

## Quality: It's All About the Bike

*Morley Robbins, for HealthLeaders Media, November 20, 2008*

I do some of my best thinking while pedaling my bike through the streets of Chicago or the countryside of North Carolina (I confess I'm a Lance Armstrong-wannabe). I was riding along the shore of Lake Michigan recently, pondering the state of healthcare in our nation, when I had an epiphany regarding the concept of "quality" in healthcare.

I believe we've got it all wrong as to what constitutes "healthcare quality." Our mistake is in thinking that quality is a unicycle—a singularly focused discipline that measures and seeks to improve the caliber of our clinical and technical processes, thus assuring superior patient outcomes. And while these clinically oriented processes and investments are centrally important to improved patient care delivery, this singular focus compromises the real depth of what determines "quality"—particularly as it relates to patients, their families, and caregivers.

The "ah-hah!" during my ride is that quality is, in fact, a bicycle. It has two wheels, both of which are essential to a successful ride—or more appropriately, a successful patient experience. One wheel is devoted to clinical excellence, while the other is devoted to service excellence. To focus solely on clinical excellence at the expense of service excellence robs the patient and the healthcare enterprise of its soul, and to engage in service excellence at the expense of clinical excellence robs the healthcare enterprise of its purpose and the patient of their improved health.

### **Relevance to my hospital**

OK, the point's been made. Just how does this concept apply to my hospital?

Here are some very real and tangible examples from a recent client engagement. I was retained by a four-hospital regional health system in the Midwest to conduct what I call a "customer commitment audit" designed to measure the organization's ability and resolve to deliver a compelling patient experience—particularly from a service excellence standpoint. The capstone diagnostic of this audit is to routinely assess a hospital's emergency room—in my experience, it's the most efficient and powerful way to "stress test" what any given healthcare organization stands for, both in the clinical and service dimensions of quality.

Across these four hospitals, my average wait time from portal to portal was just under three hours. However, my total elapsed time spent with the ED physician on average—just over two minutes. Following these assessments, I met with the president of the ED Group servicing these hospitals and shared the headlines of my encounters with "his?" emergency departments (set off in quotes because the physicians claimed they merely worked there—a noteworthy subject for a future article). When he heard about the extended length of the wait juxtaposed to the brevity of the professional encounter, he immediately responded with the immortal call of the healthcare wild: "But the physicians provided you with good quality care, didn't they?"

And that's the point—and the problem! As a professional field, we continue to hide behind the unicycle of clinical excellence and somehow justify the deplorable service provided to patients because we provided excellence along the clinical domain. The end somehow justifies the means.

My response to this ED physician leader: "Truth be known, it was excellent clinical care, but quite frankly, doctor, it wasn't worth the wait!" Once he got over his shock at my candor, he demonstrated tremendous leadership and asked to hear more about my experiences, some of which are highlighted below:

- Having a registration clerk stare at me and do nothing because I wouldn't ring the "red bell" designed to announce my arrival.
- Having another triage nurse ignore me upon arrival for several minutes (while legitimately being distracted by a much sicker patient) and then suddenly look my way and extort: "Well, find a seat; it's going to be a couple of hours!"
- Being admitted to a storage closet with a gurney—in a brand new hospital.
- Interacting with countless staff members who never introduced themselves, nor have their names badges flipped so I could see who they were.
- Being provided with four pages of "discharge instructions" in eight-point font, but not having anyone explain how to leave the ED so I wouldn't get lost.

And I could go on and on and on. But anyone who's worked in a hospital is acutely aware of similar types of experiences. And each of you reading this list could quickly add five more vignettes equally as graphic from your own institution. And we in healthcare justify this deplorable level of service because, "Well, we provided good quality care, didn't we?"

### Clinical excellence is assumed

Now the more calloused (or more cavalier) reader may respond, "Why all the fuss about service? It simply doesn't matter how nice we are to the patient—we're still going to get paid, and they're still going to come to our hospital." And truth be known, that's absolutely right—for the time being. But there are two principle reasons why more attention needs to be paid to this other wheel—one is more universal, and the other is clearly financial.

A colleague who recently had an extended interaction with several hospitals put a sharp point to this universal issue. As she explained it, the healthcare encounter is all about instilling confidence in the patient interaction—and that requires emotional intelligence, not clinical intelligence. Lay people simply don't have the requisite skills or criteria to assess clinical expertise. But they can certainly judge whether the caregiver "cares" about them and whether by their actions and their compassion they instill a sense of confidence. And she noted, without that confidence factor, the patient enters a very negative spiral, and begins to wonder: "Will I ever get out of here, and more importantly, will I get out of here alive?"

And what is it that patients remember following a hospital stay? It's not the clinical stuff—research consistently documents that patients *assume* they will receive excellent clinical care. However, what patients do remember, and what they share with friends and family members, is how they were treated (i.e. how well the staff responded to their needs, how well their questions were answered, to what extent did the staff demonstrate compassion, etc.). This is the "soft" stuff that doesn't matter in healthcare—or so we're led to believe.

And if that doesn't spark a response, then the emergence of pay for performance should. Starting in the fall of 2010, as much as 4% to 5% of your Medicare revenue will be at stake for both your clinical performance as well as your service performance, the latter being measured by your HCAHPS scores. There are, in fact, 10 factors that will be used to judge hospitals, but the key metric is to determine patient loyalty is:

- Percent of patients who reported yes, they would definitely recommend the hospital.

This question is a powerful predictor to assess the patient's overall experience.

So now let's return to our symbolic bicycle. Have you decided yet which wheel is "clinical" and which is "service?" A colleague recently asked two simple questions to clarify this issue: "Which is the wheel the patient sees? And which is the wheel that determines the 'direction' the patient experience will ultimately take?" It's very clear to me which wheel is which.

Let's explore this further. The back wheel is "out of sight," it is far more technical and infinitely more complicated, in large part because of the gears, the shifting mechanism, the rear axle design, etc. And doesn't this begin to mirror the clinical side of healthcare? But if my front wheel is not properly aligned, doesn't have sufficient air or inadvertently gets turned the wrong way, it doesn't matter how sophisticated the gearing mechanism is on my bike, I'm certain to have a bad experience. And yes, I ultimately need both wheels to have a quality riding experience—just as a patient needs peak performance on both the clinical and service dimensions to have a quality patient outcome.

So what to do?

There's quite a lot that healthcare leaders and clinical staff members can do to immediately address this redefined concept of quality as a symbiotic bicycle. Contact me at the e-mail address below and I'll send a dozen steps and initiatives that will bring balance and symmetry to the quality quotient in your hospital—literally overnight. They are categorized along three dimensions designed to materially enhance the patients' experience: demonstrate commitment, refresh your perspective, and apply reward and recognition.

So now we've come full circle.

It all starts and ends with the patient. But how we see them is strongly influenced by the lens through which we process the world. I fully endorse the need to keep relentless pressure on maintaining the clinical caliber of our healthcare institutions. But I feel equally as strongly that the pursuit of excellence in "quality" demands a bilateral focus on both clinical and service performance. Anything short of that is either a very bumpy ride or an unnecessarily sterile experience for the patient.

So grab a bike helmet, take an objective ride through your own institution, and see how you would capitalize on this analogy.

---

*Morley Robbins is a principal with Health Planning Source, a healthcare strategy consulting firm in Durham, NC. He can be reached at [morleyrobbins@healthplanningsource.com](mailto:morleyrobbins@healthplanningsource.com)*

---

For information on how you can contribute to HealthLeaders Media online, please read our Editorial Guidelines.