoing day surgery, the focus group may include individuals from the hospital reception desk, the housekeeping staff, the clerical staff, the patient/ person undergoing the surgery and their loved ones, the surgeons and the nursing staff. Through the focus group’s discussions, they may find that there is the shared concern that there is not enough face-to-face time between the patient and surgeon prior to surgery. The QI team can take that information and ensure more face-to-face time is built into the pre-surgery registration process.*

## 2. Interviews

Interviews can be very flexible and can be conducted either face-to-face or over the phone. Phone interviews are typically used to gather short responses on basic or simple topics and can be used to reach a population that is spread over a large geographical area. Face-to-face interviews elicit rich feedback but can be more costly when trying to obtain feedback from a large number of patients.

## 3. Complaint feedback or data

Complaint feedback is a valuable tool for truly understanding how a product or service affects the customer. If used correctly by an organization, patient feedback in health care can illustrate failings in the system, as experienced by the patient. Feedback in health care should be taken very seriously by health care organizations as there is a limiting factor on the volume and type of feedback that health care customers/patients are willing to provide. Patients can be reluctant to provide negative feedback about health care delivery as there is the underlying fear that if that individual requires care

*A common patient complaint in Ontario is related to wait times. Organizations would be wise to investigate each concern individually, without prejudice, as there may be potential process improvements that are revealed during the investigation. For example, investigating concerns about long wait times in the emergency may reveal that the process for test results is unreasonably long due to the staffing model currently in place in radiology. An easy improvement to staff scheduling could potentially decrease the wait for many future patients.*

from the same provider in the future, they will be seen as a 'complainer' and may not receive high quality care.

### 4. Surveys

*Placing a suggestion box inside an ICU family waiting room: visitors can make suggestions on how to improve the space to help improve the wait during this anxious time*

Surveys can be an effective method for capturing the experiences and perspectives of individual customers. The benefits of surveys are that they are flexible, can be anonymous (or not), they can be used to gather information from a large group and garner feedback from customers in a wide geographical area.

Surveys can be created to elicit feedback during a health care process, or, they can be completed after the health care process has ended. Use of anonymous surveys during the process may increase the opportunity for feedback without respondents becoming concerned about being perceived as a "complainer" (see above).

When compared to other methods, the response rate for mail-out surveys tends to be lower. This may be due to the fact that individuals may not feel compelled to respond to a 'mass mailing' and they may see little potential for improvement as a result of such a survey. In addition, there is no interaction or building upon the ideas expressed in a survey. "A key limitation of a survey is that it polls on what the organization's perception of value to the patients is, rather than what the patient actually values."[8]

1 Canadian Department of Justice (1984). The Canada Health Act. Retrieved from http://laws-lois.justice.gc.ca/eng/acts/C-6/page-2.html#docCont

2 Institute of Medicine (2002). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington: National Academies Press, p. 40

3 Pyzdek, T. & Keller, P (2010). The Six Sigma Handbook. Columbus: McGraw-Hill Professional, pp. 97-150

4 Baldridge Performance Excellence Program (2012). Criteria for Performance Excellence. Retrieved from http://www.nist.gov/baldrige/publications/upload/2011_2012_Business_Nonprofit_Criteria.pdf

5 David Gustafson (2013). Institute for Healthcare Improvement – Walkthrough Tool. Retrieved from http://www.ihi.org/knowledge/Pages/Tools/Walkthrough.aspx

6 The National Health Service (2013). The EBD Approach (Experience Based Design). Retrieved from http://www.institute.nhs.uk/quality_and_value/experienced_based_design/the_ebd_approach_%28experience_based_design%29.html

7 Kitzinger, J. (1995). Qualitative Research: Introducing Focus Groups. BMJ; 311: 299-30. doi: http://dx.doi.org/10.1136/bmj.311.7000.299

8 Kollengode, A. (2009). Voice of the Customer (Patient) for Six Sigma Processes in Healthcare. Retrieved from: http://www.processexcellencenetwork.com/lean/columns/voice-of-the-customer-patient-for-six-sigma-proces/.

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