

A REPORT ON THE BERYL INSTITUTE BENCHMARKING STUDY

# THE STATE OF PATIENT EXPERIENCE IN AMERICAN HOSPITALS 2013:

POSITIVE TRENDS AND OPPORTUNITIES FOR THE FUTURE

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The Beryl Institute is the global community of practice and premier thought leader on improving the patient experience. 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.

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# INTRODUCTION

## THE STATE OF PATIENT EXPERIENCE REVISITED

In a follow up from the 2011 landmark study, The Beryl Institute again delved into the conversation on the patient experience, but returned to examine the progress on patient experience efforts. The investigation reinforced initial findings, revealed positive trends and provided insights into new and continued opportunities for healthcare organizations. The bottom-line is clear, patient experience remains a top priority among American hospitals and continues to be a key issue for hospital leaders.

This year's study included almost 1,100 respondents, a 40% increase since the research conducted in 2011. Over 670 unique hospitals or healthcare systems from across the United States were included in the sample pool. The study again had a clear intent, to examine the state of the patient experience in the nation's hospitals and identify the greatest supports and roadblocks to implementing effective patient experience efforts. The research reveals that improving patient experience is not just a nice thing to do, but is of increasing priority for healthcare leaders. Since the last survey was conducted, the initiation of Value-Based Purchasing, impacting hospital reimbursement based on performance outcomes, may have some influence on that result.

Yet, despite its continued importance, still less than half of all hospital executives report having a clear and formal definition for patient experience (see Defining Patient Experience). As a result, while formal mandates and supporting processes exist to address this issue, the data show that actions remain primarily tactical, which continues to pose a challenge to achieving true systemic impact and lasting change.

In this study, the largest conducted to date on what hospitals are actually doing to improve the patient experience, just over half of all hospitals say they have adopted a formal mandate related to improving patient experience, down from almost six in ten in 2011. Yet, over eight in ten now have a formal structure to address patient experience, up from seven in ten in 2011. From this data it is clear that hospitals increased attention is on moving to action. While this is a positive trend it could prove challenging for hospitals as their efforts remain tactical in nature in response mostly to survey requirements. This presses at the edges of the strategic focus required for patient experience success. In this light, hospitals are continuing to tackle focused problems such as noise, pain management, and better discharge communication as top targets related to patient experience.

## Defining Patient Experience

The Beryl 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*. We offer that health care organizations can more effectively address patient experience with this definition in mind as the clarifying theme around which organization efforts can be aligned. We encourage an adaption or adoption of a patient experience definition for all healthcare organizations. In fact, data in the 2013 study show a definition leads to better self-reported performance.



From four in ten organizations relying on some type of team or committee to lead the patient experience charge in 2011, this year just over 25% are using committees. The trend has shifted with an increase in senior patient experience leaders now appearing in over two out of ten organizations. Still the data continues to suggest a strong focus on tactical improvements, and a slightly slipping mandate to drive organization and/or cultural change. The increase in a committed leadership role is a positive sign of a willingness to invest in patient experience improvement. It does not suggest that efforts are any more strategic as a result.

The research also reveals that hospital leaders remain positive about their patient experience efforts, but with a slight dip in response. Those feeling very positive dropped from 25% in 2011 to 17% in 2013. Those feeling positive followed this trend dropping from 61% in 2011 to 54% in 2013. This was offset by a change in the neutral response up to 21% in 2013 from 12% in 2011. This data is subtle, yet significant. It represents the hard reality that addressing patient experience is not an easy or soft process. It requires rigor and intentional action. The shift in scores represents a sense of reality that this issue is more challenging than some thought. The realignment of response here is not one of concern, but actually representative of a greater sense of awareness of the issue and the actions needed to address it. This resetting of understanding creates a stronger foundation for future action.

Drivers and roadblocks remained consistent as well, with support “from the top” and from clinical leadership remaining key drivers of progress. The focus needed to drive results mentioned above in looking at the positive scores was also represented in the shift in scores regarding roadblocks. The top is now that leaders accountable for driving patient experience efforts are pulled in “too many directions.” This is an acknowledgement that improving patient experience takes work, and organizations are realizing lack of focus impedes the opportunity for improvement. Interestingly enough, a new support emerged in the 2013 study: the recognition that a formal PX structure or role is a key to success.

The findings continue to represent an encouraging trend around the state of patient experience overall. They show that the conversation on patient experience now has a central place in the conversation of healthcare organizations. That while some thought it too might pass, the reality of the structures and the required effort to achieve significant and lasting improvement requires real work and intentional focus. The story revealed via the 2013 study helps us see continued movement in a positive direction, a stronger sense of reality and a solidification of intent around patient experience improvement.

The Beryl Institute 2013 Patient Experience Study provides a story of critical trends in the emerging field of patient experience and continues to serve as a practical benchmark for hospitals seeking to place the patient at the center of their efforts. The data offer key insights in how we can continue to strive towards better outcomes for all and tells a story of the opportunities we all still have ahead.

## WHY CONTINUE TO STUDY PATIENT EXPERIENCE?

When we first launched the Patient Experience Benchmarking Study, we acknowledged that while some initial studies had been conducted to explore the rising importance of patient experience in the healthcare marketplace, there was still limited data addressing the key priorities, processes, drivers and roadblocks of what influenced this emerging priority. For the 2013 study, The Beryl Institute again partnered with Catalyst Healthcare Research, an independent marketing research firm that specializes in conducting research for the healthcare industry, to continue our research on "The State of the Patient Experience." The overall purpose of this research was to determine what is continuing to happen in U.S.-based hospitals with regard to improving the "Patient Experience." (The study was also expanded to explore the data of efforts overseas and in physician practice settings. Those findings will be reported separately). Specifically, the objectives for this research remained as follows with the addition of the last bullet:

- Determine the approaches hospitals are taking, if any, to improve the patient experience
- Discover why such initiatives are planned or taking place
- Learn who is responsible for these initiatives
- Understand the key improvement priorities
- Discover how leaders involved in these efforts feel about the challenges and opportunities they face
- Examine the trends in focus, efforts and improvement to gauge the continued importance of patient experience to healthcare organizations

To continue this study, it was important to maintain a comprehensive and rigorous process to ensure a true picture of the U.S. Hospital System was represented. It also challenged the need to determine the best means by which to identify and track trends and effectively revise questions to dig deeper into this evolving issue. This required a thorough review and expansion of the question set and again outreach to a broad and representative set of respondents. To ensure strong data and the ability to draw meaningful conclusions on the evolving state of patient experience efforts, a solid methodology also needed to be maintained.





## METHODOLOGY AND SAMPLE: MATCHING THE DEMOGRAPHICS OF THE U.S. HOSPITAL SYSTEM

To collect the data for the 2013 study, The Beryl Institute and Catalyst Healthcare Research (catalysthealthcareresearch.com) reached out to a broad spectrum of hospital leaders, from senior executives to clinical and patient experience leadership and from marketing to human resources and service line managers. Potential respondents were part of large, nationally recognized contact list of healthcare leaders from hospitals across the U.S. and all respondents from the 2011 survey were again invited to participate. While in 2011 the U.S. was targeted for the initial survey, the 2013 study attempted to look beyond U.S. borders and outside hospitals and health systems to broaden the insights into patient experience efforts. The results of those new inquiries are not covered here with the intention of this paper to allow for more direct comparison of 2011 to 2013 results in the U.S. Hospital System. The additional findings will be reported in an addendum to follow.

To conduct the data collection an email survey, comprised of 44 questions, was sent out over a four-week period in February and March 2013. At the close of the survey period, 1,072 individuals had provided responses to the survey questions, a 36% increase in respondents from 2011. The responses came from over 670 healthcare organizations with at least one response from every state and the District of Columbia.

To determine the representative nature of this sample, the demographics of the study response sample were compared to the current reported demographics of the U.S. Hospital System provided by the American Hospital Association (AHA Fast Facts on U.S. Hospitals, 2011). The table below compares the sample in the study to the recent AHA data.

2011 AHA DATA	#	%	Study Data %
U.S. Community Hospitals	4,973		
Nongovernment Not-for-Profit and State and Local Government Community Hospitals	3,948	80%	88%
Investor-Owned (For-Profit) Community Hospitals	1,025	20%	10%
Rural Community Hospitals	1,984	40%	35%
Urban Community Hospitals	2,989	60%	63%

From this data it shows the broad sample collected closely represents the various types of hospitals and systems in the U.S. and matches the demographic profile of the current U.S. hospital landscape. This provides a compelling argument that the results collected present a reliable picture of the state of patient experience in U.S.-based hospitals (Figures 1 and 2).

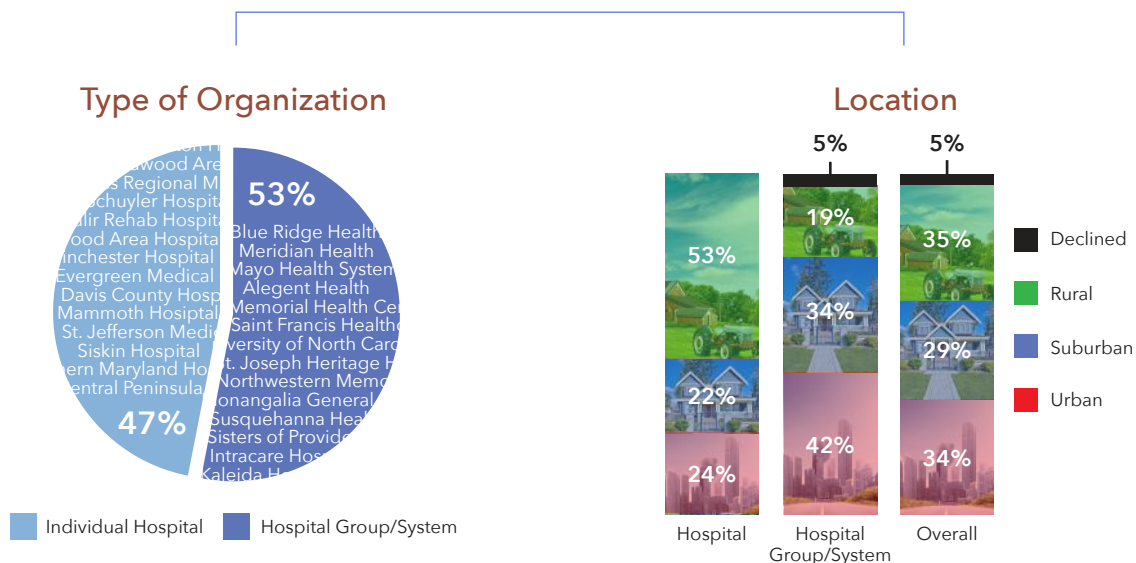
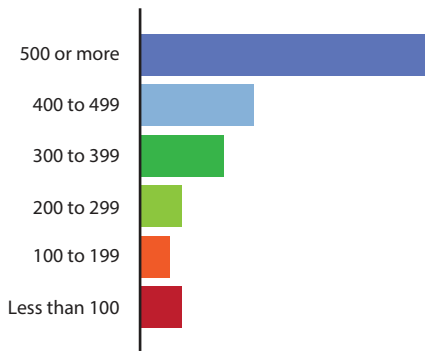
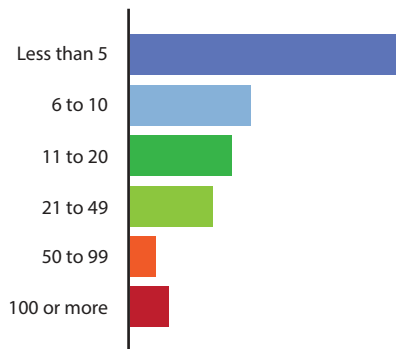


FIGURE 1.  
Respondent Demographics -  
Type and Location

### Hospitals (Free Standing) Number of Beds



### Hospital Systems Number of Beds



### Organization's Status

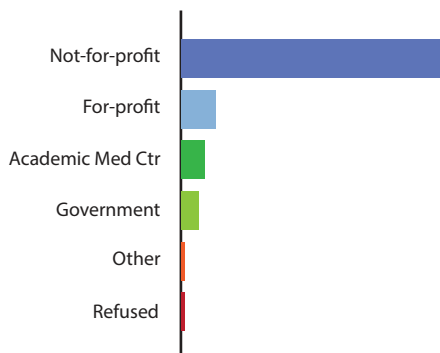


FIGURE 2.  
Respondent Demographics -  
Organization Info

In examining the demographics it was also important to understand the individual respondents to determine any potential shift in results due to the roles in organization. In looking at the breakdown of titles for 2013, we discovered the largest number of responses continued to come from senior leadership (representing CEO, COO, CFO CNO, CMO and other VPs) equating to 37% of the sample. The continued, even though slightly reduced, engagement of senior leadership is encouraging in the efforts to address patient experience improvement. Perhaps of greatest significance was the jump in those leading patient experience efforts. In 2011 Chief Experience Officers (CXOs) and patient experience leaders comprised about 14% of the sample. In 2013, they are about a quarter of all respondents, a trend that reveals the potential expansion and elevation of direct patient experience leadership roles in healthcare organizations. (Figure 3).

The demographic numbers reinforced an interesting issue that again emerged in the data: that even with the increase in CXO type roles, there are still a relatively small number of individuals with a committed title and focus on the patient experience. This is supplemented by the fact that we have seen a number of other leadership roles being given some level of accountability for this issue. This reinforces the potential revealed now as the top roadblock in 2013 as well. That those tasked with leading patient experience efforts are still often pulled in many directions to address numerous and even competing priorities. With that said, our respondents again offered that patient experience is their leading priority in their organizational efforts today.

	2011	2013
Senior Leadership	45%	37%
Quality Improvement	16%	14%
CXO/PX Leader	14%	25%
Marketing	11%	6%
HR	3%	2%

FIGURE 3.  
Respondent Demographics -  
Respondent Role

## PATIENT EXPERIENCE REMAINS A TOP PRIORITY

The 2013 study stands as continued reinforcement that patient experience remains a top and increasing priority for healthcare leaders. In asking respondents to rank their top three out of 14 possible choices, the same three items clearly bubbled to the top. Again, as in 2011, patient experience was the top selected item, showing up in the top three choices for respondents 70% of the time (up from 64%). It was followed by quality/safety at 63% of the time and third being cost management showing up 37% of the time in the top three choices. (Figure 4)

From the perspective of The Beryl Institute, we have continued to express that while experience, quality and safety are delineated in the survey, or for that matter in the way we operate our healthcare organizations, a patient or family member does not distinguish between these three areas. As a patient I do not know where the boundaries between where what is service, what is quality and what is safety start or end. More so, all of these elements are actually components of an overall experience.

This provides us great opportunity, for if we believe these to be priority items for our organizations, we are, whether consciously or not, working on the totality of the patient experience. This is of particular significance as this is the

very idea represented in the context of The Beryl Institute's definition of patient experience. It must be recognized that experience encompasses the entire continuum of care - before, during and after the clinical encounter. Interesting here as well is the impact of policy on priorities overall. The 2013 survey includes the increased focus on clear policy changes and regulatory requirements such as the technology focus of meaningful use or the integrated solutions of ACOs. That prevailing policy was still outscored by the broader topic of experience is significant. Especially recognizing that while experience is also a policy-driven effort with financial consequences, the implications from a bottom-line standpoint may not be as big as some of the other choices. This suggests people are beginning to realize that the implications for patient experience efforts and outcomes reach beyond the simple math of value-based purchasing and direct reimbursement issues and have a much broader impact.

The findings hold consistent with 2011, even in the face of a shifting policy landscape. People are recognizing there is more to patient experience efforts and that it truly has a central role to play in healthcare. It should be noted that recognizing importance and actually making the choice to not only act, but to also do so in an effective and appropriate manner is key. This is where perhaps there is still trouble in translating intention to action.



FIGURE 4. Top Three Organizational Priorities







## LEADERS ARE GAINING MORE REALISTIC PERSPECTIVE ON PROGRESS TOWARDS IMPROVEMENT

It is in the translation of intention to action where the greatest potential for disconnect may exist in the patient experience equation. Also as organizations began to address this issue, it seems many thought the perceived soft nature of patient experience improvement could make it an easy task or even something requiring minimal attention. The 2011 study reinforced this assertion with 61% of respondents offering they felt positive about their progress on patient experience improvement and 25% saying they were very positive. Considering the timing of the inquiry, the initial thoughts were that this positive feeling was prior to the broader impact of public measures and the new focus on improvement efforts. With that, a positive sentiment could have been generated across a wide range of efforts, from successful application of a single tactic, to the comprehensive implementation of a cultural or behavioral shift.

With the passage of time, an increased focus on measured outcomes and clear implications for action, the perspectives of healthcare leaders have shifted, representing what seems to be a realistic appraisal of the situation. Addressing patient experience is much harder than many thought, requires greater rigor than many anticipated and is more central to overall strategy than many planned. With that, leaders saw a dampening of their positive sentiment in 2013. This is by no means a bad or concerning outcome, rather the indication of a stronger sense of reality.





The fact that those reporting they felt positive dropped seven points to 54% and those reporting very positive fell eight points to 17% actually represents a significant level setting of perspective. This is accompanied by the report of a neutral sentiment climbing nine points to 21% overall (Figure 5). Rather than a disappointment with outcomes, these results represent the realization that more work is required and greater efforts are needed to achieve desired results. In many ways this adjustment in perspective may be what is needed to get the right commitment behind the critical nature of patient experience improvement. It may also support a sharpened focus on some of the most fundamental needs for experience improvement efforts.

### At this point, how do you feel about the progress your organization is making toward improving the "Patient Experience?"

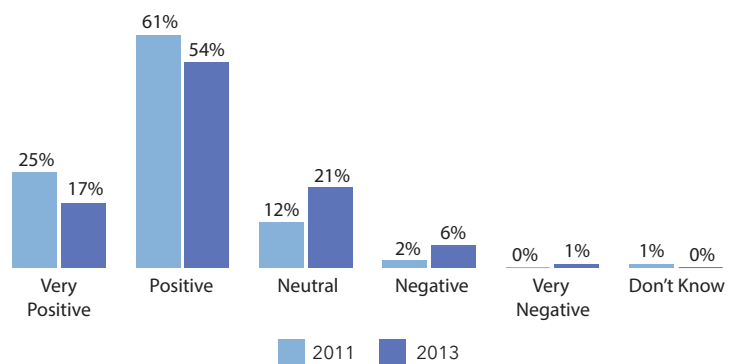


FIGURE 5.  
Feeling about Progress towards Improvement



## WHILE A CLEAR PRIORITY, PATIENT EXPERIENCE CONTINUES TO LACK FORMAL DEFINITION

A central set of questions in support of patient experience improvement efforts and progress is that of focus, commitment and structure. As in 2011, the study again asked participants whether they had a formal mandate to address patient experience in their organization, where a formal structure existed and if they had a formal definition of patient experience. A concern raised in the 2011 research was the recognition that while many organizations had a clear mandate, even though still low at just under 60%, and a formal structure, in more cases than mandates, only 27% of all organizations had a formal definition of patient experience. That finding has shaped a consistent theme reiterated throughout our work at The Beryl Institute. Simply stated, without definition an organization has little to no basis for action (Figure 6).

The responses present some interesting shifts in 2013, but many of the same concerns are still relevant. Of further interest, the 2013 study explored the implications of these variables - mandate, structure and definition - on self-reported outcomes with some interesting results. First, perhaps a little disconcerting as a data point was the drop in those organizations reporting a formal mandate to address patient experience - from 58% in 2011 to 52% in 2013. Two perspectives could be offered on this data. The first, that patient experience has been given less focus or priority over the last two years. The data from the rest of the survey

reinforcing the priority of and focus on patient experience could refute that. An alternative interpretation might be that patient experience is no longer being seen as a distinct item to be addressed and is becoming more integrated in the general strategy of organizations. This would be consistent with the point stressed via the work of The Beryl Institute, that patient experience is not an initiative to be managed, but rather an integral and ongoing component of any organizational strategy.

From exploring mandates, the question turns to that of formal structure. In 2011 the study explored the paradox that while only 58% of those surveyed said they had a formal mandate to address patient experience, almost seven in ten had a formal structure. This suggested work was potentially being done without the support needed. At the same time, structure is critical in executing on the complex nature of patient experience efforts. In fact, The Beryl Institute has always advocated, and even substantiated through research, that there is value in having a committed role addressing the patient experience. A formal structure is a simple extension of this consideration.

In 2013, the means by which the work is getting done increased rather substantially from 69% to 81% of respondents offering they had a formal structure to address patient experience efforts. The significance of this data is that now eight in ten healthcare organizations have put some form of organization in place, from an individual or a committee to a formal patient experience team. There is a much greater recognition of and support for work that needs to be done.

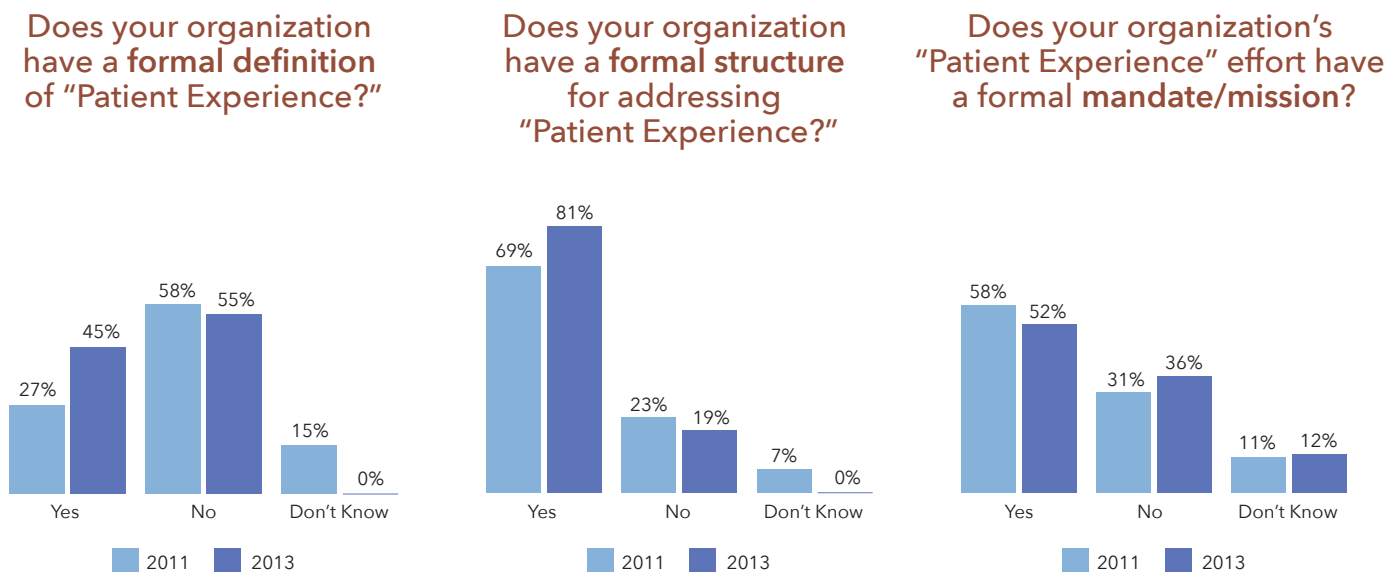
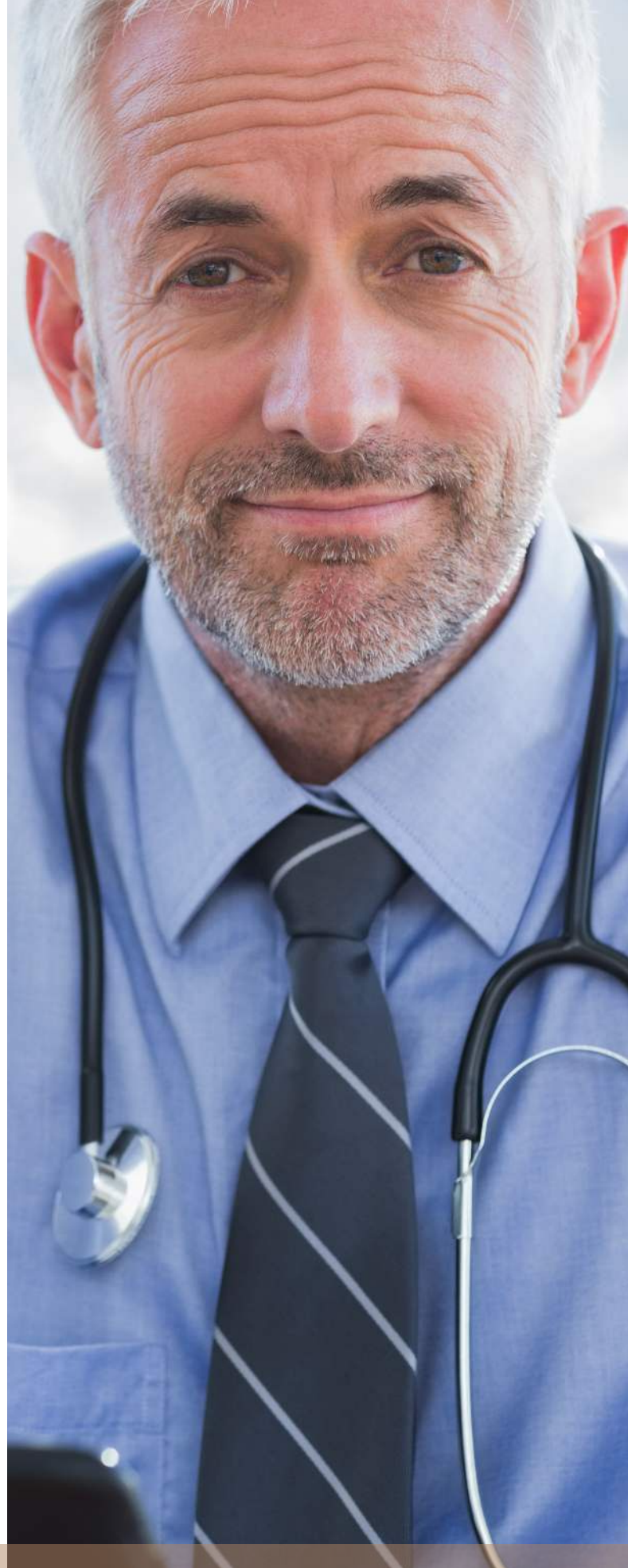


FIGURE 6.  
Top Three Organizational Priorities

The question we come back to then in examining the infrastructure in place to address patient experience, is how an organization defines its objective. What are they trying to achieve, what is the patient experience for them? The 2013 results are positive but tempered with now 45% of all respondents sharing they have a formal definition for patient experience in their organization. This is an eighteen-point increase since the 2011 study, showing that many more organizations have recognized the need to define what it is they are trying to achieve before attacking the issue.

At the same time, that number again reveals much more; in the U.S. Hospital System over half, 55%, of all organizations have yet to create or adopt a formal definition. As shared in the 2011 report, the questions remain the same: If we do not have a definition of patient experience, i.e., what we are trying to address and improve, how will we know (1) we are focusing on the right thing, (2) we are moving in the right direction, or (3) if we made any progress towards what we hope to achieve, let alone ever achieve it? Based on the responses, the data show that the target, for which an organization is striving, as represented by a clear definition, has been overlooked by a majority of healthcare organizations. So then how are organizations choosing to address their patient experience efforts?



## A Lack of Definition has Measured Implications on Outcomes

As part of the 2013 study, organizations were asked to self report their performance by percentile on the question “overall rating of hospital.” As self reported scores, we rely on the respondent to know their performance outcomes, but even as anecdotal evidence the value of formal definition is substantiated. For those organizations reporting having a formal definition, 50% are in the 75th percentile and above on overall rating, with 78% in the top 50th. For those reporting they do not have a formal definition, 40% report being in the 75th percentile and above, with just 70 being in the 50th percentile or above. In the game of patient experience improvement where every factor counts, a formal definition seems to steer organizations on a clearer path to success.

## A COMMITTEE STRUCTURE CONTINUES TO SERVE AS PRIMARY WAY IN WHICH PATIENT EXPERIENCE IS ADDRESSED

Based on survey responses, the top choice of structure in addressing patient experience remains via committee. Yet, maintaining the top spot, the number using a committee as primary resource for addressing patient experience efforts dropped from 42% to 26% in 2013. On the rise, yet maintaining a similar percentage as 2011, was the Chief Experience Officer (CXO) or Patient Experience Leader at 22%. The focused role of experience leader jumped the C-suite roles of CEO, COO and CNO respectively, with the CNO seeing an increased level of involvement versus what was reported in 2011 (Figure 7).

This shift, with a reduction in the use of committees, the elevation of the experience leader role and increases in CNO engagement represent a sharpening of focus on where patient experience efforts can be impacted. It reinforces the needs for new and special skill sets to address this issue beyond collective committee work. It also signifies an understanding of the clinical implications for experience and more so the influence nursing staff overall have on the experience outcomes of an organization.

In the 2011 study, an interesting baseline was established, showing that just 23% of the responsibility and accountability for patient experience outcomes rested with a patient experience leader or service excellence director. More specifically, 13% of those actually accountable were individuals with “patient experience” in their title. In the 2013 study, while the total numbers of responses in what could be considered similar roles held steady, we saw an interesting shift in the specificity of titles use. In the 2013 study those identifying themselves with “patient experience” as part of their title/role was 22%. This increase signifies a growing awareness of the idea of patient experience as a true body of defined work, requiring greater focus than a committee effort can muster.

### Who in your organization has the primary responsibility and direct accountability for addressing “Patient Experience?”

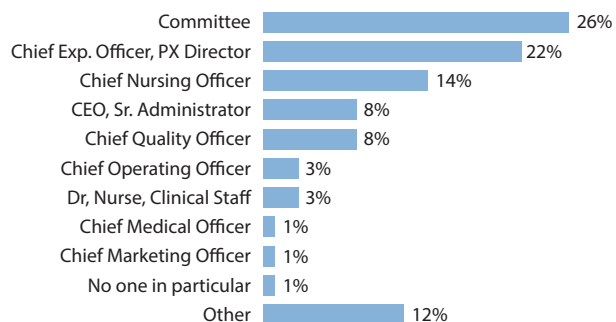


FIGURE 7.  
Committee Structure Retains Primary Responsibility



## A SMALL AND POTENTIALLY DILUTED FOCUS CHALLENGES PATIENT EXPERIENCE EFFORTS

In delving into how patient experience efforts are being addressed, while we see an increase in focus and role, there still remains an opportunity for greater support. The 2013 study asked respondents to share the estimated time the designated patient experience leader (whether a specific patient experience role or not) spends in supporting their patient experience efforts. The result was at best concerning as it revealed that time actually spent on patient experience efforts is at best diluted by the competing priorities facing healthcare organizations (Figure 8).

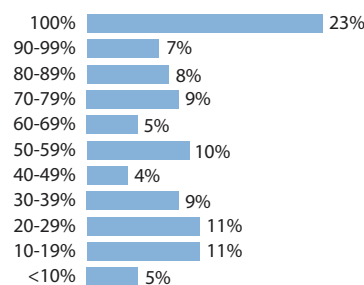
The issue this reveals is one raised by others in the patient experience discussion. The question may be as simple as this: while finance has a committed role with Chief Financial Officer, and Human Resources (HR) via Vice Presidents of HR, why it is that a critical component of a healthcare organizations deliverable - the patient experience - does not have committed or dedicated support? The data show that on average the primary person responsible for patient experience efforts only has 63% of their time to commit to efforts. Those responding 100% of the time tend to be those who are in dedicated patient experience roles, which again appear in about 25% of all organizations. That leaves the remaining 75% of healthcare organizations with only a partial focus on the experience of patients and families.

All too often, healthcare leaders say the patient experience is “everyone’s responsibility.” This is a valid point if only focused on the implementation of ideas. An organization still needs to identify, plan for and implement the ideas it chooses to pursue. It is a dedicated and committed role that enables this level of strategic thinking and execution to occur.

The data continue to explore this commitment in focus, showing that 36% of all healthcare organizations have just one to two individuals committed to patient experience success. In fact, 28% report they have no committed role at all. While size of team is not an indication of focus, direction or potential impact, it is the fact that more than one in four organizations have not yet invested in a role and the opportunity to focus on outcomes is at best diluted and distracted by competing priorities. This provides a significant opportunity for organizations to think both strategically and efficiently on how to best allocate resources, provide focused and committed support and ensure the desired outcomes an organization hopes to achieve. It is a clear and dedicated role that will lead to the strongest creation of strategy and the most effective execution of tactical priorities.



What percent of that person’s time is allocated to support PX efforts?



Who many other FT staff members are designated to these efforts?

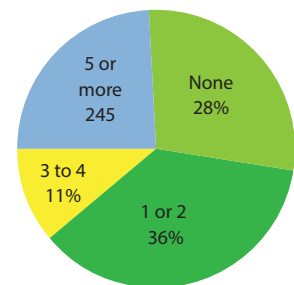


FIGURE 8.  
Time Commitment and Team Size



FIGURE 9.  
Top Patient Experience Priorities

## TOP PRIORITIES IN ADDRESSING THE PATIENT EXPERIENCE REMAIN FOCUSED ON TACTICAL ISSUES

To explore in what ways healthcare organizations are acting to improve the patient experience, the survey again asked respondents to list their organization’s top three priorities. This item, as in 2011, was an open-ended question where individual responses were reviewed and grouped into the most frequent themes. No specific direction was given on the response suggesting they list strategies, tactics or outcomes in order to gather the most natural responses. The word cloud that resulted (Figure 9) represents the frequency with which a grouped theme appeared in the responses. The larger the word or phrase, the more often it was mentioned in the responses.

What was revealed through this process was that the top overall priorities identified remained focused on tactical and tangible actions. Perhaps more intriguing is that the top reported items in 2013 almost mirrored the 2011 results exactly. The top five priorities for action identified in 2011 were reducing noise, discharge process, rounding, responsiveness of staff/communication, and pain management. As you look at the 2013 results in Figure 9 you too see reduce noise, hourly rounding, pain management, discharge process and communication. The data reveal that the top five priorities remained in essence the same with a reprioritization of importance. Also reduce noise still remains the top priority.

As noted in 2011 and found again in 2013, with each of the priority items, there are specific tactics associated with accomplishing them. Reduce noise, pain management, discharge process and hourly rounding are all tied to tangible processes that can be designed for tactical implementation. This is not reported as a positive or negative result, but rather

the 2013 study reinforces that hospitals continue to look for specific “things” they can do to address and improve patient experience.

The one behavioral priority remains communication, which while broad in scope has significant implications for patient experience performance. If we return to the definition of patient experience as “the sum of all interactions,” it is only in these personal moments, touch-points of communication, through which the patient experience is delivered. How individuals interact, what they say, how they say it, how effectively it is delivered and received, impact so much of the care experience. It has impact if patients or family members feel listened to, creating an engaged patient. It impacts how they understand care plans and other information to ensure an activated patient. It results in the very way patients and families will share their experience with others with stories about how they were treated, versus what was done while there were there. Communication clearly remains an open and broad challenge in the patient experience conversation; one clearly needing continued focus.

The 2013 survey did not inquire deeper into why organizations identified these items as a priority, yet the same insights as shared in 2011 seem to hold true. As tangible activities, these priorities are easier to identify as issues, build plans around and act on. As noted also in 2011, noise, discharge instructions and pain management are directly related to questions asked on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The remaining items, rounding and communication, continue to be seen in both popular literature and research as a lever to impacting satisfaction and HCAHPS scores as well.

What is interesting in reviewing the 2013 findings is that while responses solidified top patient experience priorities over time, the list of priorities also expanded. It



## The Emergence of the Patient Experience Professional

As the focus on patient experience efforts lie increasingly in the hands of those specifically designated patient experience leaders, the need to support this evolving role is significant. In fact, the 2013 study saw an increase in those responding from patient experience roles from 14% in 2011 to 25%, leading the list of all respondent groups. This continued expansion of the patient experience role reinforces an important observation by and supporting effort of The Beryl Institute: to encourage and support the development of the patient experience leadership role. This is an important focus of The Beryl Institute as a global community of practice bringing together leaders from around the world to refine their knowledge and skills. It is supported by the continued work on formalizing a body of knowledge and certification for patient experience leaders. This effort, launched right after the release of the 2011 study, has supported the expansion of the patient experience role. It will be interesting to revisit the growth in the role during the 2015 study at which time the body of knowledge and certification program will be in full operation.

seems as organizations have focused their efforts on experience improvement, they have begun to see the broad range of areas that touch on patient experience overall. Other efforts that may seem indirectly related to patient care are also emerging, with the prominence in the data of "beside shift report," a means to engage patients in their care plans at shift change and "patient and family advisory councils," as a means to engage patients long-term in providing guidance to an organization's effort. These emerging ideas represent a potentially powerful and encouraging shift in thinking that is taking place, that patients are not just recipients of an experience, but partners in it.

The headline for the inquiry into priorities is that while many activities continue to take place in addressing patient experience, a central focus on specific tactics is emerging, accompanied by a growing realization that patients are active partners in experience. A continued bias for action is revealed and a clear awareness of the performance measures being used is evident. This was supported by the responses to a follow-up question to priorities in asking respondents to select the top five components of their patient experience efforts.

These emerging ideas represent a potentially powerful and encouraging shift in thinking that is taking place, that patients are not just recipients of an experience, but partners in it.





## KEY COMPONENTS OF EXPERIENCE EFFORTS REVEAL A SHIFT FROM REACTIONARY TO “IN THE MOMENT” IMPROVEMENT

While the results from 2011 and 2013 on the top five components of patient experience efforts show some similarities, this item experienced a bigger shift. Staff training, identified by 87% of respondents, topped the 2011 data. It was followed by a continued list of tactics including the use of follow-up phone calls (78%), service recovery programs (76%), the use of performance scorecards (75%), and process review (72%). While these items remained in the 2013 questioning, a shift in perspective was revealed by the data. While the tactics identified in 2011 are still valuable processes in a patient experience effort, they were reactive efforts of sorts. Post discharge calls, service recovery, performance scorecards all call for action after an experience has already occurred. What was interesting in the 2013 data was the emergence of more real time opportunities for action.

In exploring the 2013 data (Figure 10), we see that staff training remains a top five item, but drops to fourth on the list appearing only in 49% of respondent’s choices. The new top five is lead by the sharing of scores, a powerful and indirect statement of the importance of engaging staff at all levels in patient experience efforts. By revealing the data, organizations can be best equipped to make adjustment or even significant changes. From this response representing broad awareness, the following two items begin to show consistency with the priorities for action identified above, with the first being hourly rounding and the next leadership rounding. The data reveal that organizations are starting to realize the experience happens at every touch point and can be addressed in any moment. That real data based on in the moment interactions trumps information gains post facto.

These results also begin to show the recognition that the patient plays in patient experience efforts overall.

It is only here then that training resurfaces. Anecdotally, the inclusion of training here, while the same response in words, takes on a whole new perspective. As a top item in 2011 it seemed as if training was a direct solution. That is, staff could be trained to be better providers of experience and it would drive better outcomes. Seeing this shift in training as a complement to patient engagement and real time action rather than a leading driver of change reveals that organizations recognize training needs to be based on what an organization is attempting to do, what it is hearing, how it is defining its priorities for action and what it hopes to achieve. Training here is not simply about creating service-minded staff; it is about an awareness of patient experience strategy and the key knowledge and skills on which to execute efforts effectively.

The final item, a focus on HCAHPS domain improvement, makes sense as a top five item with the significant focus in the United States on this survey. It is also encouraging that it is the fifth versus the first item. Yes, HCAHPS items do need to be addressed. They represent the common standard by which all U.S. hospitals are being evaluated, but they too are not the leading indicators of patient experience efforts. Rather HCAHPS results reflect the totality of an organizational effort, the blend of strategic and tactical priorities and reinforced and rewarded actions. This also supports a point we make often at the Institute: you cannot simply tackle experience by targeting HCAHPS domains one at a time. This leads to a potential game of, as one CEO called it, “whack-a-mole,” where you are consistently chasing the low score. The encouraging story in the 2013 data is that organizations are moving to a strategic mindset, based on simple but solid tactics for improvement.

### Which of the following are key components of your organization’s “Patient Experience” effort (top 5 of 25)?

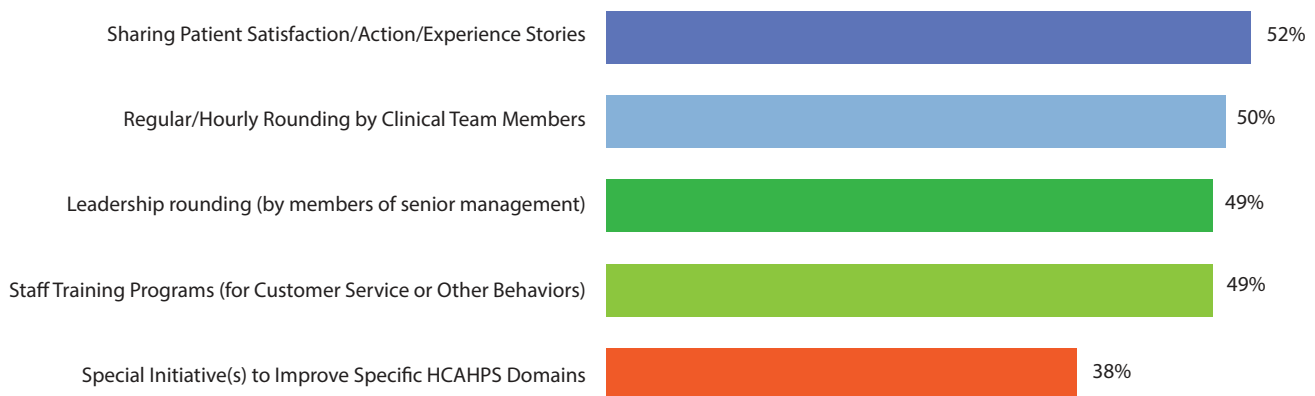


FIGURE 10.  
Key Component of Patient Experience Effort

## MEASUREMENT NOW FOCUSES ON MANDATES, SUPPLEMENTED BY TRADITIONAL FORMS

The question so often raised on the patient experience adventure is how do we measure it all? How do we know if we are successful? In the U.S., HCAHPS scores have created a common grounding for this question, but by no means do organizations seem to take these scores as the extent of their performance measurement or achievement.

As in 2011, it is important to note that measuring success remains much more difficult if you do not know where you are going or what you are trying to achieve. This is especially a challenge for those more than 50% of organizations that still lack a formal definition of patient experience for themselves and therefore even in naming experience a strategic priority do not have a true north to which to point.

The priorities for measurement again reveal that surveys remain the greatest point of measurement for U.S. Hospitals (Figure 11), first via HCAHPS and then personalized internal satisfaction surveys. Post discharge calls round out a grouping of the top three measures. All three again enable post encounter evaluation. The second grouping of items, though appearing less frequently, get to the importance of direct and real time feedback in making adjustments to patient experience efforts. From bedside surveys, to advisory committees to focus groups the story follows a similar trend to the components question above. It is evident that the direct voice of the patient is becoming more central to the patient experience improvement conversation. The responses to this question reinforce that trend.

Healthcare organizations are realizing that experience happens in the moment, in every moment, so the closer they can get to understanding what happens there, versus just via statistically validated surveys that provide post encounter insights, the better. This is not to suggest one trumps the other, but rather that this combination of measurement methodology bodes well for both immediate and long-term improvements. The data support a shift in perspective as noted above, that experience is not just another initiative you can measure and plan your way through, it requires direct, personal and in-the-moment efforts to achieve the greatest results.

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### Aside from tracking the success of individual improvement activities, what metrics is your organization using to measure overall improvement in the "Patient Experience?"

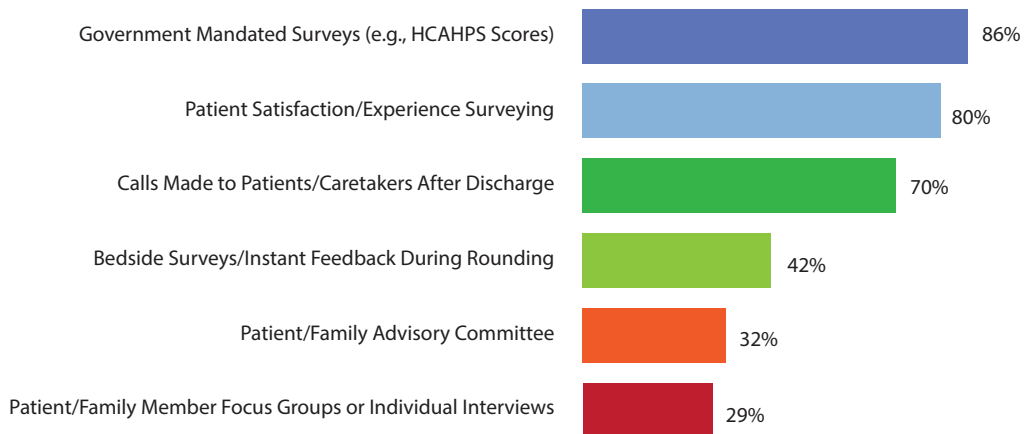


FIGURE 11.  
Key Component of Patient Experience Effort



## STRONG LEADERSHIP CONTINUES TO SUPPORT EFFORTS, WHILE DIFFUSED FOCUS NOW LEADS ROADBLOCK

The 2013 study again asked respondents what supported or impeded their overall success in patient experience efforts. When all is said and done around structures, priorities, and measures it is that ability to execute (or lack thereof) that perhaps has the greatest significance. The results revealed great consistency from 2011 with a few new and important shifts (Figure 12).

In examining the drivers of success four of the top five remained the same, in fact the top two items, “visible support from the top” and “manager support” for efforts remained in the same place as in 2011. “Formalized process review” and “internal communication efforts” also remained part of the top five as well in 2013. Off the list for 2013 was employee orientation, but this item was replaced by a very significant new addition. Respondents shared that having a formal patient experience structure or role was a top driver of success. This response is in line with earlier research conducted by The Beryl Institute showing the positive impact of a patient experience leadership role.

In exploring roadblocks, of greatest interest is perhaps that the top five items reported in 2011 remained in 2013. This reveals that healthcare organizations continue to struggle with the same issues. At the same time the ranking of the roadblocks reveals a subtle shift in how patient experience is both viewed and addressed in healthcare organizations today. While “cultural resistance to change” was top of the list in 2011, it dropped to third overall, signifying a potential shift in openness to addressing experience issues in organizations. This change is supported by the rise of “leaders pulled in too many directions” to the top of the list with “other organizational priorities” following. These results suggest that organizations are recognizing the focus and intention needed to make patient experience improvements, yet as also discovered in question of allocation of time committed, there is clearly a diffused focus on experience efforts in organizations.

The positive story here is the data seem to suggest that organizations are realizing there is a need for full commitment, in either time or direct resources; they just have yet to be able to act on this recognition. This is supported by the fact that “lack of resources” to support patient experience efforts remains a top five roadblock as well. “Lack of support from physicians” rounds out the roadblocks and still remains an issue for over a quarter of all organizations.

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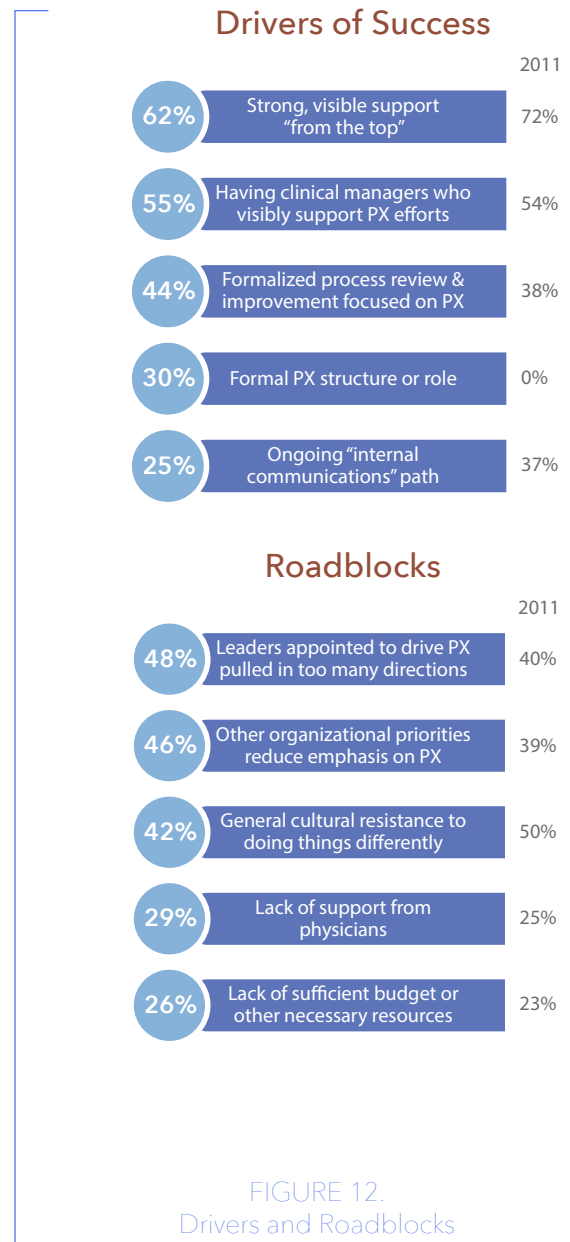


FIGURE 12.  
Drivers and Roadblocks

It is here where the overall results of the 2013 study culminate and the story they tell is realized. While so much has remained the same in responses, the subtle shifts in priorities and recognition, in focus and effort, can be seen and they are encouraging. Continuing to reinforce the supports and to address the roadblocks to effective action identified here may rest at the heart of patient experience efforts for a significant portion of healthcare organizations. By realizing where priorities are and should be and what will support success or impede progress, healthcare organizations can begin to make the best choices for action in moving towards patient experience success.

## THE STATE OF PATIENT EXPERIENCE IS GETTING STRONGER EVERY DAY

The intention of this study was twofold, to gather a clear snapshot on the state of patient experience in the U.S. hospital system today and to understand the trends influencing and the shifts taking place in the emerging field of patient experience overall. From the original benchmarks set in the 2011 study, both subtle and significant trends are revealed and positive progress has been realized.

In working directly with healthcare organizations and looking at the 2013 data there are true changes around the way in which patient experience is viewed and addressed. Support structures have changed and priorities have realigned. There is also a growing recognition of the complex strategic nature of patient experience. This is not something to raise concern, but rather to encourage. As healthcare organizations come to acknowledge and act upon the true strategic significance of patient experience, positive trends will continue.

The 2013 study again offers a broad, practical and grounded sample, the largest to date collected on this topic, and one that continues to be representative of the system the research looked to explore. Of greatest importance remains the generosity of the respondents themselves. In providing honest responses and valuable insights, these individuals and organizations helped frame a continuously developing picture of where opportunities exist, challenges must be addressed and successes rest in positively impacting patient experience efforts. Ultimately the 2013 study continued to reinforce and further expand the reality that patient experience is a top priority and will be for a long time to come.

The headlines in 2013 do not stray too far from the discoveries of 2011, but they do reveal positive shifts and important progress. They continue to highlight the struggle that exists between acknowledging the importance of this issue and the willingness to define and invest in it. The progress being made and the trends show a true sense of movement overall. This is what we have seen since the early days of The Beryl Institute and the 2011 study. That in fact patient experience itself has emerged as a movement in healthcare, one driven from all corners of the industry and one we, at the Institute, work hard every to nurture, support and grow. From nurses and physicians, administrators and ancillary staff, vendors and resource partners, to the voices or patients and families, of our loved ones and of professional advocates, everyone has a role to play in this conversation, in this patient experience movement. It is through this volume of voices that changes are starting to be seen.

In 2013, the responses of almost 1,100 healthcare leaders have shown us that:

- Patient experience remains a top priority
- Leaders are gaining more realistic perspective on progress towards improvement
- While a clear priority, patient experience continues to lack formal definition
- A committee structure continues to serve as primary way in which patient experience is addressed
- A small and potentially diluted focus challenges patient experience efforts
- Top priorities in addressing the patient experience remain focused on tactical issues
- Key components of experience efforts reveal a shift from reactionary to "in the moment" improvement
- Measurement now focuses on mandates, supplemented by traditional forms
- Strong leadership continues to support efforts, while diffused focus now leads roadblocks

In exploring the story line of this study, the results show us that organizations are recognizing the need to act beyond simply acknowledging experience as a priority. Knowing it is so and actually doing the things to ensure it is are two very different things. The 2013 study shows a shift from a bias of words to one of action. The study also shows us that patient experience, perhaps most significantly, has shifted from something that is done to, to something that many are beginning to recognize is something done with patients and families.

Lastly, respondents have shown their understanding that experience is work, hard work that takes committed resources, serious intentionality and focus, and clear plans. Our hope at The Beryl Institute, not only through this study as a defined marker in time, but in the work we do every day, produced through, by and for the global patient experience community, is that we can continue to push this conversation forward. That as the data show, a patient experience movement is afoot, it is an important and powerful flame to be fanned and one in which so much is at stake.

The state of patient experience is growing stronger every day because the voices committed to this work, and the impact it has grows stronger with it. It remains a top priority and reinforces the point that the patient and their experience - the quality of their outcomes, the safety of their environment, the service they are provided - must be and should remain central to our healthcare conversation. This is about choice of where an organization and its leadership sets its strategy and invests its resources. The 2013 study helps us see while much has been accomplished, there is much more room to grow. The challenge remains to stay focused on and committed to what we can, and should, accomplish together.





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