Finding the Voice of the Healthcare Customer

Interview by Amanda Hankel

According to Robin Lawton, president of International Management Technologies Inc. (IMT), language is inherently ambiguous. The challenge in capturing the voice of the customer (VOC) is to eliminate confusion about who the customers are and understand what they want. In his article, "Voice of the Customer in a Widget-Free World," Lawton presents a simple way to redefine work and use word formulas to eliminate ambiguity.

The quality management system, referred to as the customer-centered culture (C3) methods, is relevant to any industry but as Lawton told *Healthcare Update* in a recent interview, it may be particularly beneficial in healthcare, where identifying the customer and defining the product can often be especially unclear. The end-user customer for a specific product is not always the patient. Lawton will be conducting a workshop on this topic, titled "Heart, Mind and Voice of the Customer," at ASQ's Quality Institute for Healthcare, May 21-23 in Anaheim, CA.

HCU: Can you provide us with a brief overview of the C3 method you present in your article?

Lawton: A graphic of the 8 Dimensions of Excellence (Figure 1) is probably the most simple, powerful graphic that can be used to describe the entire C3 system.

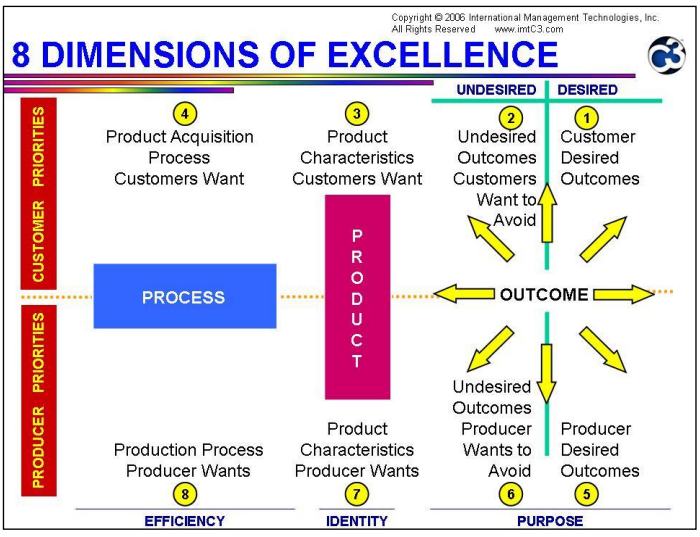

Figure 1

There are an unlimited number of ways to pursue excellence in healthcare. That flexibility of paths often leads to adopting different improvement approaches over time that are not well integrated and create the impression among employees that leadership is inconsistent. And not all improvement initiatives are effective. The eight dimensions show the eight principal areas that an organization can focus on to improve quality and overall performance.

The 8 Dimensions framework is relevant at the enterprise level in healthcare, as well as applicable at the department, functional and personal level. The framework also doesn't use jargon, but its elegant simplicity hides its power to transform.

When you look at the graphic, you find that Dimension 8 is where most of the improvement energy goes today in quality management. Initiatives such as continuous improvement, and lean and Six Sigma, for instance, put the focus on improving processes from the producer's perspective.

For example, healthcare providers intentionally design their working process so that patients must sit in the waiting room. Customer waiting time is not unique to healthcare. Disney has customers wait in line. At Disney, there is a conscious and pervasive effort to embed entertainment into the wait so the perception of waiting is transformed into being entertained. Many of those lines have signs that indicate how much time is left before the ride begins, making the customer's experience more predictable. These practices demonstrate Disney's attentiveness to Dimension 4.

On the other hand, I've seen many waiting rooms in the healthcare setting that expect the patient to remind staff that they are still waiting if they haven't been called to the examination room after 30 minutes. There is a clear difference between the focus on the producer's process and the one where the customer's process experience is actively designed. We should—and can—attend to both. But let's start at the beginning.

Understanding the VOC and providing superb customer experience is the focus of Dimensions 1-4. Let's start with Dimension 1. Satisfying customer-desired outcomes are main concerns for every enterprise, particularly healthcare. When you ask customers in healthcare, "What is the No. 1 desired outcome you'd ultimately like to achieve when you work with anybody

in healthcare?" Over 99% will say the desired outcome they want is "good health." This should not be news.

Interestingly, in the 35 years or so I've been in this business I have seldom found a written definition of good health, based on what patients have said. That is the situation on the first day I arrive. Once the hospital understands the 8 Dimensions of Excellence framework, the picture changes. My observation has been that if we don't have the customer's desired outcome defined, we don't measure it, nor establish numerical goals for improvement.

In 1948, the World Health Organization (WHO) definite "good health" as "Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

From that statement, what is it in healthcare that we're actually working on? Are we trying to create a state of physical, mental and social well-being? Or, are we trying to get rid of disease and infirmity? Unfortunately, we focus most of our energies on Dimension 2: the undesired outcomes that customers want to avoid.

In healthcare, there are two undesired outcomes that top most customers' list: death and morbidity. The healthcare industry has begun to monetarily define the idea of "do no wrong" (preventable errors), which is really defining Dimension 2. Has healthcare defined death? Yes, with two measures:

1. The number of heartbeats per minute.

2. Oscillation of electrical brain waves per minute.

The heartbeats and brain waves associated with life or death are well-defined and sufficient so that we can agree in healthcare when someone is dead. As federal and state healthcare agencies promote the measurement and reduction of undesired outcomes such as death and morbidity, we are tempted to believe that the absence of death results in good health. Of course, that is an absurd conclusion. The absence of death doesn't necessarily have anything to do with good health. Desired clinical outcomes—staying alive—are not the same as the customer's desired outcome.

This C3 methodology matters because it changes the paradigm of how we think by putting a strong bias on the way customers think and even the language we use and they use.

HCU: In your article, you talk about how ambiguity of language is at the core of many organization's patient satisfaction issues because an organization may not understand who the customer or what the product or service is. Can you expand on what you mean by this ambiguity?

Lawton: When we get to Dimensions 3 and 7, both define what a product is: either from the customer perspective or the producer perspective. The difficulty we have in healthcare is that, when we refer to products, we could be talking about manufactured products—medical devices and other widgets—or health service. That term "service" is problematic.

If you asked any 10 people in a healthcare organization whether good service is something that enterprise leadership holds as a priority, everyone would agree it is.

Then ask them for their definition of service. You're likely to get at least eight different answers. This tells us good service is important, but we haven't defined it in a way we agree on. Everyone will have a different view of the goal. If you asked those same folks what the answer to five plus seven is, you'd expect them to agree. If someone got a nonconforming answer, we'd want to take corrective action because the wrong answer is not likely to be tolerated. When people disagree on the meaning of an important word like service, we tend to just let it go. C3 involves changing what we tolerate in our linguistic variations, just as rigorously as we seek perfection in mathematical and measurement variations.

As quality professionals, we know the practice of defining quality in an *ad hoc* manner as "I'll know it when I see it" went out of fashion long ago. We don't accept the notion that quality is up to everybody's individual judgment. Instead, we try to characterize quality in objective terms so we can replicate production and use of products so the outcomes obtained by the use of the product are consistent over time.

When service is defined in a way that is ambiguous, measures of performance are going to suffer, and the goals for improvement become a moving or invisible target. This is not a great context for creating excellence.

The reason service is often ambiguous is because when we talk about it, we tend to describe an activity. For example, if you ask a doctor: "What do you do?" He or she might say, "I'm an ophthalmologist, working for Mercy Hospital and I examine eyes." What the doctor has said is his or her title, the activity he or she performs and the location or group with which he or she is affiliated. None of these things are products: items we can give to others, count and make plural with an s.

A prescription is a product. A diagnosis, treatment plan and pills are three different products that may be related to the prescription. The end-user customer of each of these products can be different. The end user of the prescription is the pharmacist. The end-user customer for the pills is the patient. But our lack of rigor about product definition can cause us to think of all of these related products as a single concept.

It is common for people to think that the end-user of the prescription is the patient, but is actually the pharmacist. The patient is the end-user of the pills. If we are crystal clear about exactly which product it is that we're referring to, determining who the end user customer is easy. Confusion about the product leads to confusion about is who the end user customer. What is also problematic is that we are not always clear about whom the customer is, making it just as ambiguous when we talk about service.

When the product is an eye prescription, for example, the doctor gives it to the patient. That person could be an end user or a broker. He/she may carry the prescription from the prescribing ophthalmologist to the party who will grind the lenses and make the glasses. The producer of the prescription is a physician. The producer of the glasses might be the lens grinder. The end user of the prescription is the lens grinder. The end user of the glasses is the patient.

This notion of the product, initially, sounds pretty simple. But the problem is that our brains are already confused with different related work products. The prescription, as the

product we had in our minds, gets confused with the eyeglasses. Those are two different products with two different producers and different end users. To make matters more confusing, not all customers are end users. Some are brokers, meaning they pass the product (literally or figuratively) to the end user. In this example, the insurance company is a broker customer for the doctor exam, the prescription and the glasses because it may pay the bill for each of those products. Brokers often have more power than end users to change the design, quality, cost or other characteristics of the product.

So, C3 translates a service activity into products, dramatically simplifying the definition of not only who the customer is for a specific product, but also what kind of customer a party plays for that product. This enables you to uncover what they want regarding that product and the outcome they want.

HCU: How's this method different from other VOC methods?

Lawton: Virtually all methods that are used to drive quality in healthcare can trace their roots back to the industrial age and manufacturing methods. Quality function deployment (QFD) is one of those methods.

When you get into the nonmanufacturing world, where we don't traditionally define work as products, we find QFD tends to fall apart because we don't have a product in the usual sense of a widget. Furthermore, nowhere in QFD is the concept of outcomes actually addressed, and yet we know outcomes are essential when we talk about the VOC. It's critical that outcomes are uncovered, understood, translated, satisfied and measured. Yet QFD doesn't address it.

The 5 Whys is another classic quality improvement tool that originated in the industrial age. Its purpose is to identify the root cause of a problem. The theory being that we would eliminate that problem in the future. This tool helps improve Dimensions 2 (or 6): reduce or eliminate customers' (or producers') undesired outcomes.

There is a tool in the C3 method called the 5 Whys for Desired Outcomes, which drives the questioning process forward to the ultimate purpose wanted.

There is really no other systems approach that works proactively to manage an organization's performance with a strong customer bias that's relevant for executives down to first-line responders. The closest approach is Baldrige Award. Baldrige does not address desired outcomes, but it does address results. Yet, it doesn't define whose results it's addressing.

The history of the quality discipline is weighted on two things: things gone wrong and process.

What about things gone right, desired outcomes and differentiation of the three roles customers play? What this VOC method supports is emphasizing the proactive part of the areas of performance because it pulls things in the direction they should go by requiring an organization to identify outcomes, define all work as products and differentiate customers for every product.

Methods, such as ISO, document process. ISO has evolved and will continue to evolve to become more holistic, but we could shorten that process by welding together ISO, Baldrige, lean and Six Sigma and continuous improvement together. Then you'd almost have something like the 8 Dimensions of Excellence.

HCU: In the article, you write about the concept of vital lies—excuses or denials about how an organization obtains VOC—that keeps it from truly finding out customer desires. Can you give some specific examples related to healthcare?

Lawton: Vital lies are excuses, denials or unsupported assumptions about what is true that allow us to keep doing what we've been doing. For many organizations, examples of vital lies regarding gathering VOC information include, "We conduct regular surveys that tell us how satisfied our customers are," or "The marketing department conducts focus groups and market research."

Another example is that every industry has its own version of "We can't control it." In healthcare, it's patients' weight. Often, healthcare organizations say they have no way of control

patients' weight, even if it adversely affects their health. But there are other organizations that have demonstrated great effectiveness in controlling peoples' weight, such as Weight Watchers.

In healthcare, we say we are practicing evidence-based management. If we were, we would be looking at whether we have healthcare programs in our organizations engaging every customer that is already in good health but would like to be in better health. But in reality, a small percentage of organizations in healthcare actually use programs such as this.

HCU: In your article, you discuss four key questions that organizations using the C3 method should ask? Can you walk through those questions as it relates to healthcare?

Figure 2: FOUR KEY QUESTIONS			
1	2	3	4
What is the product? ➡	**Who are the customers?** ➡	**What do they really want?** ➡	**How can we improve?**
DEFINE	**DIFFERENTIATE**	**REVEAL**	**TRANSLATE**
All Work As: • Deliverables • Plural with an 's' • Countable • Specific	**Roles:** • End-users • Brokers • Fixers	**Expectations Regarding:** • Outcomes (desired & undesired) • Product (functions & features) • Process (product acquisition)	Subjective perceptions into objective performance measures, then: • **Apply** the C3 Roadmap • **Align** new practices with strategic and operational priorities

Figure 2

Lawton: The 8 Dimensions of Excellence in C3 requires an organization to define desired outcomes from the customer's perspective. You have to define all work as a product, which is related to question one of the four questions (Figure 2).

There is also the requirement that customers are divided into one or more of the three roles they play for that product. For example, look at end users, brokers and fixers for a cardiology exam. The exam is the product. The end user of the exam may be the patient, but the report that is produced from the exam is used by another cardiologist, who will create the treatment plan.

We ask: Who's the customer? But if we don't identify the end user for each one, we won't be clear.

When we ask these questions, we will also inevitably ask who pays for it? That is the broker, the insurance company. In general, brokers have far more power to change the design of the product than the end user. The insurer may decide it is only going to pay for cardiograms done in a particular manner and are giving certain readings and certain scales. The person who uses of the cardiogram, however, may want other things provided and the insurance company refuses to pay. This means the broker has far more power than the cardiogram end user and ultimately, the producer of the health plan and the health plan all suffer. In healthcare, the whole notion of knowing who the customer is absolutely of vital importance.

Question 3 gets to the VOC with word formulas to determine the customers' wants (Figure 3). An example in healthcare of a patient's satisfaction with a healthy heart plan might look like Figure 3:

WORD FORMULAS	A satisfying healthy heart plan…		
	1. Results in:	2. Does not result in:	3. Is:
	• Be able to walk up a flight of stairs without getting out of breath. • Run a mile. • Qualify for the Boston Marathon.	• Death. • Heart attack. • Being dependent on others after treatment.	• Easy to understand. • Easy to implement. • Brief to execute.

Figure 3

Surveys have been ineffective in getting these answers from customers. Overwhelmingly, focus groups are overwhelmingly the best approach for this.

HCU: Why might a method such as one be effective for healthcare, specifically to improve quality and patient satisfaction?

Lawton: When working with healthcare organizations, what we almost always discover is that the things that are most important to customers or patients are not what the producer of the product is focused on. Nor are customer desires being measured, nor is there an improvement plan to improve them. This actually leads you to working on things most important to customers to the benefit of the customers and the end users, as well as the producing organization.

Right now in healthcare, a hot topic is how patients and customers have some responsibility for their own health. I read one article about guidelines from the Association for Professionals in Infection Control and Epidemiology which say patients have a responsibility to ask providers if what they're about to be injected with has been used before. That is the quality practice in healthcare. If we can't control it ourselves because of our vital lies, we put the burden on the customer, and that is why my article is written.

Read Lawton's full article, "Voice of the Customer in a Widget-Free World."

Robin Lawton is president of International Management Technologies Inc. (IMT) in Lakewood Ranch, FL, and an author and internationally recognized expert in creating rapid strategic alignment between enterprise objectives and customer priorities. Lawton holds a bachelor's degree in sociology and master's degree in educational psychology from Michigan State University. He is the author of Creating a Customer-Centered Culture: Leadership in Quality, Innovation and Speed*. In addition to his workshop, "Heart, Mind and Voice of the Customer," at ASQ's Quality Institute for Healthcare, Lawton will also be a keynote speaker at the Institute for Continual Quality Improvement, also taking place May 21-23 in Anaheim, CA.*

Additional Resources:

Lawton, Robin L., *Creating a Customer-Centered Culture: Leadership in Quality, Innovation, and Speed*, Quality Press, 1993.

"8 Dimensions of Excellence," article.

"5 Whys for Desired Outcomes," tool.

"Product Definition & Selection," tool.

"Customer Roles," tool.

"Index of Tools," comprehensive index of tools and tool suites.