Structuring the Patient Experience Effort: An Inquiry of Effective Practice

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The Beryl Institute is the global community of practice and premier thought leader on improving the patient experience in healthcare. The Institute serves as a reliable resource for shared information and proven practices, a dynamic incubator of leading research and new ideas and an interactive connector of leaders and practitioners. The Institute is uniquely positioned to develop and publicize cutting-edge concepts focused on improving the patient experience, touching thousands of healthcare executives and patients.

The Institute defines the patient experience as the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care.

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Introduction

As the issue of patient experience gains both attention and traction the conversation has grown from one of simply “how do we address it” to one that now includes the question “how do we create a function or structure to support it.” Increasing numbers of healthcare organizations across care settings are moving beyond the simple idea of implementing tactics. They are recognizing the value and importance of building a function through which patient experience efforts can be developed and driven.

This is critical as from the perspective of The Beryl Institute as we believe and have consistently supported the idea that a patient experience leader and a committed focus are critical first steps in effectively framing and addressing patient experience efforts. In earlier papers, such as The Four Cornerstones of an Exceptional Patient Experience we even reinforced the impact that having a committed individual has on overall experience performance. Now though, the idea evolves further into one where organizations are moving beyond individuals to consider function and structure. With this we believed it would be important to explore the way in which healthcare organizations are beginning to shape these efforts.

This led to the inquiry reported in this paper. It is an investigation that is not designed to be conclusive, but rather one that is focused on catalyzing an expanded dialogue on how we begin to shape a greater patient experience effort. The input from the over 80 healthcare organizations is but a sampling of what is currently taking place. The hope is that these ideas spark others and that as a reader you too (if you have not already) consider submitting your responses as we continue to grow the database of ideas and opportunities through The Beryl Institute. (You can share contribute your input via this link: https://www.surveymonkey.com/s/PXSTRUCTURE)

The power of this effort is grounded in the Institute’s very commitment to service as a global community of practice. At its core this means we have a collective commitment to share our thoughts and ideas with one another in the hopes that we all contribute to a greater experience for patients and families in healthcare settings around the globe. To those that shared their ideas we thank you, to those looking for answers we hope you find some and to those with thoughts of your own, we hope you contribute those ideas as well.

This investigation is just the start of the effort, not the final result. If you believe, as we suggest at the Institute, that patient experience is not an initiative, but an ongoing effort or movement, a continuous journey, then you will find great value in these pages of ideas shared by your peers. They signify the great opportunity that still lies ahead for so many.

Jason Wolf
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A Consideration of Structure

An effective organizational structure supports the achievement of an organization’s goals and serves as a cultural foundation for ongoing performance. The survey and interview process conducted for this paper looks to explore the range of existing models for structuring the patient experience function and to uncover proven practices aligned with sustained outcomes around the patient experience effort. Responses were collected through in person/on phone interviews and via an online questionnaire.

The intent of this paper is that it provides insights into how readers benchmark, build or adjust their own structures. Recognizing the structure of your patient experience effort could have a significant impact on your overall results. Structure is representative of support and intention, as well as commitment and focus on patient experience efforts.

Consider the metaphor of how a building is structured, both its frame and foundation, dictates what can be built and how long it will last. The more thoughtful and purposeful the initial design, the greater potential for the sustainability of the final structure. The principle of form follows function is equally true when it comes to establishing and managing patient experience activities.

The Beryl Institute has long supported the premise that the organizational infrastructure supporting patient experience matters. It has a significant impact on the success of those efforts in terms of impact and sustainability. In the 2011 paper *The State of Patient Experience in American Hospitals* benchmarking study, the Beryl Institute identified patient experience as a top priority among American hospitals — now on par with quality, safety and financial performance as key issues for hospital leaders. However, while a clearly identified business focus, patient experience remains largely undefined by healthcare organizations with only 27% of American hospitals having a clear definition of patient experience. This has significant implications on how efforts might be structured overall.

The 2011 research revealed that hospital leaders felt positive about their patient experience efforts, citing support “from the top” and from clinical leadership as the key drivers of progress. Still, across the board, “cultural resistance” was reported as the major obstacle to success. This finding alone reinforces how structure may be a critical lever in driving patient experience success. Creating a solid and accepted structure builds in the process for moving beyond cultural resistance to creating cultural acceptance and a solid foundation for future success.

The Beryl Institute supports the premise that the structure beneath patient experience activities can help overcome the very obstacles that push against efforts to improve. Through our earlier work, we have emphatically demonstrated the importance of having a concrete definition for patient experience as an organizational guide, as well as the importance of incorporating improving patient experience into a health care organization’s mission. This inquiry continues the in-depth analysis into patient experience. It is by no means the conclusion of this exploration, but a critical milestone in the continued development of patient experience as a function and a field.

This paper explores how health care organizations are structuring their patient experience activities and the trends that may be contributing to positive results. It is meant to serve as a catalyst for ongoing sharing and dialogue about patient experience activities. While the results may not be statistically representative of the entire healthcare population, they can be used to guide the ongoing efforts to support and improve patient experience.
Participant Demographics

To get a picture of the participants in this inquiry, initial questions were asked to provide a brief demographic overview of the organizations contributing information. The first question examined the type of organization with the options to identify as an integrated delivery system, multi-hospital system or single hospital. Respondents were evenly distributed between these options with about 30% coming from integrated or multi-hospital systems, while 40% of respondents were from single hospitals (Figure 1).

To get an idea of the size of the participating organizations, they were asked to report both number of beds and number of employees. The respondents primarily represented individuals from medium to large health care organizations. While about 15% of participants were from organizations of less than 100 beds, a majority of respondents (54%) were in the 100-500 bed range. The remaining over 30% were in organizations of 500 beds or greater. (Figure 2)

Additional demographics broke down as follows:

- **Employee Size:** Over 80% of respondents said they had 1000 employees or more, about 9% were between 500 and 1000 and another 9% under 500 employees.
- **Operational Focus:** 84% of respondents were from not for profit organizations, while both for profit and academic medical centers represented about 8% of respondents each.

- **Teaching Hospital:** About 47% identified their organizations as teaching hospitals.
- **Geography:** About 64% identified their organizations as urban and about 34% identifying as rural organizations. The remainder noted some combination of both settings.

65% of organizations identifying themselves as rural in this inquiry reported having established patient experience structures (in comparison to 60% of those identifying as urban). The most recent publicly reported results from Hospital Compare show that in almost all Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) domains rural hospitals tend to outperform their urban counterparts. The only domain in which urban organizations outperform is in “Would you recommend”. Several factors may come into play here, including the complexity of medical cases; operating with smaller staffs, which makes it easier to bring people together to support a central mission; and even familiarity of staff with patients in the communities, meaning the patients are not likely to give “Aunt Sue” any bad scores. Yet, rather than relying on these built-in advantages, it seems the rural hospitals in this inquiry have made the strategic decision to invest in patient experience efforts.

Figure 2
Part I — A Framework For Patient Experience

Moving from the demographic context, the central purpose of this inquiry was to get a sense of whether and then how organizations were structuring their patient experience efforts. The results showed that 61% of the organizations participating identified having a centralized patient experience department.

Department Name
In asking for the name of the specific department they clustered around three major themes:

1. Patient (and Family) Experience: Appeared in about 36% of the responses
2. Service Excellence: Appeared in about 21% of the responses
3. Customer Service or Satisfaction: Appeared in about 13% of the responses

Other language that appeared as part of the department names included patient advocacy or relations and guest services.

Areas of Accountability
The organizations that responded as having a patient experience department were also asked to identify the main areas of accountability. While the open-ended responses were broad, they tended to cluster around a number of central themes as identified in the word cloud below. The most prevalent areas of focus included, clustered in order of frequency:

1. Patient (and Family) Experience (which would make sense as the focus of the department)
2. Patient Satisfaction — Surveys and Data Reports
3. Complaint and Grievance Processes
4. Patient Relations/Guest Services
5. Volunteer Services
6. Service Recovery
7. Coaching, Education and Process Improvement

While a number of other areas (Figure 3) fell into the Patient Experience Department bucket, the consistency with which these responses appeared begins to frame some of the core areas of focus for these departments.

Figure 3
Staffing Considerations
With respect to the size of the departments that own the patient experience agenda, the responses had a significant range yet almost half were comprised of 3 or fewer team members (Figure 4). At the other extreme, about 25% or all departments reported having 6 or more members with just around 8%, including 10 or more. In looking at the impact of organization size on the size of department, the general trend saw larger departments in those organizations comprised of larger numbers of employees.

The most common roles found in Patient Experience Departments were around the titles of Director or Manager of Patient Experience or Service Excellence. These titles seemed more prevalent in the smaller departments as a stand along or “senior” patient experience role. In larger organizations you began to see the use of Chief (Patient) Experience Officer and other titles such as VP, Patient Experience. In the larger units there are also more clearly delineated sub roles such as manager or coordinator positions over such areas as Volunteer Services, Patient Representatives, Complaint Management/Service Recovery, Pastoral Care, Patient Education and Patient Satisfaction. There was not one consistent set of titles, but the functions and roles tended to line up with the areas of accountability identified above.

This interesting dynamic of accountabilities and resulting roles also raises one of the challenges discovered in The Beryl Institute’s 2011 benchmarking study, which found one of the greatest roadblocks to patient experience success was the accountable leader being pulled in too many directions. With the broad range of responsibilities being placed on the patient experience function and the limited staffing resources committed, many healthcare organizations may also be setting themselves up for this very risk.

This broad span of control also feeds the dilemma that some patient experience leaders expressed regarding having too many ancillary duties, only some of which directly impact the patient experience goals on which they are being measured. Looking at the broad list of responsibilities covered by the patient experience leaders gives a greater understanding as to why many patient experience leaders feel overwhelmed and distracted, especially given that half of them have limited staff support. Appropriately staffing a patient experience team may be a big challenge for resource-constrained organizations but a critical consideration for organizations looking to make clear and measurable improvement.
**39% of Respondents Patient Experience Efforts Do Not Have a Home**

While we can look at the 61% of organizations who have a formal department for guidance, there are insights to be gained from those almost 40%, that do not have formal structures in place. It should be noted that not having a department did not preclude an organization from having a dedicated patient experience leader, though those with no leader tended not to have a department, while those with departments most often had a dedicated leader.

Respondents who did not assign responsibility for patient experience activities to a specific department within their organizations said their patient experience efforts are supported through the combined efforts of multiple departments. Collectively, the departments identified with carrying some of this responsibility included, but were not limited to the following (not listed based on frequency):

- Executive Suite/Senior Leadership
- Nursing Administration
- Patient and Customer Relations/Guest Services
- Marketing/Community Relations
- Quality/Performance Improvement
- Planning/Strategic Support Services
- Organizational Effectiveness/Learning and Development
- Human Resources

For those organizations without a formalized patient experience department, patient experience activities are forced to aggressively compete for attention with other priorities, such as human resource or operational issues. It seems that organizations that have not yet committed to formal patient experience structures are temporarily housing the work in departments that either connect tangentially to patient experience or reside in a department where an advocate for patient experience efforts might already work. As discussed later in this inquiry, responses collected suggest that a hospital must create a dedicated department to lead an effective patient experience effort. In fact, those who self-reported their patient experience performance as above average or top tier (90th percentile) identified having a formal patient experience structure four times as much as those performing at that level without a formal structure.

This at least suggests that a focus and commitment to this effort drives some measurable outcome.

**A Committed Leader for Patient Experience**

As important as it is to have a patient experience department to serve as the foundation for the patient experience work, having a leader in place to direct the patient experience activities is crucial. Approximately 64% of the respondents said their organization has a dedicated patient experience leader.

The titles most often reported included:

- Director of Service Excellence
- Director of Patient Experience (or Administrative/System Director of Patient Experience)
- Director of Guest Services
- Vice President, Patient (& Family) Experience

It should be noted that over a third of the reported titles for dedicated roles incorporated some use of the words “Patient Experience” or “Experience.”

The additional titles offered ranged from Chief Patient Experience & Service Officer to Patient Advocate, indicating that these roles, while identified as dedicated, might reside at multiple levels in the organization and have as a result varying impact and leadership presence. In fact, only 45% of respondents identified their dedicated patient experience leader as an executive level role, though an analysis of the titles shared above seems to suggest that these roles do not often take on the same importance as C-Suite titles or even VP level roles such as with Human Resources or Quality.

Organizations responding that they do not have a dedicated leader most often listed the CNO or CEO/President as the individual responsible for patient experience efforts. Interestingly enough for those responding that their dedicated leader was not considered a senior level role; the identified executive champion was very much the same including the roles of CEO, CNO, CMO, COO or Chief Quality Officer/VP Quality.
Organizational Positioning and Support
This direct linkage to the C-Suite is maintained in examining the question of where the Patient Experience Function Reports. In asking where the senior most Patient Experience Leader or where the function overall reports 50% of responses identified the CEO, followed by the COO and then CNO (see figure 5). It is evident from these responses that patient experience is a priority at the level of the C-Suite (a finding reinforced by the Institute’s 2011 benchmarking study). The question that remains is where this issue then falls in terms of true operational priorities for these senior leaders. A top driver for patient experience success identified in the benchmarking study was clear and visible support “from the top”. While this reporting relationship is encouraging in terms of access, whether it equates to actual support cannot be determined by the data.

Participants in the inquiry provided some comments on their positioning, providing additional insights into the opportunity and considerations of where patient experience fits into healthcare organizations.

“I have the support of the CNO, but where I struggle is with the CFO. He understands the financial impact but service or the patient experience seems to take a backseat to quality and to finances, and so it's a hard sell.”

“I’m reporting to the vice president of quality. It’s a good match, and we collaborate very closely with nursing, and I also meet intermittently with the president of the hospital to make sure that we’re aligned in all of our priorities and what we’re working on.”

“I report directly to our president/COO. What I like about it is that we can engage a lot of times on the clinical side as well as the leadership side and the service side. We’re very close, we’re all very close, so we are constantly talking and seeing what works.”

“Our organization has rolled out a ‘Leader Greeter’ program. We have six entrances at one of our hospitals, our main hospital, so we picked one of those entrances to have hospital leaders stand and greet patients and families and other visitors as they arrive to the hospital and help escort them to various destinations. The energy and vibe around the campus was really engaging.”

Interviews with patient experience leaders in this inquiry identified that having the blessing and support of executive leadership is central to success.

Background for a Patient Experience Leader Varies
In 38% percent of the responses on the patient experience leader’s background, there was a mention of Nursing. However, there was a great breadth of experience identified for patient experience leaders. They had backgrounds ranging from Healthcare Administration to Marketing, from HR/Organization Development to the Hospitality industry. It would seem that a solid understanding of clinical issues and nursing makes it easier to gain respect and involvement from other clinicians, but the diversity of the backgrounds of the individuals currently engaged in patient experience leadership demonstrates that a nursing degree is not the ultimate determinant for this role. Indeed, the emphasis on patients being “guests,” and the incorporation of service excellence models from outside healthcare, open the door for people with a breadth of experience to be valuable contributors to patient experience activities.

Shared Responsibility: The Value of Committees
While having a single person in charge of the vision for patient experience, and having senior leadership on board is key, the strongest patient experience platforms are built when they engage others who can help inform and direct
patient experience endeavors. 70% of the respondents indicated that committees were an important part of their patient experience work, or that their work was connected to specific committees already operating within the organization.

Many of the committees connected to patient experience efforts are service excellence or patient satisfaction focused; they also encompass clinical quality and even service line improvement committees. In most of these cases, patient experience leaders are connected to these committees, but are not always responsible for driving the agenda. Of note is that only 25% of those identifying committee efforts had a patient experience committee by name. Yet, most of the respondents indicated that multiple committees were engaged in areas that impacted the patient experience, and the committees served as both advisory bodies and decision-making bodies, rather than operating under an either/or framework. Many of the committees identified appear to be tasked with examining issues, developing solutions and guiding and evaluating implementation of efforts to improve care.

A sampling of frequently reported committee titles include:

- Patient Satisfaction Strategy Team
- Patient/Family-Centered Care Committee
- Patient Experience Committee
- Patient Experience Improvement Council
- Patient and Family Advisory Council
- Customer Experience Steering Committee
- Service Recovery Committee
- Service Excellence Team

Many of the inquiry participants indicated that they were still working on how to establish or engage relevant committees within their organizations to address patient experience. It may be encouraging to those still working to establish more formal structures to find the work can move forward while patient experience is trying to find a home by working through the existing committee structures like the ones listed above.

“I bring the voice of the patient into the organization through a patient and family advisory council. We established that about three years ago and find that to be a wonderful resource. We’re to the point now that managers actually ask me if they can come and present their ideas, their initiatives, their new projects to the advisory council.”

A Commitment to Action

In gauging the timeframe and commitment of patient experience, efforts respondents were asked both how long their efforts have been in place and how consistent their efforts have been. 78% of all participants said their patient experience structures have been in place for less than five years. Of greater significance is that 50% of respondents have patient experience structures less than two years old. This, above all the other data gathered, may be the most telling about the state of patient experience. It has been in just the last two years that the focus on patient experience has called for more intentional efforts either identified by formal committee work or formal organizational structures. This is reinforced as addressed above by the growing number of questions received at The Beryl Institute on how healthcare organizations should be structuring their efforts to address experience. At the same time it means we do not yet have strong data to support one mode of operating over another. This will require continued investigation.

In asking about the commitment to patient experience efforts, especially considering the short window of activity to date, some challenging data emerged. The respondents revealed that in almost 40% of all efforts to date, structures have not operated consistently since inception. The start and stop nature of patient experience endeavors within organizations is problematic at best as it does not allow organizations time to integrate efforts into their operations, gain traction on critical strategies, or see outcome from action. This inconsistency in addressing

This finding on the use of committees is consistent with the findings of the 2011 benchmarking study, which revealed a committee structure was the most prevalent way patient experience was being addressed. Based on survey responses, the overwhelming choice of structure in addressing patient experience was through committee. 42% of respondents identified a committee as “who” in their organization that has primary responsibility and direct accountability for addressing the patient experience. While this inquiry on structure did not ask if committees were primary drivers of patient experience efforts, their use and importance remains clear.
patient experience is akin to a building project that is started, abandoned, restarted, abandoned and restarted again. Eventually, passers-by will wonder what’s going, who’s in charge, and whether the final product will be worth experiencing. Whether you are conscious of it or not, our patients, families and communities can sense this inconsistent commitment and see these inconsistent actions as well.

If you believe that patient experience efforts, which in many ways are akin to large culture change efforts, take time to deliver significant and lasting results, any disruption in focus, support or structure can significantly impede the outcomes. Perhaps this is one reason it may be crucial to have an individual in the role of patient experience leader who is able to help frame a practical structure of execution and maintain a close connection to the executive audience that will provide the support and resources to sustain patient experience work.

Part II — The Impact of Action

Signs of Success
Measuring the success of patient experience activities is not as easy as it appears, because success isn’t simply about improving short-term patient experience scores. Achieving high patient experience scores at one point in time does not guarantee that they will be surpassed or even maintained over time. As with all measures in healthcare, the results can vary due to changes in patient populations, organizational directives and staffing fluctuations, etc. These numerous factors can influence an organization’s ability to attack patient experience goals consistently.

While there has been some consistency in the model of patient experience leaders and organizational structures have proven to be somewhat similar, individual organizations’ definitions of success have seen some level of variation. In some cases, patient experience leaders identify success as simply infusing awareness of patient experience priorities across the organization. Other healthcare organizations are consistently holding out HCAHPS measures as their patient experience standard. In the near term as much as organizations are striving for the perfect measure for patient experience success, it is likely that organizations will have to weave together softer measures of success as more concrete measures evolve over time.

This should serve as a word of caution to senior leaders who press only concrete measures for patient experience endeavors. The ability to measure concrete, and more so lasting, results may take longer than anticipated (or desired) to establish, as culture change, communication with broad audiences and consistent application of proven practices, will take time to frame and then take root in an organization. (This is of even greater challenge if the lack of consistency found above impedes an organization’s long-term focus and commitment to sustained action.)

This does not mean an organization cannot achieve some quick wins through process improvements, such as addressing patient wait times or noise reduction, but these changes may not immediately translate into broader objective outcomes or scores. The challenge, of course, is sustaining focus while waiting on positive results.
In asking participants about the greatest successes they achieved with their structure they offered a potential path on which to begin to focus efforts. These successes included:

**Regarding role:**
- A dedicated, funded position enabling the organization to promote activities and elevate focus on patient experience
- The patient experience position given free agent authority to break down any silos that would potentially impede patient experience efforts

**Regarding relationships:**
- Connection with executive management ensuring shared accountability across divisions
- Engagement with HR supported organization-wide training on patient experience, for both new and current employees
- Engagement with CMO enabling the creation of residency training courses to ensure that residents understood patient experience early in their careers
- Engagement with CMO ensuring communication with physicians about patient experience
- Engagement with Quality Improvement ensuring the connection between patient experience and quality outcomes

**Regarding Structure:**
- Standardizing patient experience structures at the system level
- Formation of patient-family committees ensuring the voice of the patient was incorporated into our efforts to improve patient experience
- Implementation of weekly meetings on patient experience providing continuity to organization-wide efforts

**Experience Roadblocks**
As committed as respondents were to their successes, they were also asked to share some of the greatest roadblocks they faced. In reviewing their responses there were some consistent responses that emerged. They included (listed from most to least frequently mentioned):

- Difficulty in sustaining momentum
- Lack of consistent executive support
- Nursing buy-in
- Competing priorities
- Resource constraints (people and dollars)
- Efforts are too broad
- Lack of physician support
- Lack of dedicated patient experience leader
- Staff turnover
- Communications
- Resistance to change

This data reinforces a phenomenon we have challenged at The Beryl Institute; that of making patient experience an initiative versus a way of being for a healthcare organization. Initiatives have shelf lives and become items to rank in the face of new priorities. This leads to winners and losers. We cannot afford to have patient experience seen in this way. In contrast, a way of being means it becomes part of the way an organization lives and breathes. Through this, a big opportunity for patient experience is revealed.

When patient experience is first introduced as a priority topic from an initiative mindset, it is likely to garner support. The patient experience leaders who are in the trenches now have noted that some of the initial enthusiasm for promoting patient experience work has faded. This may be one of the biggest challenges to sustaining patient experience success.

One of the dynamics that emerged from the conference calls with patient experience leaders who participated in this inquiry was that having contact with other patient experience leaders energized them and gave them fresh ideas, which they hoped to use to reinvigorate their efforts. This highlights the importance of networking and the power of community connection (such as offered through The Beryl Institute) as a channel to develop ideas for maintaining momentum. It also reinforces the need to move beyond initiative-based thinking on experience.

These findings are important for organizations that are working to establish a patient experience effort. Setting up a structure to drive patient experience work is only the first step, and may not be the most challenging. Maintaining momentum once the structure is set is a concern that needs consistent and ongoing attention.

**Leveraging Hindsight**
It is said that hindsight is 20/20. Perhaps it is better stated that hindsight may provide the greatest of insight from which we can learn (and others can adjust) in driving
critical efforts. In this inquiry the value of insight from experience was captured by asking participants what they would do differently if given the chance to start again. The open-ended question produced a range of responses but there was some consistency in the emergent themes. The reflections provided below are listed in order of frequency.

They included:
• Centralize the patient experience effort and create a department to focus on patient experience activities
• Improve the integration of patient experience efforts with the rest of the organization
• Increase the number of staff focused on patient experience
• Make the patient experience leader role an executive position
• Create a direct reporting relationship for patient experience leader to CEO (or CNO, COO…)
• Create a clear and shared patient experience strategic plan
• Engage nursing and front-line workers early in the process
• Focus on getting the right person, not just a warm body to lead patient experience efforts
• Ensure an effective training program to reinforce patient experience ideas
• Develop patient experience plan based on a multi-disciplinary approach
• Engage physicians from the beginning of the patient experience effort
• Ensure full accountability to the patient experience cause

The input received regarding these critical questions and reflecting on current practice is particularly helpful for organizations that have yet to invest heavily in a patient experience effort or structure. They provide an important line of sight into what has worked in supporting success and allow for smarter choices by all taking on a strategic patient experience effort.

At the close of the paper is an appendix that addresses one final question asked of participants. The question asked for the top tactics or strategies they would recommend to others starting their patient experience efforts. These suggestions offer a great perspective in conjunction with these lessons learned for those looking to get their own effort underway.

“I think the alignment teams that we’ve created that are part of the patient experience performance excellence teams, I think that has been critical in communication, in education, in buy-in. I wouldn’t want to change that. In fact it’s actually grown to include more representation from across the house, and I think it’s been very critical in our success thus far.”

“The biggest factor or key for me was really being able to integrate with all the clinical staff to really work together to make sure that we are working towards a really positive experience for our patients. And that’s really the biggest key and the biggest hurdle as well.”

“…we also work very closely with our human resources department and we’ve done a lot with our onboarding process, so when staff come in they get trained in service excellence, and then they’re invited back after they’ve been working for 30 days, they’re invited to come back and they meet with the executive staff and they talk about what’s gone well with their orientation so far and what needs to be improved.”
Reflecting on Performance

At the conclusion of the inquiry respondents were asked to rate themselves on their patient experience performance from below average to top performer (90th percentile). This question is self reported, so is not validated with publicly reported data, but still offers a few closing insights into the choices critical to driving patient experience success.

Of those responding, the results seemed to be consistent with the general feeling on patient experience performance in the market to date. While 2% of respondents reported below average performance, the majority, 55% reported average performance. A significant number, 35% reported above average performance and 8% reported being a top performer. The significance of these scores to some of our most central questions includes the following.

Centralized Patient Experience Department

| Above average or top performer | 81% have a centralized department |
| Average or below average | 57% have a centralized department |

These numbers tend to support the impact of a centralized effort on driving better results.

Longevity and Consistency of Effort

| Above average or top performer | 76% have been addressing patient experience for 3 or more years and 71% have operated consistently since starting |
| Average or below average | 37% have been addressing patient experience for 3 or more years and 52% have operated consistently since starting |

These results offer some encouragement that consistency and follow-through on effort will tend to drive higher performance over time. This reinforces the need for focus and consistent action in light of the potential to waiver on patient experience efforts.

Dedicated Patient Experience Leader

| Above average or top performer | 71% have a dedicated patient experience leader |
| Average or below average | 64% have a dedicated patient experience leader |

This is interesting data in suggesting that while a leader is important it is not the only factor in driving performance. A structured effort, as shown above, adds an additional boost to performance.

Of note is that in asking if the role is an executive level position the data is almost even at 42% for average or below average and 45% for above average or top performers. This could be explained by the more intentional structures the higher performers put in place to drive success or perhaps the inflated perspective lower performers have about the patient experience role.

In the end it is clear that both the leader and with greater influence the structure has an impact on patient experience outcomes. This exercise in self-reflection helps us to recognize the impact and importance of focus overall in ensuring patient experience success.
Conclusion: A Consideration for Structured Effort

While this paper does not suggest just one specific model by which to shape a patient experience function, it reinforces the idea that a dedicated role and centralized structure are key levers to patient experience success. It also reinforces the idea that patient experience is not a passing fad, but a significant strategic consideration for healthcare organizations. Moving patient experience from an initiative to an integrated activity is a critical first step in driving positive patient experience outcomes.

In revisiting the ideas shared from the participants in this inquiry, there are some key structural components central to achieving success in improving patient experience. While these are not the extent of every recommendation one can pull from this paper, these are central ideas that are reflective of the shared learning of respondents:

- Create and support an identifiable patient experience leader and communicate and reinforce the role and importance of the effort at all levels
- Whether an “army of one” or a small team, establish a recognized patient experience function and focus with accountability for outcomes and the ability to influence actions across the organization
- Publicly link patient experience efforts to the senior levels of the organization, not necessarily for execution, which may dilute an effort, but rather to champion and support the effort
- Free the patient experience leader to evangelize across the organization, without fear of violating department boundaries
- Establish a multi-disciplinary approach for gathering input and ideas and ensuring shared ownership for patient experience outcomes, this includes close integration with clinical (both nursing and physician) leadership and quality efforts

While the structure of patient experience efforts can and will vary, it is clear that it need not be complex. There is no evidence that creating large and complex structures will enable organizations to do more. Rather it is the intentionality reinforced by both a defined role and structure that begins to pave a healthcare organization’s path to patient experience success.
Appendix — Words of Wisdom from Lessons Learned

Participants in this inquiry were asked, if you were acting as a consultant to another facility looking to structure their patient experience efforts, what 3-5 strategies/tactics would be early essentials? The following represents a consolidated listing of responses to guide you in your effort. The data is presented as actions to consider and options to explore and in the raw form in which respondents provided it. The hope is that the context of the findings from this paper combined with the recommendations captured here will allow you to take the first steps or adjust your path as you engage your organization in its patient experience journey. Safe travels!

• Assess current state against best practices
• Be prepared to coach those who are not in alignment, either up or out (including executives)
• Behavior based interviewing to hire the right people
• Build accountability for results and into performance evaluations top to bottom
• Buy in from the top — ALL of them
• Celebrate successes, but make sure they are real successes
• Centralize structure with support of local operating entities
• CEO/CNO rounding daily
• Clearly defined role/goals
• Commit to annual mandatory education for all levels
• Communicate, communicate, communicate (vision and plan)
• Communication to patients, families and staff
• Consistent education/coaching for staff and physicians
• Create a no-excuses culture
• Create a strategic plan that reaches out to at least 2-3 years
• Create collaborative relationships with clinical and nonclinical directors and leaders
• Create on-going training opportunities for managers (and employees)
• Create several mechanisms/modes for listening to and engaging the patient and family member voice. Surveys and written comments are not enough.
• Designate a patient experience champion in your facility/organization and formulate his/her role solely around patient experience initiatives
• Determine 3 top objectives
• Differentiating work from a “customer service” or only “patient sat” focus — broader and deeper culture change on improving care and service
• Discharge phone calls
• Education for all caregivers inclusive of physicians and executives about patient feedback
• Engage leaders early and often — senior leader engagement is a non-negotiable!
• Engagement of physicians
• Engagement of the Board and CEO
• Engaging “informal” leaders early in process
• Ensure administrative buy in
• Ensure that one person is responsible for writing responses to concerned patients. This ensures consistency in response; that person should report only to the Director of Service Excellence
• Ensure that quantitative goals are set to gauge progress. Eliminate all the fog around accountability and action.
• Ensure the lead is passionate about patients having a voice
• Establish accountability measures
• Establish designated patient experience team
• Executive team buy in and leadership
• Expectations incorporated into performance evaluations
• Find creative ways to keep the Patient Experience and patient satisfaction scores in front of employees
• Focus on HCAHPs with champions for the areas
• Focus on one win at a time
• Formal physician communication improvement program mandated for every credentialed clinician
• Gain buy-in from every department leader. Meet with them early and often. Find a way to drill into every conversation that you are there to serve as a resource FOR them and to support their successful efforts. Be prepared to back everything with data/research/best practices.
• Get nurses on board
• Get the vision down to the front line employees and then give them a forum for bringing out their ideas
• Good data is key — create great reports and publish them regularly to empower people at all levels, all roles to know how they impact patient satisfaction
• Hospital-wide education on the benefit of patient focused care to patients, families and STAFF
• Hourly Rounding on Patients/Staff
• HR support for enforcing accountability for Service Behaviors
• Identify key service lines, prioritize, and take one at a time and use spotlighting process/experience design from welcome through farewell for ideal patient experience
• Implement a physician engagement strategy
• Implement Bedside Report (handoff)
• Implement physician coaching
• Include asking at every meeting, what is best for the patient in how we make/made our decisions?
• Increase awareness and visibility of patient’s feedback
• Increase reporting of patient feedback and experiences
• Integrate the work with organizational culture initiatives. Without culture, the evidence-based practices will not take root and sustain
• Involve care site leaders
• Involve patients and families
• Involvement of ALL staff both clinical and non-clinical
• Leader’s title needs to reflect the focus on Patient Experience — not Service, which keeps things stuck in the 80’s
• Learn all of your constituents’ hot buttons (nurses vs. doctors vs. frontline vs. executives/directors) and speak their language.
• Linkage of hospital’s vision and values to work
• Look at what you are doing well and improve or expand on those ideas first.
• Make sure all areas providing service to the patient have adequate training
• Make team multi-disciplinary
• Many meetings to listen and learn from others
• Measure the important stuff — what gets measured and reported on gets attention
• Meet regularly to review your progress or areas that need improvement & hold staff accountable. Again include all discipline.
• Meet with council chairs/co-chairs for strategy discussion and input for details and rollout
• Meet with department/unit leaders for final development and agreement
• Meet with staff, units, departments, councils to gauge success, work through details, communicate, explain, coach, train, encourage, empower, support the transition
• Multi-disciplinary rounding
• Nurse Leader Rounding
• Organizational goals explicit to patient satisfaction and patient experience
• Outcomes on Patient Experience need to be included in performance evaluations, not Incentive plans
• Patient advisory councils
• Physician and nursing champions — must be engaged
• Physician led culture of clinical excellence
• Pick 1-2 tools/best practices and implement fully before moving on
• Place a dedicated executive to the patient and family experience
• Process for documentation of patient complaints and resolution
• Recognize and reward and celebrate, but coach immediately when necessary
• Recognize that length of employment does not equal performance
• Robust complaint reporting software
• Roll out one piece at a time — too much at once will cause roadblocks for all of it
• Selecting the appropriate Leader of the Patient & Family Experience
• Set clear expectations on what data is important and what are the expectations for those receiving data
• Set clear standards and ensure management measures performance against those standards
• Set-up accountability structures
• Significant resources and commitment to learning and development that are rooted in systems and processes that measure the transfer of learning into action. The patient experience must inspire our caregivers and ensure that our intent is supported by behaviors and actions. This is the magical mix of culture and practices.
• Structure to assure accountability
• Talk to your patients! Rounding, focus groups however works for you
• Think with your heart, not your head. The smallest gesture is sometimes unforgettable in the mind the patient, family & staff. Always be kind.
• Tie individual incentives to patient satisfaction results
• Training and education for staff and physicians
• Transparency regarding feedback and scoring
• Use not just the patient experience survey tool to make decisions, talk to your patients to dig deeper
• Visibility to patients, families and staff
• Walk the talk in every aspect of the culture — look for hypocrisy and root it out
• When speaking with nursing be sure to tie everything back to patient safety and clinical outcomes.
• Work in a matrix rather than hierarchy
About the Authors

**Jason A. Wolf, Ph.D.**  
Executive Director, The Beryl Institute

A passionate champion and recognized expert on organizational effectiveness, service excellence and high performance in healthcare, Jason is revolutionizing the Institute’s services and outreach to position the organization as a globally recognized thought leader on improving the patient experience. Prior to joining the Institute, Wolf designed and led the Organization Change, Service and Leadership Development strategies for more than 45 facilities and 45,000 employees as the director of organization development for the Eastern Group of the Hospital Corporation of America (HCA). His 20-year career has spanned the health care and service industries in such roles as senior leader, internal and external consultant and entrepreneur. Wolf has authored numerous articles and publications on organization culture, change and performance in healthcare.

**Doug Della Pietra**  
Director, Customer Services and Volunteers, Rochester General Hospital

In addition to responsibilities overseeing an intentionally-designed patient- and family-centered volunteer program and frontline First & Last Impression teams and initiatives, Doug co-chairs the hospital’s Patient Experience Team charged with improving the patient and family experience across the entire continuum of care. With his background as a minister, Doug’s greatest desire is promoting a holistic — mind, body, emotions and spirit — approach to patient and family care and service.

Personally, Doug enjoys researching and reading, running (is almost always “half-marathon” ready), nature and wildlife photography, dabbling in social media including Facebook, LinkedIn, Twitter, and blogging, and most importantly, spending time with his wife Nancy.

**Jamie Markel**  
Patient Experience Officer, WellSpan Health

With 29 years of healthcare experience, Jamie started out as a receptionist and then office manager in a practice of five specialists, where she learned the importance of customer service and developed a great understanding of patient and family anxieties. Her focus on the patient experience grew when she accepted a position as a Guest Relations Coordinator for a small community hospital where she coordinated a patient rounding process and facilitated service education programs. Moving on to a large teaching hospital gave Jamie the opportunities to expand her work as Quality Improvement Facilitator and Director of Organizational Development. Remaining for 20 years, she has seen that hospital grow into a multi-hospital integrated delivery system. Her passion is with the patient experience and she is currently the WellSpan Health Patient Experience Officer.
Charting a Course to Quiet: Addressing the Challenge of Noise in Hospitals
The paper shares the findings of The Noise Project, a joint research study between The Beryl Institute and Making Hospitals Quiet. Over 240 responses were gathered from hospitals across the United States with participants answering questions such as: What processes are hospitals putting in place to address this priority issue? How are they structuring their efforts? Where in their facilities are they focusing their attention? What kind of success are they realizing? The paper also shares best practices to address this critical topic as a key component in providing a positive patient experience.

Physician Perspectives on Patient Experience
Investigating the importance of physicians in the overall experience of patients, this paper incorporates numerous views in exploring physician perspectives on patient experience. First, Dr. Latha Shankar shares her knowledge based on hands-on experience in the urgent care setting. She offers insight on the importance of various topics within the scope of patient experience including communication, active listening, lasting impressions, and the importance of quality care. Additionally, the paper includes six interviews with respected physician leaders from across the United States that offer thoughtful opinions on the various issues surrounding physician engagement in patient experience. These provocative insights underscore the importance of physicians in all facets of patient interaction.

Benchmarking the Patient Experience: Five Priorities for Improvement
This white paper explores qualitative data obtained in the 2011 benchmarking study, The State of Patient Experience in American Hospitals. While the original research report provided an overview of the study findings, this paper takes a deeper dive to share specific actions discovered that help shape a systemic solution to improving overall patient experience. It includes verbatim responses on how survey participants are addressing top patient experience priorities including: Reducing Noise, Discharge Process, Rounding, Responsiveness of Staff/Communication and Pain Management.