PATIENT EXPERIENCE:
Cultural Transformation to Move Beyond HCAHPS
NEW REPORT reveals how a growing number of patient experience programs have moved beyond focusing primarily on training nurses to also include physicians and a host of nonclinical staff.

- Discover how the Cleveland Clinic’s REDE training program has increased CG-CAHPS outcomes, resulting in doctor communication scores rising from the 46th to the 99rd percentile.
- Find out how Carolinas Healthcare is targeting patient experience performance in specific service areas by using a process improvement effort based on Lean fundamentals.
- Find out how Sharp Healthcare’s “The Sharp Experience” program is complemented by Planetree designation efforts.

For more information or to purchase this report, go to HealthLeadersMedia.com/Intelligence or call 800-753-0131. Reference promotion code upon ordering.
About the Premium Edition

This is a summary of the Premium edition of the report. In the full report, you’ll find a wealth of additional information. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

In addition to this valuable survey data, you’ll also get the tools you need to turn the data into decisions:

- A Foreword by Adrienne Boissy, MD, MA, chief experience officer for Cleveland Clinic, and lead advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Carolinas HealthCare in Charlotte, North Carolina; Sharp HealthCare in San Diego; and Cleveland Clinic in Ohio
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team
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**Recommendations**

**Meeting Guide**
Methodology

The 2015 Patient Experience Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In May 2015, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 341 completed surveys are included in the analysis. The margin of error for a base of 341 is +/-5.3% at the 95% confidence interval.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

Adrienne Boissy, MD, MA
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Ohio

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Carolinas HealthCare
Charlotte, North Carolina

Mike Murphy
President and CEO
Sharp HealthCare
San Diego

UPCOMING INTELLIGENCE REPORT TOPICS

SEPTEMBER
Physician-Hospital Alignment

OCTOBER
Population Health Management

NOVEMBER
Executive Compensation

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.
Respondent Profile

Respondents represent titles from across the various functions at hospitals, health systems, and physician organizations.

**Title**

- **Senior leaders**: 37%
- **Clinical leaders**: 30%
- **Operations leaders**: 24%
- **Financial leaders**: 6%
- **Marketing leaders**: 2%
- **Information leaders**: 1%

**Type of organization**

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**Number of beds**

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<td>49%</td>
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<td>200–499</td>
<td>34%</td>
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<td>500+</td>
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**Number of sites**

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<td>6–20</td>
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<tr>
<td>21+</td>
<td>50%</td>
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**Number of physicians**

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<td>12%</td>
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<tr>
<td>10–49</td>
<td>37%</td>
</tr>
<tr>
<td>50+</td>
<td>51%</td>
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**Region**

- **WEST**: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
- **MIDWEST**: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin
- **SOUTH**: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware
- **NORTHEAST**: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

**Senior leaders** | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, President, Chief of Staff, Chief Information Officer, Chief Nursing Officer, Chief Medical Information Officer

**Clinical leaders** | Chief of Cardiology, Chief of Neurology, Chief of Oncology, Chief of Orthopedics, Chief of Radiology, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Inpatient Services, Dir. of Intensive Care Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MDI), VP Nursing

**Operations leaders** | Chief Compliance Officer, Chief Purchasing Officer, Audt. Administrator, Chief Counsel, Dir. of Patient Safety, Dir. of Purchasing, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/ Administration, Other VP

**Financial leaders** | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Patient Financial Services, Director of RAC, Director of Reimbursement, Director of Revenue Cycle

**Marketing leaders** | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

**Information leaders** | Chief Technology Officer, VP/ Dir. Technology/MIS/IT
Changing Organizational Culture to Support Patient Experience Excellence

Over the years, the healthcare industry has relied upon continuing medical education and training to enhance the knowledge and skills of clinicians and, ultimately, to improve clinical outcomes, but using such a disciplined approach to improve patient experience is relatively new for many organizations. As the relationship between clinical outcomes and patient experience has become more established, a growing number of patient experience programs have moved beyond focusing primarily on training nurses to also include physicians and a host of nonclinical staff who serve in a variety of front- and back-office roles.

Perhaps one of the more visible signs of the degree to which organizations are embracing patient experience is the increased presence of a chief experience officer (or individual with similar responsibilities) on the senior leadership team (Figure 4). This year, 40% of respondents say their organization has one, up from 30% last year, and another 10% say they will add such a position within the next three years (Figure 5). Having a dedicated C-suite executive driving an organization’s patient experience effort is an important step toward solving one of the key challenges for healthcare organizations: How does one change the organizational culture such that patient experience excellence is embraced by all employees?

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders regarding how growth in retail clinics and consumer-focused outpatient locations will impact their organization’s patient experience programs and initiatives.

“I expect growth in retail clinics to impact low-acuity visits to our emergency department. Like many EDs, we already offer a fast-track option for these patients. The introduction of retail clinics will push us to provide these services in a more cost-effective and even more time-efficient manner.”
—CEO at a medium health system

“Specialty hospitals and organizations with limited or single focus can always outperform more complex organizations. We risk having profitable business siphoned off and receiving the leftovers.”
—Chief financial officer at a large health system

“The commercial and retail clinics may help to decompress our ED but will not replace the care our organization provides. We have diversified and increased market presence through a series of initiatives.”
—Director of clinical services at a medium health system

“Their ability to be nimble and responsive to the consumer is likely to draw patients away from our facility. We will need to not meet but exceed expectations in other areas to retain them.”
—Vice president of patient experience at a large health system

“These types of organizations skim off very targeted groups of patients by focusing only on that type of patient, so it is very easy for them to achieve a high rate of satisfaction. Hospitals must deal with a much broader scope, so have more challenges in addressing satisfaction goals.”
—Chief financial officer at a small hospital
Patient satisfaction: Delivering what the patient values? Patient satisfaction is a core aspect of patient experience (Figure 1); cited by 93% of respondents, it tops the list of main concepts incorporated into an organization’s patient experience program or initiative, followed by HCAHPS or other CMS survey metrics (79%), patient safety (79%), and clinical quality (78%). Interestingly, responses for delivering what the patient values (51%) place it well down the list, indicating that, at least for now, there is a disconnect between the providers' view of patient satisfaction and what the patient actually values.

Adrienne Boissy, MD, MA, is chief experience officer at the Cleveland Clinic, a nonprofit academic medical center and multisite healthcare delivery system based in Ohio, and the lead advisor for this Intelligence Report. She says that the key to patient satisfaction is the physician-patient relationship.

“There’s been a very important shift in how providers are relating to patients, and [in] their thinking about their role and the patient’s role. We [as an industry] used to be doctor-centered, and now we’ve swung way over [to] patient-centered, and I think in the middle is relationship-centered care. Recognizing that both people have value, both people influence each other, and then trying to leverage and optimize that relationship such that you're designing a care path that guides patients toward better health is the way to go.”

While there is widespread recognition that following HCAHPS metrics alone won’t lead organizations to patient experience excellence, the reality is that HCAHPS plays a central role in setting clear and measurable goals for healthcare organizations, and this simplifies patient satisfaction monitoring. At some point, however, the more difficult task of understanding the patient’s perspective of value must come into play.

Improvement areas to meet patient experience goals. Although there is a high degree of focus on patient satisfaction, cited by 93% as a key concept of patient experience programs (Figure 1), we also see that 68% of respondents say there is room for improvement in that regard (Figure 2). The same is also true for HCAHPS or other CMS survey scores (67%), which finishes a close second to patient satisfaction. Only 9% of respondents listed staff satisfaction among the top three areas in which their organization seeks improvement in an effort to meet patient experience goals.
Mike Murphy, president and CEO of Sharp HealthCare, a nonprofit healthcare system serving Southern California, says that staff satisfaction is a critical aspect of providing a good patient experience. “Our vision statement talks about Sharp being the best place to work, the best place to practice medicine, and the best place to receive care. We intentionally talk about being the best place to work because we need to create an environment where our people are happy working and doing great things and focused on making the difference for our patients.”

Boissy says that the link between patient satisfaction and staff satisfaction is one of the most important in terms of fostering engagement and ultimately creating a culture of patient experience excellence, and that one really doesn’t really exist without the other in a successful program. “It’s kind of ironic that on one end of the scale in the survey results [Figure 2] you have patient satisfaction improvement ranked so highly and then at the very bottom it’s staff satisfaction. As providers we keep saying they’re linked, and how one drives the other. This gives us the opportunity to reflect on our practice and what we preach.”

**Measurement tools and social media.** While some organizations may complain about HCAHPS, one of the keys to improving a healthcare organization’s patient experience program is accurate and timely tracking of performance. HCAHPS or other CMS surveys (84%) remain at the top of the list of patient experience measurement tools (Figure 3) because they adequately fulfill the accuracy component, although they are not the timeliest of metrics. And, of course, such benchmarks also are a mandate for most organizations.

Note that interest in tracking and measuring patient experience activity using postdischarge telephone calls remains popular (Figure 3; 55% this year, nearly the same as last year’s 57%), and monitoring social media (30%, up from 22% in last year’s report) is growing as organizations seek to acquire more timely patient satisfaction data. Postdischarge calls also provide an opportunity to ensure that care coordination activities are taking place appropriately.

Murphy agrees that using social media to track patient experience is growing in importance because results can be accessed in real time, but he points out that it’s also an opportunity to be proactive. “We spend a
significant amount of time monitoring social media, and I get a report of
every comment that appeared in any social media site. Depending upon
the comments that are being made, we’ll reach out and talk to them
based on whether it’s a tweet or a Facebook posting and try to intervene.”

Connie Bonebrake, senior vice president and chief patient experience
officer at Carolinas HealthCare, a nonprofit healthcare system that
serves residents of North Carolina and South Carolina, says, “We have
a designated individual that monitors what is being said on sites,
such as Facebook and Twitter, and he literally responds immediately.
He’s constantly looking at what’s being said by individuals on social
media about us. And then, if the situation escalates, he sends it to my
department. I suspect many organizations are doing this and many more
will be.”

Training nurses and physicians. Nurses and patients are in frequent
contact, putting nurses in an important position to influence a patient’s
experience. Indeed, nurses (90%) are the top group targeted for patient
experience training to improve communication with patients (Figure
6). Interestingly, when respondents are asked about which HCAHPS
component they have the most difficulty with (Figure 13), responses
for nurses communicate well is just 4%, placing them at the bottom of
the problem list. Nurses are receiving training because of the critical
nature of their relationship with the patient, and that training, no doubt,
helps to keep nurse communication an aspect of HCAHPS surveys few
organizations are struggling with.

There is an emerging awareness, however, that physicians need patient
experience training as much as nurses do, because of the key role that
they play as care team leaders and the degree to which CMS surveys in
particular target their patient experience skills. In fact, respondents cite
physicians’ ability to communicate well with patients as the HCAHPS
component they have the most difficulty with (Figure 13), tied with
achieving a rating of 9 or 10 on a scale of 0 to 10 (16% each).

In this year’s survey, 74% of respondents say that they conduct patient
experience training with physicians to improve communication
with patients (Figure 6). Advisors note that mandatory training for
employed physicians has some complications—pulling physicians
out of clinics affects the bottom line—while training nurses is easier
because organizations have much more control over nursing schedules.
Perhaps because they are better able to absorb the costs, based on net
patient revenue, more medium (82%) and large (76%) organizations cite
physician training than small (67%) organizations.

Bonebrake notes that patient experience training for back-office staff
is increasingly a priority, given the changing financial dynamics of the
healthcare industry. More than one-third of respondents (38%) report
patient experience training with back-office staff. “I would imagine you’re going to see the numbers go up as we face a changing financial patient experience, because of high-deductible plans and the move toward greater personal responsibility for bills.”

**Patient experience improvement trends.** Survey respondents are evenly split as to where they plan on focusing their patient experience improvement efforts over the next three years (Figure 7). The top three areas are coordination inside your organization (53%), increased rounding (51%), and identifying concerns while a patient is still on-site (50%). Further, while the focus areas are in nearly the same order of response as in last year’s report, the response percentages themselves are much lower across the board. These results are an indication that it’s not any one area that drives patient experience, but the sum total of many different patient interactions. In other words, they are just a few of the many components that comprise an organization’s patient experience culture.

Similarly, when asked a follow-up question to single out the one area that would provide the biggest improvement (Figure 8), respondents listed the same items in nearly the same order as in Figure 7 and, again, with no dominant favorite. The top areas are care coordination inside your organization (21%), increased rounding (19%), and identifying concerns while a patient is still on-site (19%). While providers seem to have a clear idea of where they will generally focus their patient experience improvement activities, the relative parity among responses here indicates a lack of consensus as to which areas will produce the biggest patient experience improvement.

Murphy points out that patient experience improvement has to be viewed in the context of the entire enterprise. “It’s not one thing that’s going to increase patient experience in all our pillars—quality, safety, service, people, finance, growth, and community. It’s all of them.”

Respondents say that infrastructure improvements over the next three years (Figure 9) will focus on patient portals for medical records, appointments, etc. (77%), analytics supporting PE performance monitoring (55%), and facility upgrades (46%). Note that some of the high response overall for patient portals may be because it is a requirement of the stage 2 meaningful use EHR incentive program. Interest in facility upgrades may be part of an effort to improve HCAHPS
scores related to facility noise and cleanliness, which explains why hospitals (51%) and health systems (44%) are more focused on this element than physician organizations (27%).

**First impressions and patient experience.** While a positive patient experience is always desirable no matter where the patient interaction takes place, there are some areas that respondents view as more important than others (Figure 12). The top tier of patient experience areas are the emergency department (66%), inpatient rooms (52%), discharge and follow-up (51%), and outpatient/ambulatory visits (48%). Note that hospitals (75%) and health systems (67%) most often name the emergency department as the top area, but for physician organizations, it is outpatient/ambulatory visits (78%).

There is a certain logic behind the findings. Respondents understand that a positive experience in the ED helps patients form a first impression that is conducive to using other hospital services in the future. And because patients spend a lot of time in inpatient rooms, this offers ample opportunities to evaluate a room’s cleanliness and noise levels. Lastly, performing well at discharge and follow-up can also help reduce hospital readmissions and decrease negative patient experiences. All of these areas are critical to forming an opinion of an organization, and that opinion is likely to be passed on to others through either social media or word of mouth.

Murphy points out that outpatient/ambulatory visits (48%) receives a nearly identical response as inpatient rooms and discharge and follow-up, and that it belongs in the discussion. “I’d say outpatient/ambulatory visits are one of the key areas—we have probably close to 2 million visits in our outpatient areas annually. So if you can’t get that right, it’s going to impact how you retain patients and grow market share.”

While billing, collections, and insurance coordination (22%) receives only a moderate response, Boissy says respondents may be understating the importance of a positive experience in this area, especially given the amount of negative feeling that can be generated. “When I look at this, I feel like one of the biggest dissatisfiers for patients has to be around billing, collections, and insurance.”

**Chief experience officer role.** Certainly one of the more important pieces of the patient experience puzzle is having a chief patient experience officer on staff who can provide leadership and commitment to the

“We spend a significant amount of time monitoring social media, and I get a report of every comment that appeared in any social media site.”

—Mike Murphy
effort, which is sometimes missing in organizations.

As we have noted earlier, 40% of respondents say they have a chief experience officer or individual with similar responsibilities, up from 30% in last year’s report, and another 10% say they plan on adding one within the next three years (Figures 4, 5). But given that the top stumbling block to creating an effective patient experience program—cited by 34% of respondents (Figure 14)—is the difficulty changing organizational culture, it would make sense to have a chief experience officer dedicated to driving organizational change.

It is worth noting that, based on supplemental data segmentation not included in this report, 11% of respondents from organizations who have a chief experience officer say they have no stumbling blocks, compared to 3% of those from organizations without one. Similarly, in organizations with a chief experience officer, only 22% cite an abundance of other priorities, compared to 28% among those without that C-suite position. Still, the presence of the chief experience officer does not solve the issue of culture change; 39% of organizations with a chief experience officer and 31% of those without cite that as the biggest obstacle to creating an effective patient experience program.

Further evidence of the extent of the chief experience officer’s influence is found throughout the survey. For example, all of the responses for main concepts that have been incorporated into an organization’s patient experience program are higher for organizations that have a chief experience officer compared to those who do not. Likewise, respondents from organizations with a chief experience officer mention the top three infrastructure improvement focus areas more than organizations without one: patient portals for medical records (84% versus 73%), analytics supporting PE performance monitoring (61% versus 52%), facility upgrade (50% versus 43%), and devices for real-time patient feedback (38% versus 25%).

For all the positives, more than half of the respondents in our survey don’t currently have a chief experience officer, and of those, approximately half don’t plan on creating a position within the next three years (Figures 4, 5). There is much uncertainty on the issue, with 41% saying that they don’t know whether a position would be created within the next three years. All of this suggests that respondents are divided on whether a dedicated C-suite presence is needed, although there has been a steady but small growth in converts.

“I feel like one of the biggest dissatisfiers for patients has to be around billing, collections, and insurance.”

—Adrienne Boissy, MD, MA
Dealing with stumbling blocks. Advisors and respondents alike acknowledge that organizational culture is the biggest stumbling block for creating an effective patient experience program (Figure 14). The top two stumbling blocks are difficulty changing organizational culture (34%) and abundance of other priorities (26%); after that, the responses are bunched up in the 4%–7% range.

Interestingly, achieving organizational culture change is typically driven by senior leadership, yet only 6% of respondents say that lack of leadership commitment is the problem. Perhaps the answer may be found in the second highest stumbling block—abundance of other priorities (26%). The fact that the problem is not abundance of higher priorities (6%) indicates that healthcare CEOs must set the agenda for culture change and ensure that funding, resources, and commitment are present to back it up.

Boissy agrees there is a discrepancy. “I think it’s interesting that changing organizational culture is disconnected from leadership commitment. Isn’t lack of leadership typically the problem most organizations cite? The way to change culture is to get leadership buy-in and make sure your executive team is promoting it.”

The importance of culture can’t be overstated. Organizations can choose to function in a tactical way, responding to HCAHPS scores and creating targeted patient experience initiatives, or they can operate more strategically by focusing on organizational culture.

Says Boissy, “Some organizations pilot a bunch of initiatives around HCAHPS scores, and in some respects that’s good because people are trying to move the needle in a meaningful way. However, at the same time, I also see many organizations say, ‘You know what? We’re not going to teach to the exam anymore. We’re going to try to move our culture.’ I don’t know that one is right or wrong, but obviously I’m a bigger fan of moving the culture.”

“...We face a changing financial patient experience, because of high-deductible plans and the move toward greater personal responsibility for bills.”

—Connie Bonebrake
What are the top three areas in which your organization seeks improvement in an effort to meet your patient experience goals?

**FIGURE 2 | Improvement Areas to Meet Patient Experience Goals**

<table>
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<tr>
<th>Total responses</th>
<th>Patient satisfaction</th>
<th>68%</th>
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<tr>
<td></td>
<td>HCAHPS or other CMS survey scores</td>
<td>67%</td>
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<tr>
<td></td>
<td>Clinical outcomes</td>
<td>39%</td>
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<td></td>
<td>Patient safety</td>
<td>36%</td>
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<td></td>
<td>Patient engagement</td>
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<td></td>
<td>Staff engagement</td>
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<td></td>
<td>Reimbursement</td>
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<td></td>
<td>Market share</td>
<td>11%</td>
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<tr>
<td></td>
<td>Staff satisfaction</td>
<td>9%</td>
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Base = 341, Multi-Response

**TAKEAWAYS**

- Patient satisfaction (68%) and HCAHPS or other CMS survey scores (67%) are the leading improvement areas, eclipsing clinical outcomes (39%) and patient safety (36%) by a wide margin.

- A greater share of physician organizations (85%) cite patient satisfaction than hospitals (67%) and health systems (65%), and more hospitals (73%) cite HCAHPS or other CMS surveys than health systems (61%) and physician organizations (49%).

- Based on net patient revenue, more small organizations (77%) cite patient satisfaction than medium (64%) and large (60%) organizations.

- Overall, patient satisfaction (68%) has the highest response and staff satisfaction (9%) has the lowest.

**WHAT DOES IT MEAN?**

Although there is a high degree of focus on patient satisfaction as a key concept of patient experience programs (see Figure 1), healthcare organizations still indicate there is room for improvement. Respondents are clear on two of the top three areas in which they will seek improvement, but no other item is included among areas for improvement by more than 39%. While patient satisfaction is a priority for all organizations, staff satisfaction (without which patient satisfaction is unlikely) falls at the bottom of the list.

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