ABSTRACT

High patient satisfaction is not simply a customer service goal; it is an important dimension of quality and part of financial incentives and public reporting requirements. However, patient experience is often siloed within health system organizational charts and considered separately from quality and safety initiatives, instead of being seen predominantly as a “customer service” initiative. Representatives from 52 health care systems across the United States completed an online survey to explore both the processes and infrastructure hospitals employ to improve patient experience, and the metrics hospitals use
to assess the quality of patient experience beyond patient satisfaction survey data. When asked about performance metrics beyond satisfaction, most hospitals or systems noted other metrics of the entire patient experience such as the rate of complaints or grievances and direct feedback from patient and family advisors. Additionally, respondents suggested that a broader definition of “quality of the patient experience” may be appropriate to encompass measures of access, clinical processes, and quality of care and patient safety outcomes. Almost all respondents that we surveyed listed metrics from these less traditional categories, indicating that performance improvement within the patient experience domain in these organizations is linked with other areas of hospital performance that rely on the same metrics, such as clinical quality and patient safety.

**Keywords:** Patient experience; patient satisfaction, quality improvement, patient safety, quality indicators; quality; safety outcomes

**INTRODUCTION**

High patient satisfaction is not simply a customer service goal; it is part of financial incentives and public reporting requirements that are included in accreditation and pay-for-performance programs. Driven by these policy pressures, there have been significant improvements in US hospitals’ scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey between 2008 and 2011 (Elliott, Cohea, & Lehrman, 2015). As such, HCAHPS scores are positioned as the main indicator of the patient experience, and higher scores have been correlated with improved patient outcomes and hospital efficiency (Browne, Roseman, & Shaller, 2010; Doyle, Lennox, & Bell, 2013; Price, Elliott, & Zaslavsky, 2014; Tsai, Orav, & Jha, 2015; Wolf, 2015). Research continues to suggest that patient experience is an important dimension of quality (Doyle et al., 2013; Wolf, 2015). Moreover, the Beryl Institute, a leading force in the patient experience movement, proposes that patient experience encompasses quality, safety, service, cost, and outcomes (Institute TB, 2017), highlighting the importance of this topic.

Given this multidimensional definition of patient experience, leaders of the patient experience movement have advocated for viewing patient experience initiatives as a type of quality improvement (QI) that can be improved by employing traditional QI techniques (Cornwell, 2015). However, patient experience is often siloed within health system organizational charts and considered separately from quality and safety initiatives, instead of being seen predominantly as a “customer service” initiative (Cornwell, 2015; Moffatt-Bruce, Hefner, & McAlearney, 2015). Recent articles on the use of patient experience data in QI projects have found a paucity of research into how patient experience data are collected, communicated, and used for QI in health care settings (Doyle et al., 2013; LaVela and Gallan, 2014). While the Beryl Institute conducted a large survey of how hospitals define patient experience and are structured to address this topic (Wolf, 2015), there is still much to learn about what processes hospitals use to measure patient experience, how supportive services for patient
experience are structured, and how institutions then communicate experience data to all levels of the organization.

To explore these questions, the study authors partnered with Vizient—a member-driven, member-owned health care performance improvement company whose members represent more than half of the nation’s acute care health care systems—to survey member organizations participating in Vizient’s performance improvement (PI) collaboratives. Survey participants included academic medical centers, health care systems, and community hospitals. The aim was to explore both the processes and infrastructure hospitals employ to improve patient experience as well as the metrics hospitals use to assess the quality of patient experience beyond patient satisfaction survey data. In the following section, we describe the findings of this survey and discuss how these findings inform the current emphasis on improving the patient experience in US hospitals.

METHODS

Data Collection

In partnership with Vizient, the study team sent a recruitment email to four Vizient email listservs including those of the Chief Nursing Officers, Chief Quality Officers, Quality Management teams, and Chief Medical Officer Leadership; 247 Vizient member organizations participated in these listservs. Potential participants were told that their responses would be identifiable to Vizient, but that the study team would not have access to identified data. The email directed recipients to a link to the survey instrument hosted on the Qualtrics survey platform (Qualtrics, 2019). Given that each member organization participates in all four listservs, there was potential for more than one response per organization. In this case, our analytic decision rule was to retain the most complete response, and in the case of two responses with no missing data, retain the first response. The survey response rate and study sample are described in the Results section.

Survey Instrument

The survey instrument was constructed by the study team, in consultation with Vizient. The first set of questions asked about the hospital’s structure for managing the patient experience: Is patient experience a separate department? Who is in charge? What services are encompassed under patient experience? The second section of questions asked about how the hospital communicates internally about the patient experience, including communication with front-line staff and leaders, as well as asking how the voice of the consumer is collected. All questions were multiple choice, with response options drafted by the Survey Taskforce; an “Other, please describe” write-in option was also included. The survey also included an open-ended question: “Briefly describe up to three reliable performance measures, other than patient satisfaction scores, that your hospital uses to help assess the quality of the patient experience provided.” The full survey instrument is available upon request.
Analysis

Basic descriptive statistics were calculated for all multiple-choice questions. These included a tabulation of the number and percent of responses across answer categories for categorical variables and calculation of the mean and range for continuous variables. The “Other, please describe” response choices were reviewed, with responses assigned to an existing response choice if appropriate and recurrent new themes categorized around frequent write-in responses. The first and second authors double-coded responses to the open-ended question to characterize emergent themes following the Glaser and Strauss process of building grounded theory (Glaser and Strauss, 1967). Coding disagreements were discussed between the two coders until consensus was reached.

RESULTS

Demographics

Representatives from 52 Vizient member organizations responded to the survey, a response rate of 21%. Thirty-seven respondents (70%) identified their organization as an Academic Medical Center/University hospital, with the rest identifying as a Teaching hospital (15%) or Community hospital (13%). The majority of respondents reported between 240 and 664 adult inpatient beds for their organization (range 17 to 1,300 beds). Thirty-eight organizations (73%) reported having a “dedicated, structured department of patient experience (e.g., customer service, patient satisfaction, patient engagement, patient- and family-centered care).” Of these organizations, 10 had been in place more than 10 years, six for 6–10 years, and 22 reported a patient experience department less than five years old. The rest reported that patient experience is either the primary responsibility of the quality assurance or PI staff, or that there is no centralized structure but individual departments have their own patient experience staff or teams. One organization reported that “No department(s) holds specific responsibility for the patient experience, but it is the hospital’s expectation that staff will provide good customer service.”

Metrics of Success

Thirty-two organizations responded to the write-in question asking about performance measures of patient experience beyond patient satisfaction. These responses were coded into four themes: Reports of Patient Experience, Access, Processes, and Outcomes. See Table 1 for a list of performance measures reported by respondents within each of these themes. In summary, reports of Patient Experience metrics included the rate and response time to complaints and grievances as well as patient and family comments. Access metrics included wait time in both the emergency department and ambulatory settings. Clinical processes — such as unit audits and leadership rounding — and the rate of compliance with patient safety metrics were also reported. Outcomes included measures of quality and safety such as patient safety events and readmissions.
Forty-seven organizations (90%) reported regularly sharing patient satisfaction data with front-line staff. Commonly reported data-sharing methods included posting applicable unit/department/service satisfaction scores in the work area (72%), communication during department/unit/service meetings (85%), publishing in the department/unit/service scorecard (51%), and sharing patient comments with staff (74%). Two organizations provided the write-in response “variation in methods across units,” indicating decentralized responsibility for the patient experience. When asked how patient satisfaction data are communicated to leaders, all but one organization reported communication during leadership meetings, and more than half of organizations reported communication during system meetings and board meetings. Only one organization reported posting satisfaction measures in the organization’s scorecards.

**DISCUSSION**

When asked about performance metrics beyond satisfaction, most hospitals or systems noted other metrics of the entire patient experience such as the rate of complaints or grievances or direct feedback from patient and family advisors. These are considered traditional metrics of patient experience and were the focus of the recent Beryl survey asking about patient experience metrics (Wolf, 2015). However, respondents to our open-ended question also suggested that a broader definition of “quality of the patient experience” may be appropriate; this broader definition would encompass measures of access, clinical processes, and quality of care and patient safety outcomes. Almost all respondents that we
surveyed listed metrics from these less traditional categories, indicating that PI within the patient experience domain in these organizations is linked with other areas of hospital performance that rely on the same metrics, such as clinical quality and patient safety. Our findings show that some US health systems have broken down the silos of hospital performance that separate patient experience from other quality and safety initiatives (Cornwell, 2015; Moffatt-Bruce et al., 2015).

In practice, integrating measures of the patient experience into the quality of the hospital stay is paramount to the success of a value-based delivery system. Aligning the performance metrics of an organization to encompass quality, patient safety, and experience would be consistent with the Institute of Medicine definition of quality (Institute of Medicine, 2001) and could ideally be accomplished by setting metrics that cascade in a bidirectional manner from leadership to front-line staff. One example would be to implement incentive programs that benefit both senior leaders and the front-line staff based on meeting specific HCAHPS goals, patient safety process metrics, and Hospital Value-Based Purchasing metrics, as well as meeting The Clinician and Group Consumer Assessment of Healthcare Providers and Systems goals that are more reflective of the ambulatory or access experience. While not yet generally publicly reported, these ambulatory metrics set the tone for a patient experience that is timely and based on excellent communication with all staff and providers in the outpatient setting. For instance, wait time to next appointment for both primary and specialty care can provide a target and establish expectations for all providers across all disciplines.

One limitation of this study is that the survey was anonymous; therefore, it was not possible to compare the characteristics or performance of responders to nonresponders. A condition of Vizient participation in this study was that only anonymous data would be provided to the study authors. This fact, along with the low response rate, limits generalizability of the study findings. However, this study presents detailed information on how patient experience and quality efforts are structured within a sample of US hospitals. Sharing this information will open the black box of processes currently employed to improve experience and quality and set the stage for larger investigations.

Our results suggest that this type of multidimensional performance is frequently employed within acute care health systems in the United States. As a descriptive characterization of both the processes and infrastructure of patient experience, and the metrics hospitals use to assess the quality of patient experience, these survey results provide hospital administrators with proposed metrics that patient experience professionals suggest span across quality silos to enhance the patient experience. Managers can employ access, process, and outcome measures from Table 1 in QI efforts that are directed toward improving the patient experience and simultaneously improving safety and quality outcomes.
REFERENCES


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