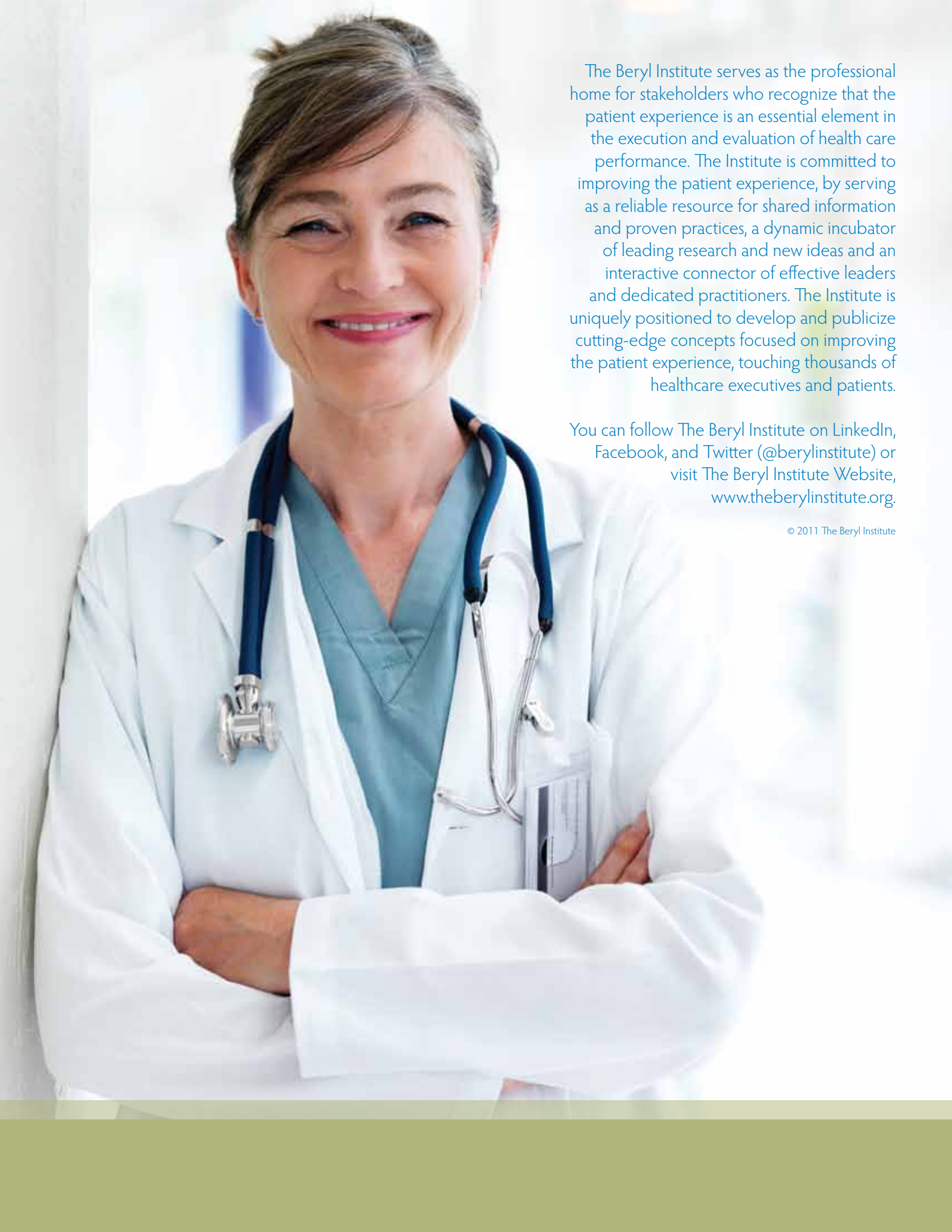# THE STATE OF PATIENT EXPERIENCE IN AMERICAN HOSPITALS

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SPRING 2011

THE BERYL INSTITUTE

The Beryl Institute serves as the professional home for stakeholders who recognize that the patient experience is an essential element in the execution and evaluation of health care performance. The Institute is committed to improving the patient experience, by serving as a reliable resource for shared information and proven practices, a dynamic incubator of leading research and new ideas and an interactive connector of effective leaders and dedicated 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.

You can follow The Beryl Institute on LinkedIn, Facebook, and Twitter (@berylinstitute) or visit The Beryl Institute Website, www.theberylinstitute.org.

INTRODUCTION

According to a landmark study by The Beryl Institute, "Patient Experience" is 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, according to research conducted in the first quarter of 2011.

Almost 800 hospital executives from across the United States examined the state of the patient experience in the nation's hospitals and identified the greatest roadblocks to implementing change. The research reveals that improving patient experience is not just a nice thing to do, but is now a significant priority. Yet, despite its importance, only one in four hospital executives actually has a clear and formal definition for patient experience (see Defining Patient Experience). While formal mandates and supporting processes exist to address this issue, the data shows that actions are primarily tactical, which pose challenges to achieving true systemic impact and lasting change.

The research reveals that hospital leaders feel 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. Despite the challenges uncovered in this study, the recognition of patient experience as a top priority is a significant statement and represents the increasing importance of patient and family experience across the continuum of care.

The findings are encouraging. They show that the conversation on patient experience in healthcare is no longer just a passing idea, but a true executive priority with significant consequences and an increasing focus. The information gleaned from the survey shows movement in a positive direction and identifies where change can be made.

The Beryl Institute 2011 Patient Experience Study provides a relevant and practical "benchmark" for hospitals seeking to place the patient at the center of healthcare and offers key insights in how we can continue to strive towards better outcomes for everyone.

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 believe that healthcare organizations will be able to more effectively address patient experience with this definition to clarify where efforts can be aligned.

WHY A STUDY ON

PATIENT EXPERIENCE?

While some initial studies have been conducted that began to explore the rising importance of patient experience in the healthcare marketplace, there is little data addressing the key priorities, processes, drivers and roadblocks of what influenced this emerging priority. In 2011, The Beryl Institute partnered with Catalyst Healthcare Research, an independent marketing research firm that specializes in conducting research for the healthcare industry, to conduct research on "The State of the Patient Experience." The overall purpose of this research was to determine what is happening in American hospitals with regard to improving the "Patient Experience." Specifically, the objectives for this research were:

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

METHODOLOGY AND SAMPLE:

MATCHING THE DEMOGRAPHICS OF THE U.S. HOSPITAL SYSTEM

To collect the data for this study, The Beryl Institute and Catalyst Healthcare Research 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 a large, nationally recognized contact list of healthcare leaders from hospitals across the U.S. The U.S. was selected for this initial survey for logistics reasons and because of the availability of comprehensive contacts as well as comparable data in determining a representative sample in the responses. This baseline benchmark provides U.S.-based data that can be transferable to some extent across national and systems boundaries. To conduct the data collection, an email survey comprised of 33 questions, was sent to the list of healthcare leaders over a 16-day period in March 2011 during which time all responses were collected.

At the close of the survey period, 790 individuals had provided responses to the survey questions, resulting in a margin of error of +/- 3.6%. More significant in the results is that the responses came from over 660 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 was 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, 2010). The table below compares the sample in the study to the recent AHA data.

2010 AHA DATA	#	%	STUDY DATA %
U.S. Community Hospitals	5,008		
Nongovernment Not-for-Profit and State and Local Government Community Hospitals	4,010	80%	81%
Investor-Owned (For-Profit) Community Hospitals	998	20%	15%
Rural Community Hospitals	1,997	40%	39%
Urban Community Hospitals	3,011	60%	59%

From this data it is not only clear that the broad sample collected represented the various types of hospitals and systems in the U.S., but is also apparent that the sample closely matched the demographic profile of the current U.S. hospital landscape (Figures 1 & 2).

The largest number of responses came from senior leadership (representing CEO, COO or CFO roles) and senior clinical leadership (CNO, VP Nursing). Those two groups equaled 45% of the sample supporting the intent of the survey to convey significant leadership perspective on this issue. The number of responses coming from individuals that actually had the words "patient experience" in their title represented 9% of the responses. Peers of this role in service excellence, customer service or patient advocate roles comprised another 5% (See Figure 2).
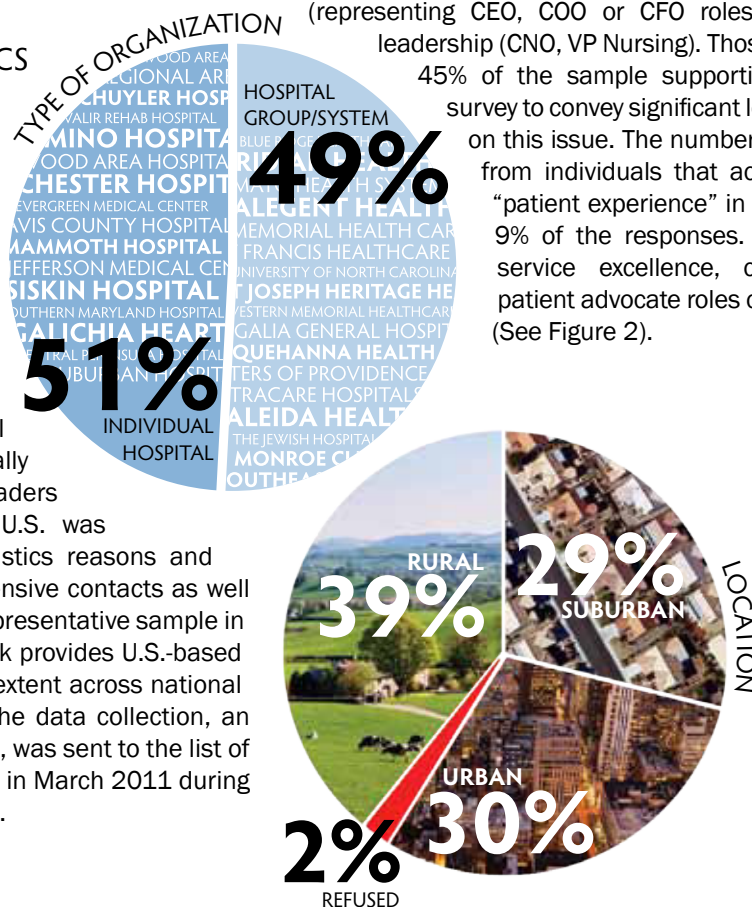

TYPE OF ORGANIZATION

HOSPITAL GROUP/SYSTEM **49%**

INDIVIDUAL HOSPITAL **51%**

RURAL **39%**
SUBURBAN **29%**
URBAN **30%**
REFUSED **2%**
LOCATION

The numbers raise another issue that can be interpreted from this data; there are still a relatively small number of individuals with a committed title and focus on the patient experience. This is not to suggest other leadership roles may not have some accountability for this issue, but it suggests that focus on the patient experience is still often diffused among other competing priorities. This potential is supported later in the data by the second greatest roadblock to patient experience success, leaders with accountability for the patient experience being "pulled in too many directions." This presents a significant challenge from the start as hospitals look to address the patient experience, especially since it is an issue they deem to be a significant priority.
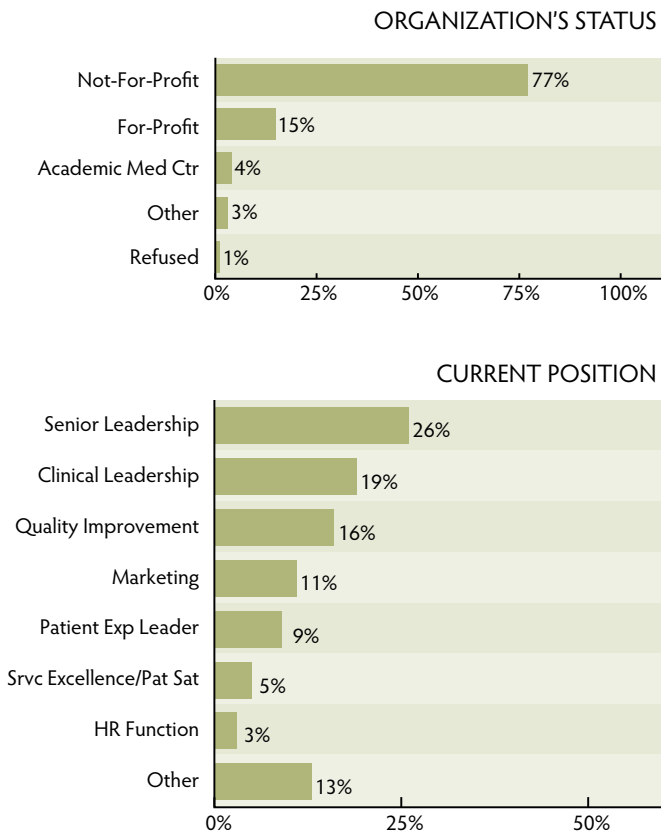
PATIENT EXPERIENCE IS A
TOP PRIORITY

This study is not the first to make this determination, but it is the first to substantiate previous assertions with such a rigorous sample. Without question, patient experience is a top priority. While our question asked respondents to rank their top three out of 20 possible choices, three items clearly bubbled to the top. There were even some distinctions at this top level as well. In looking at the number one priority in the responses, Quality/Safety was ranked first 31% of the time. Patient Experience was ranked first a comparable 21% of the time (Figure 3). This ranking makes a great deal of sense from the perspective that without a safe and quality outcome, the concept of experience itself becomes much less important. By looking at it from the experience perspective, safety and quality could be considered an integral part of an overall patient experience.

Also of interest was the placement of cost reduction in the ranking. While this was the third highest item ranked as a top priority, it garnered only 9% of the responses. While this could have been influenced by the very nature of this study asking about patient experience from the outset, it is the dramatic drop from the second ranked patient experience to third ranked cost reduction that creates room for additional questions. Is there a shift in recognition that quality/safety and experience now have expanding financial significance? Is there a greater awareness of the impact these efforts can have on the bottom line and/or productivity and efficiency? Does the pending shift in reimbursement policy add an unspoken financial consideration to the other priorities that cannot be flushed out with greater clarity?

In examining the percentage of responses in the top three overall, patient experience/satisfaction appeared in 64% of the responses with quality/safety in 58%. The data shows patient experience capturing a slightly larger portion of the overall priorities, primarily due to its high rankings as a second and third priority. The implications of this finding have yet to be seen, but seem to be represented in further discoveries in the data discussed below. There is a strong bias for action in addressing the patient experience, yet a lack of clarity about what those actions are attempting to address.

ORGANIZATION'S STATUS

Not-For-Profit	77%
For-Profit	15%
Academic Med Ctr	4%
Other	3%
Refused	1%

CURRENT POSITION

Senior Leadership	26%
Clinical Leadership	19%
Quality Improvement	16%
Marketing	11%
Patient Exp Leader	9%
Srvc Excellence/Pat Sat	5%
HR Function	3%
Other	13%

PLEASE RANK YOUR ORGANIZATION'S TOP 3 PRIORITIES FOR THE NEXT 3 YEARS

	#1	#2	#3
Quality/Patient Safety	31%	16%	11%
Patient Exp/Satisfaction	21%	28%	15%
Cost Reduction	9%	7%	8%

LEADERS FEEL THEY ARE MAKING

POSITIVE PROGRESS TOWARD IMPROVEMENT

AT THIS POINT, HOW DO YOU **FEEL** ABOUT THE PROGRESS YOUR ORGANIZATION IS MAKING TOWARD IMPROVING "PATIENT EXPERIENCE?"

Very Positive	25%
Positive	61%
Neutral	12%
Negative	2%
Very Negative	0%
Don't Know	1%
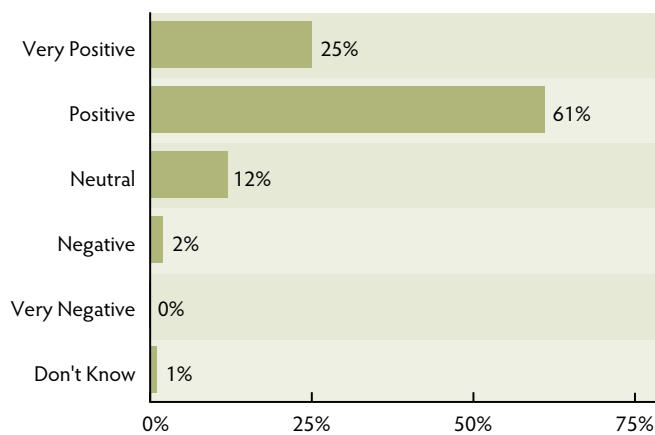
The possibility discussed above can also be seen in the overall feeling of respondents that positive actions were being taken to address the patient experience. The data in its raw form reflected that 86% of those surveyed had a positive perspective on the progress made toward improving the patient experience (Figure 4).

More importantly than the rationale, people generally feel positive about their efforts. The way in which the 86% with positive perspective was broken down also has some potential implications. While a majority (61%) rated their progress as positive, significantly lower numbers (25%) felt very positive about their progress.

Only one in four are feeling as if they are making very positive strides. On the other hand, over one in ten are not sure or negative about making progress at all. These results suggest that respondents recognize that there is still more that can be done. This perspective can be seen as potentially embedded in the next set of questions – how patient experience is defined and addressed in organizations today.
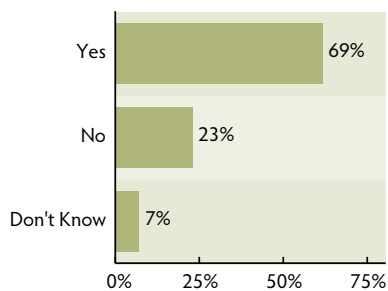
FIGURE 5.
DEFINITION, STRUCTURE
AND MANDATE

DOES YOUR
ORGANIZATION HAVE
A **FORMAL DEFINITION**
OF "PATIENT EXPERIENCE?"

Yes	27%
No	58%
Don't Know	15%

0%   25%   50%   75%
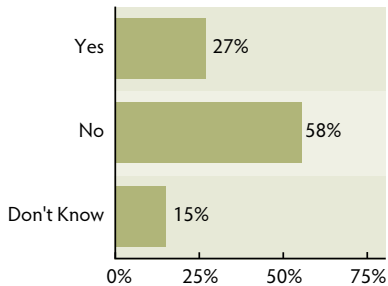
DOES YOUR
ORGANIZATION HAVE
A **FORMAL STRUCTURE** FOR
ADDRESSING "PATIENT EXPERIENCE?"

Yes	69%
No	23%
Don't Know	7%

0%   25%   50%   75%

DOES YOUR
ORGANIZATION'S "PATIENT
EXPERIENCE" EFFORT HAVE
A **FORMAL MANDATE/MISSION**?

Yes	58%
No	31%
Don't Know	11%

0%   25%   50%   75%
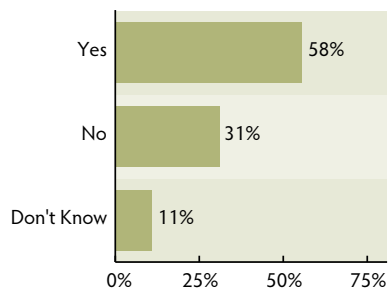
WHILE A BIAS FOR ACTION EXISTS,
PATIENT EXPERIENCE REMAINS LARGELY UNDEFINED

While recognizing the patient experience is both seen as a priority and making progress toward improvement, the next set of questions provided both an interesting and disturbing discovery. With the acknowledgement of patient experience as a top priority the data shows that healthcare organizations have made some positive strides towards action. First, a significant number (69%) of those surveyed reported having a formal structure in place to address the patient experience.

While almost seven in ten have a structure, only 58% of those surveyed said they had a formal mandate to address patient experience. This data represents a clear desire to put something in place (formal structure) to address patient experience even more than being clear on what that structure will do. This could very well equate to the number of those relating positive progress, but not very positive. There is a clear bias for action, with a slightly less clear purpose for

that action. Could this mean that some are addressing patient experience simply because they think they are supposed to?

The most compelling (and potentially alarming) finding in this set of questions was that while there was bias for action in structure and mandate, only 27% of respondents said they had a formal definition for patient experience. Just slightly over one in four of all U.S. hospitals based on this data have defined what patient experience is, yet many of them are working to address "it" and even have positive feelings of progress. In contrast, 58% responded that they did not have a definition and 15% of respondents did not know whether their organization had a formal definition at all. Even if these organizations did have a definition, the fact that the respondents did not know what it was is not a good sign, especially in considering the priority that organizations are now giving to the patient experience (Figure 5).

If hospitals do not have (or do not know) the definition of patient experience, i.e., what they are trying to address and improve, how will they know (1) they are focusing on the right thing, (2) they are moving in the right direction, or (3) if they made any progress towards what they wanted to achieve, let alone ever achieve it?

A Critical Opportunity: Clarity Before Action Experience

The data reveals a critical opportunity and a potential concern in our patient experience efforts. First, we must work to define what we are attempting to improve before simply moving to action. We would not shoot a bow and arrow in the dark if we could not see or did not know our target. Based on this, we reiterate the consideration of a shared definition of patient experience, as framed by The Beryl Institute. As noted above, we encourage the adoption (or adaptation) of a common language to which we can speak and build solutions to support the improvement of patient experience.

A COMMITTEE STRUCTURE IS THE MOST
PREVALENT WAY PATIENT EXPERIENCE IS BEING ADDRESSED

Based on survey responses, the overwhelming choice of structure in addressing patient experience is through committee. 42% of respondents identified a committee as "who" in their organization that has primary responsibility and direct accountability. In the second spot and a great deal behind the committee was a CEO/COO role at 14%, following by Patient Experience Leaders or Service Excellence Directors at 13% and 10% respectively (Figure 6).

Beneath the committee accountability, the disbursement among direct roles is clustered in the lower end of the responses, from a high of 14% for CEO/COO to a low of 6% for both CNOs and Quality Leaders. The challenge for these leadership roles (i.e. CEO, CNO, COO or Quality Leader), is that by their very nature they carry other responsibilities outside of patient experience; while not specified in the data directly, it suggests that their ability to focus on patient experience efforts would be limited by competing priorities. Based on an earlier study and white paper from The Beryl Institute, it is clear that organizations with a distinct leader and definitive time to commit to the patient experience tended to lead to better outcomes in both HCAHPS and internal satisfaction surveys (The Four Cornerstones of an Exceptional Patient Experience, The Beryl Institute, 2010).

A baseline established in this study is that just under 25% of the responsibility and accountability for patient experience outcomes now rests with a patient experience leader or service excellence director. More specifically, 13% of those actually accountable are now individuals with "patient experience" in their title. It will be interesting to follow the trend of where accountability rests for patient experience outcomes with the increasing profile of this issue and pending pressure of emerging government policy.

The survey questions also led to a deeper exploration of the committee structure and process. While addressing issues in healthcare with a committee process is not new, this model presents particular challenges in addressing the complexities of patient experience. Based on the data, committees most often tend to be small to moderately in size with 53% consisting of fewer than 11 people. On the other extreme, 25% of committees actually have 16 or more people, with 11% of that total actually reported to include 21 or more people. The study did not determine the make-up of these groups (Figure 7).

For 57%, their committee met once per month. While the data did not show if these primarily monthly committees had subgroups that met more regularly, the improvement opportunities available to a group that meets only 12 times in a year could be potentially limited, both by time together and by what happens in the gray space in between.

While the "how" patient experience is addressed can have an impact on overall efforts, the "what" healthcare organizations choose to focus on is equally revealing. The next question asked respondents to list their top priorities for improving experience.

FIGURE 6.
COMMITTEE STRUCTURE
LEADS PRIMARY RESPONSIBILITY

WHO IN YOUR ORGANIZATION HAS THE **PRIMARY RESPONSIBILITY AND DIRECT ACCOUNTABILITY** FOR ADDRESSING "PATIENT EXPERIENCE?"
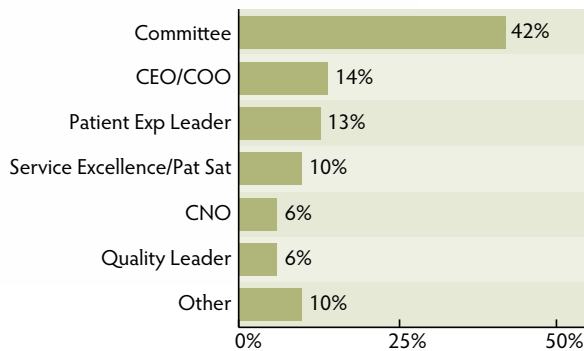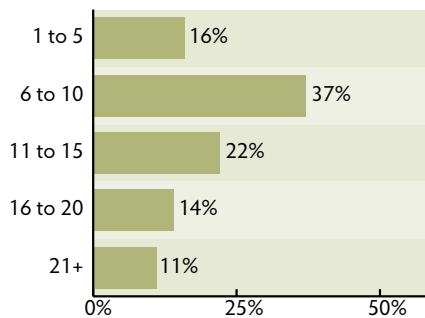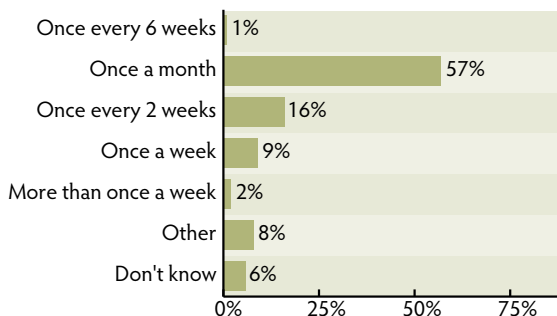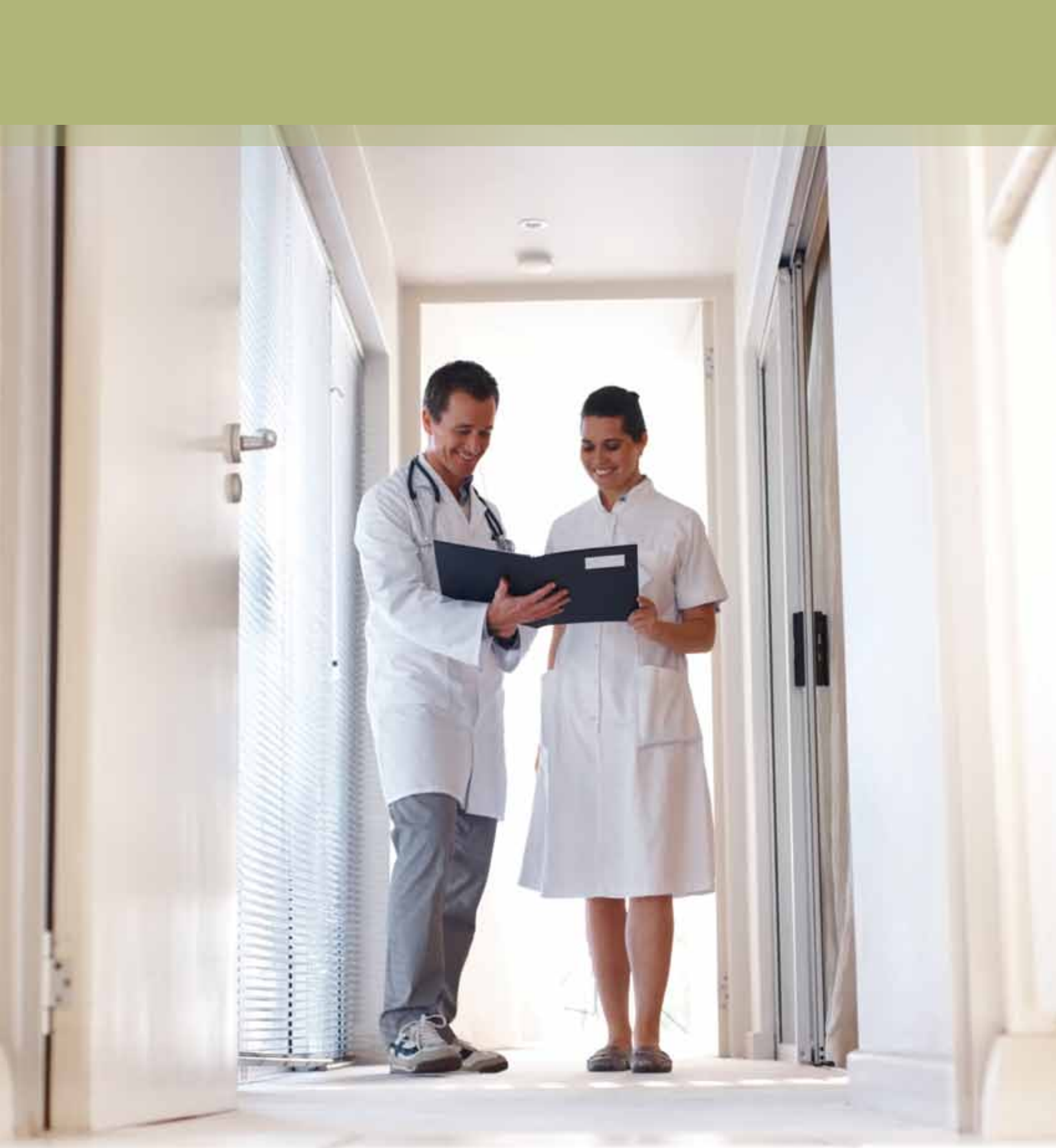
Committee	42%
CEO/COO	14%
Patient Exp Leader	13%
Service Excellence/Pat Sat	10%
CNO	6%
Quality Leader	6%
Other	10%

0% 25% 50%

FIGURE 7.
COMMITTEE STRUCTURE
AND PROCESS

HOW **MANY PEOPLE** ARE ON THIS COMMITTEE?

1 to 5	16%
6 to 10	37%
11 to 15	22%
16 to 20	14%
21+	11%

0% 25% 50%

HOW **OFTEN** DOES THIS COMMITTEE USUALLY MEET?

Once every 6 weeks	1%
Once a month	57%
Once every 2 weeks	16%
Once a week	9%
More than once a week	2%
Other	8%
Don't know	6%

0% 25% 50% 75%

Organizations with a distinct leader and definitive time to commit to the patient experience tend to lead to better outcomes in both HCAHPS and internal satisfaction surveys.

TOP THREE PRIORITIES IN ADDRESSING THE PATIENT EXPERIENCE REVEAL

A TACTICAL APPROACH

To get a clear sense of what healthcare organizations were undertaking to improve the patient experience, the survey asked respondents to list their organization's top three priorities. This item was an open-ended question where individual responses were reviewed and grouped into the most frequent themes. No coaching was given on the response suggesting they list strategies, tactics or outcomes, which is why in reviewing the responses you will see a combination of the three. The word cloud that resulted (Figure 8) 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.
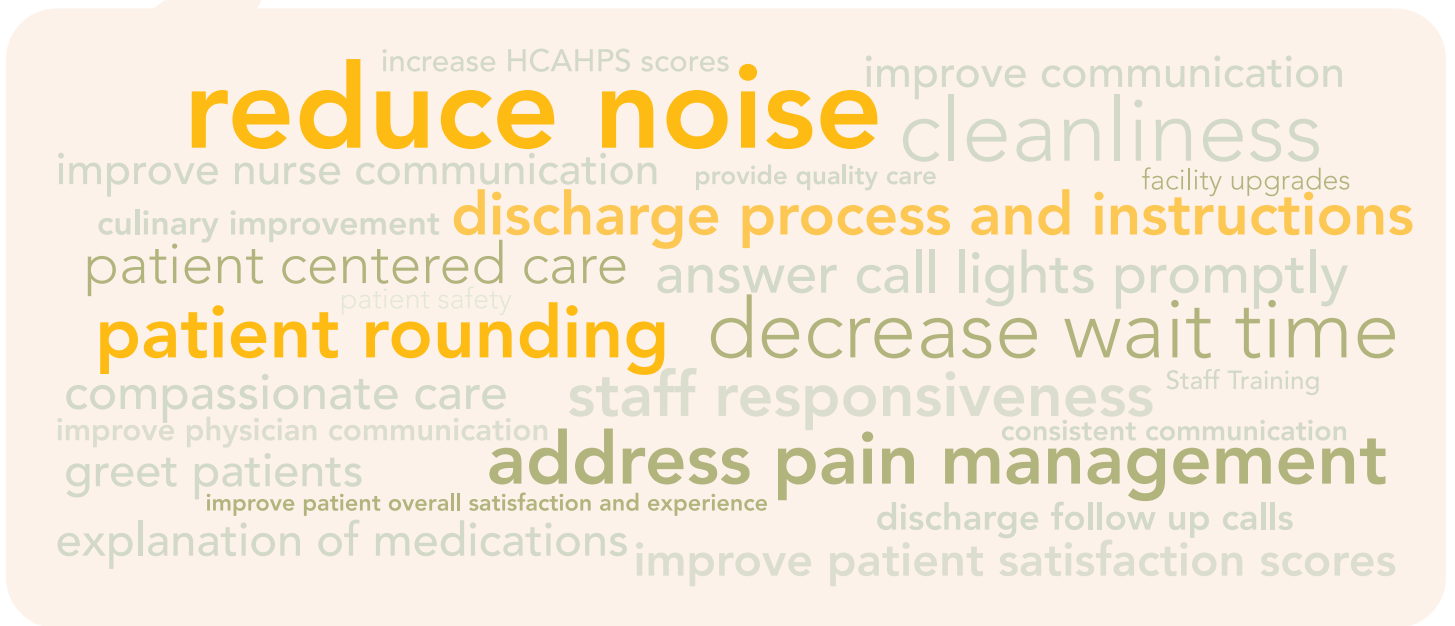
The top three overall priorities identified were quite tactical and tangible in nature, and included:

- Reduce Noise
- Discharge Process and Instructions
- Patient Rounding

While the first item – reduce noise – represents an outcome, there are specific tactics that can be associated with accomplishing this outcome. Discharge process and instructions and patient rounding are also processes that can be designed for tactical implementation. This is not reported as a positive or negative result, but rather based on the data that American hospitals are currently looking for specific "things" they can do to address and improve patient experience.

While the survey did not delve into the "why" these were a priority, a few possibilities are evident. Being tangible activities, they are easier to identify and act upon. In addition, the first two items – noise and discharge instructions – are directly related to questions asked on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The third item, rounding, has been associated through both popular literature and research to have impact on satisfaction and HCAHPS scores as well.

FIGURE 8.
TOP THREE PATIENT EXPERIENCE PRIORITIES

WHAT ARE YOUR ORGANIZATION'S **TOP THREE PRIORITIES** FOR IMPROVING THE "PATIENT EXPERIENCE?"

increase HCAHPS scores   improve communication

reduce noise   cleanliness

improve nurse communication   provide quality care   facility upgrades

culinary improvement   **discharge process and instructions**

patient centered care   answer call lights promptly

patient safety

patient rounding   decrease wait time

compassionate care   **staff responsiveness**   Staff Training

improve physician communication   consistent communication

greet patients   **address pain management**

improve patient overall satisfaction and experience

explanation of medications   discharge follow up calls

improve patient satisfaction scores

While the top three items were process-based tactics, the next item – staff responsiveness – begins to touch on the behavioral side of patient experience improvement efforts in healthcare organizations. Whether the priorities are processes, behavioral, or more conceptual such as patient-centered care or outcomes-oriented like increasing scores, there needs to be some means by which they are addressed and/or implemented. This led us to ask, beyond priorities, what the key components are of our respondents patient experience efforts in order to address these priorities.

The headline for the response to this question is that there are many activities taking place to address patient experience in American hospitals. A majority of healthcare organizations have structures and mandates, and they have a clear bias for action. This is supported by the responses to the question on key components.

A key group of activities emerged in the responses to what is being used to address patient experience priorities. Consistent with the improvement priorities, these components took on a tactical nature and supported the areas that seem to be most prevalent in patient experience efforts based on the priority responses above.

Most respondents (87%) identified staff training as the top action. When reviewing the priority word cloud this makes good sense, since much of what is being identified for action requires the development of new skills or behaviors. The next three items, continue to support a tactical approach in addressing our patient experience needs, including the use of follow-up phone calls (78%), service recovery programs (76%) and the use of performance scorecards (75%) (Figure 9).

In the fifth item – process review and design – a suggestion of systemic and strategic action in concert with tactical efforts is clear in the data. Based on what the survey results have shown, with a bias for action, a broader committee focus and a lack of definition, the U.S. Hospital System acts with greatest energy in addressing the items it knows it can. The data shows hospitals are less likely to act at a broader organizational or systemic level. This does not mean it is not part of the plans, as the responses do not indicate this one way or the other. It does show hospitals working hard to get their arms around what they can do to make improvement and feel positive about their efforts. This is a positive baseline as organizations continue to examine the progress of these efforts at the national level. It also leads to the question, what is ultimately supporting our success and what might be in the way of taking these next steps?

FIGURE 9.
KEY COMPONENT OF PATIENT EXPERIENCE EFFORT

WHICH OF THE FOLLOWING, IF ANY, ARE **KEY COMPONENTS** OF YOUR ORGANIZATION'S "PATIENT EXPERIENCE" EFFORT?

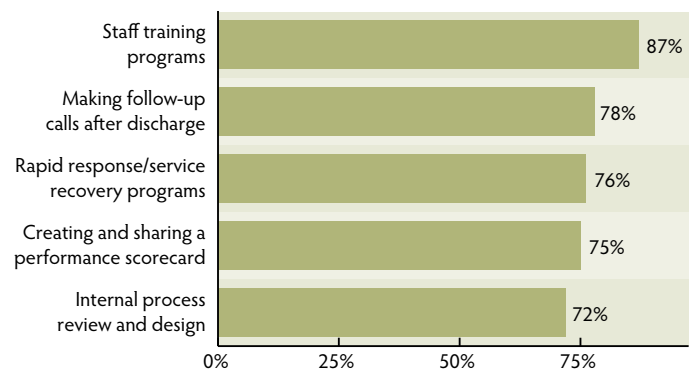| Component	Percent
Staff training programs	87%
Making follow-up calls after discharge	78%
Rapid response/service recovery programs	76%
Creating and sharing a performance scorecard	75%
Internal process review and design	72%

0%   25%   50%   75%

FIGURE 10.
DRIVERS AND ROADBLOCKS

STRONG LEADERSHIP SUPPORTS,
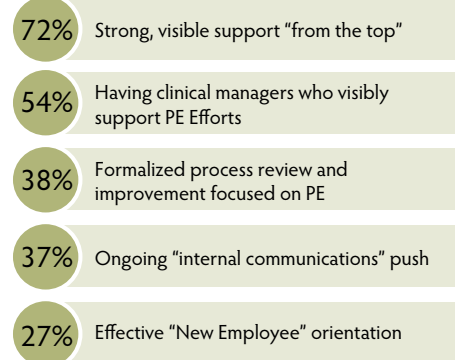## WHILE CULTURAL RESISTANCE IMPEDES IMPROVEMENT

While understanding the what, how and why around patient experience is key to the ability to best address this issue and take the most effective steps towards improvement, it is important to have a realistic understanding of what supports and what impedes progress.

For drivers of success, the two key items that emerged were both based on leadership support (Figure 10). The top item, strong, visible support "from the top," was significantly higher at 72% than all other responses. The second item touched on the clinical level – having clinical managers who support patient experience efforts – with a 54% response. The data shows that leadership is key to making progress with patient experience efforts.

For roadblocks, the top item identified in the data is cultural resistance. This is significant in that this resistance to doing things differently can potentially impede the very changes needed to make patient experience improvements. The next two items are closely packed at 40% and 39%, and both represent a story in the data about multiple priorities. The first, the leader appointed to drive patient experience being pulled in too many other directions, is significant and has implications for data revealed earlier about who owns patient experience improvement – is it a committee or an individual with multiple responsibilities? These all become considerations as organizations look to improve patient experience. The third item is closely linked as it addresses the issue of competing priorities reducing emphasis on patient experience. While patient experience is clearly an identified priority, based on the data it is still at risk of getting lost in the multiple efforts we take on daily in healthcare.

In understanding supports and obstacles, priorities and processes to achieve them, and clarity on where hospitals are going, the survey responses begin to tell a story that can help focus patient experience efforts. Yet it leaves one last question – how do organizations measure success and incent effective action?

DRIVERS OF SUCCESS

%	
72%	Strong, visible support "from the top"
54%	Having clinical managers who visibly support PE Efforts
38%	Formalized process review and improvement focused on PE
37%	Ongoing "internal communications" push
27%	Effective "New Employee" orientation

ROADBLOCKS

%	
50%	General cultural resistance to doing things differently
40%	Leaders appointed to drive PE are pulled in too many other directions
39%	Other organizational priorities reduce emphasis on PE
25%	Lack of support from physicians
23%	Lack of sufficient budget or other necessary resources

ASIDE FROM TRACKING THE SUCCESS OF
INDIVIDUAL IMPROVEMENT ACTIVITES, WHAT
METRICS IS YOUR ORGANIZATION USING TO
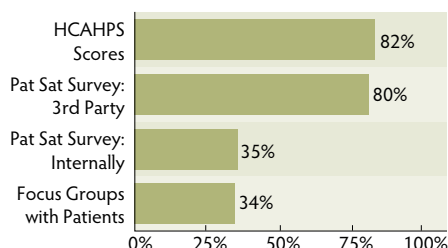MEASURE **OVERALL IMPROVEMENT**
IN THE "PATIENT EXPERIENCE?"

Metric	Percentage
HCAHPS Scores	82%
Pat Sat Survey: 3rd Party	80%
Pat Sat Survey: Internally	35%
Focus Groups with Patients	34%

0%   25%   50%   75%   100%

ARE THERE ANY "CONSEQUENCES"
ASSOCIATED WITH THE RELATIVE DEGREE
OF SUCCESS ACHIEVED AROUND
THE "PATIENT EXPERIENCE?"

15% Said PE Efforts are tied to
Individual Performance Reviews
(but not formally to bonuses)

· "Patient satisfaction can affect
annual evaluations."

· "It is part of everyone's evaluation."

· "Consequences are tied to
performance reviews. There are
no monetary bonuses or penalties."

45% Reported **bonuses and
incentives** being tied to
PE scores and measures

· "Incentives are given based on
Patient Satisfaction scores."

· "There are consequences related
to yearly bonuses."

· "We have an Employee Incentive Plan
that is 100% driven off of patient
experience scores."

MEASUREMENT FOLLOWS TRADITIONAL FORMS WHILE

INCENTIVES ARE NOW PART
OF THE EQUATION

For all the data revealed about action and process, the question was posed, how do organizations know they are achieving success in improving patient experience? This might be the trickiest question of all, especially considering the data shows almost three out of four organizations had no formal definition of patient experience. How can you measure something you don't define? Also, this could be why when looking at the responses to this question, that the primary modes of measurement are HCAHPS scores and third-party patient satisfaction measures. While the respondents were not asked why these measures were primary, the responses supporting these two methodologies stand out (Figure 11). Also with the data showing patient experience priorities align with specific HCAHPS domains, the HCAHPS survey could serve as an effective measure for progress on these items. This leads to one final question, are there opportunities to define new measures in the effort to improve patient experience?

Lastly, respondents were asked, how, if at all, they used incentives in their organizations to support patient experience efforts. The data revealed that to support a consistent focus, many organizations are linking improvements in patient experience to performance reviews. About 60% of respondents reported that achieving progress toward patient experience goals carried financial consequences either in performance reviews or bonus pay (Figure 12).

SUMMARY

THE STATE OF PATIENT EXPERIENCE
IN AMERICAN HOSPITALS

The intention of this study was to provide a clear snapshot on the state of patient experience in the U.S. hospital system and to benchmark and acquire a baseline for driving patient experience efforts across the country. The questions were designed to dig at the heart of the issues across the spectrum of what it is, why it is important, who is leading it and how efforts are moving forward to improve patient experience.

The study offers a realistic and grounded sample, the largest to date collected on this topic, and one clearly representative of the system the research looked to explore. More importantly, the respondents provided valuable insights and helped frame a picture of where opportunities exist and the challenges that must be addressed. Ultimately it reinforced that patient experience is a top priority and our healthcare system is still working hard to determine the most effective way to drive improvement.

The headlines, while at first glance may not be shocking, in many ways they were. They uncover conflicts between the importance of and the willingness to define this issue. They pose questions on commitment and focus in tackling what is a clearly identified priority. They expose the opportunities and challenges that must be addressed to ensure a better experience overall for patients, families and communities.

The last point listed is important (See The responses of almost 800 healthcare leaders, left), as the snapshot provided through this research is about the state of patient experience in the entire U.S. Hospital System. It begs us to think systemically about how we address this issue, not only in our own facility, network or system, but also at the macro level about how we collectively contribute to improving patient experience overall. Our commitment at The Beryl Institute remains that by bringing together the community of practice (both at a national and international level) and providing the venues for not just learning, but interactions and sharing, we break down barriers to success and expose new paths to improvement. The patient experience does not belong to any one organization. Rather it should be the commitment of everyone that touches healthcare.

The responses of almost 800 healthcare leaders show that:

- Patient experience is a top priority
- Leaders feel they are making positive progress towards improvement
- While a bias for action exists, patient experience remains largely undefined
- A committee structure is the most prevalent way patient experience is being addressed
- The top three priorities in addressing the patient experience reveal a tactical approach
- Strong leadership supports, while cultural resistance impedes improvement
- Measurement follows traditional forms with incentives now part of the equation
- While tactical change is underway, there is not yet collective movement to address patient experience at the systemic level

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From scheduling processes and first impressions to back end collections and follow-up communications, understanding the potential impact of every point along the care continuum is crucial. This paper explores the often overlooked importance of effectively managing the revenue cycle, not from solely a financial management perspective, but from the true role effective revenue cycle processes can play in ensuring an unparalleled experience for patients.

ENHANCING THE PATIENT EXPERIENCE
THROUGH THE USE OF INTERACTIVE TECHNOLOGY

One significant trend in providing exceptional patient experiences is the use of interactive technology. This paper highlights the benefits of using interactive technology and provides six case studies that quantify significant patient satisfaction improvements and impact on HCAHPS scores.

SEPTEMBER/OCTOBER 2010
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This paper highlights the results of two new surveys that illuminate the importance of the patient experience and describes the components of a successful service culture. Characteristics of top performers are detailed followed by case studies that illustrate service excellence.

OCTOBER 2010
INSIGHTS INTO THE PATIENT EXPERIENCE –
RESEARCH BRIEF

In spring of 2010, The Beryl Institute surveyed its members to learn what patient experience efforts they had implemented within their organizations. The result gave important insights into the priorities of and challenges facing organizations working to tackle this critical issue. To see the latest data on challenges and opportunities in addressing the patient experience download this brief.

JULY/AUGUST 2010
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VIEWS AND VOICES FROM THE FRONTLINES

Executives from The Beryl Institute hosted three patient experience leaders in a roundtable discussion on improving the patient experience. These patient experience champions come from varied backgrounds, but they bear one strong similarity – a passionate commitment to creating exceptional experiences for patients, patient families and friends. In this paper they share the opportunities and challenges as they commit to improving how patients connect with their organizations.

FEBRUARY 2010
PERSPECTIVES ON A
PATIENT-CENTERED ENVIRONMENT

The Beryl Institute partnered with Sodexo, Inc. to release the white paper, "Perspectives on a Patient-Centered Environment." This healthcare industry focused paper explains how increasing employee engagement is the cornerstone for creating a patient-centered environment. When employees are engaged, they live the organization's mission, vision and purpose. They strive for the organization to succeed, and therefore, are more willing to do whatever it takes to meet customer expectations. The white paper includes three case studies that explore the connection between engaged employees and patient-centered care, the keys to creating an engaged workforce and drivers of employee satisfaction.

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