Zeroing in on the Patient Experience
Views and Voices from the Frontlines

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The Beryl Institute serves as a professional home for stakeholders who recognize that the patient experience is an essential element in the execution and evaluation of healthcare 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.

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Zeroing in on the Patient Experience

This white paper takes a close look into the professional lives of three patient experience leaders who share opportunities and challenges as they commit to improving how patients connect with their organizations. Executives from The Beryl Institute hosted these 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’s families and friends.

This paper covers what it takes to both launch and sustain patient experience efforts and includes practical advice and tips for hospitals that want to begin to focus on improving the patient’s experience.
Q. WHAT IS THE PATIENT EXPERIENCE AND HOW DID WE GET HERE?

A. One definition equates to the patient’s perceptions of the personal and virtual interactions, clinical interventions and physical environment associated with a given clinical episode, encompassing the time immediately before, during and after the delivery of care. As concepts like medical homes and accountable care organizations evolve, providers will be forced to look more long-term at the concept of the patient experience, but for now, the industry is evaluating patient experience most often in terms of individual acute care episodes.

Q. WHY IS THE INDUSTRY FOCUSING SO INTENTLY ON PATIENT EXPERIENCE NOW?

A. Truthfully, it’s been going on for the past 20 years or so. In the early 1990s, a handful of hospitals across the nation began constructing luxury birthing rooms, offering five-star meals and renovating lobbies and hospital wings to look like hotels. Why? These changes certainly weren’t focused on improving the nursing care, or the doctors’ decision making. The sole purpose was to address some of the emotional and comfort needs that patients had. In other words, these efforts were designed to address patient experience.

“The early attempts to improve patient experience by creating a less intimidating atmosphere acknowledged that addressing the patient experience was the right thing to do,” says Jason Wolf, executive director of The Beryl Institute. “It still is, even if no one can fully gauge the impact of these efforts long term. Hospitals are struggling right now to determine the right formula for sustaining superior patient experience evaluations. It’s very difficult to create continuity with patient experience improvement efforts because every patient’s healthcare encounter is different. Even patients suffering from chronic conditions with fairly stable symptoms are likely to have substantially different experiences with each encounter. Healthcare is not like the fast food industry, which promises the same type of food experience every time, and your taste buds know what to expect. Improving the patient experience and creating consistency is hard.”

“THE FIXATION ON PATIENT SATISFACTION IS ONE OF THE REASONS HOSPITALS ARE STRUGGLING RIGHT NOW TO WRAP THEIR BRAINS AROUND THE PATIENT EXPERIENCE.”

Wolf states that one point of confusion for the industry is the marketplace over the last 20 years or so. In 1990, when U.S. News & World Report issued its first report on “America’s Best Hospitals,” most people in the healthcare industry were shocked, labeling it a crude and senseless gesture by the magazine, offended that journalists would attempt to ‘evaluate’ healthcare providers. In the late 1990s, as Websites like Dr.Koop.com,
laurushealth.com and WebMD.com proliferated, promising to give consumers information to help them evaluate their health and healthcare providers, many hospitals decided it was time to pay closer attention to what patients thought. Hospitals that had resources began to explore using the Web to reach out to consumers, even before the hospitals understood how to actually do Web marketing. Still, there was an influential and large segment of the healthcare community that resisted this trend. Their mindset was that patients come into the hospital sick, hospital personnel work their magic, and the patients’ perspectives on their experiences shouldn’t matter—the ends justify the means.

This attitude universally changed in 1999 when the industry received a cold slap in the face with the distribution of the Institute of Medicine’s (IOM) first report on hospital quality and patient safety (*To Err is Human*). With that report, hospitals had to acknowledge that they needed to focus on offering better, safer care. When J.D. Power & Associates began handing out patient satisfaction awards to hospitals in 2003, many more hospitals began to pay closer attention to patient satisfaction, even without a concrete game plan to address it, and no recognition that patient experience and patient satisfaction weren’t solidly connected.

“The fixation on patient satisfaction is one of the reasons hospitals are struggling right now to wrap their brains around the patient experience,” said Wolf. “Most hospital administrators assumed that patient satisfaction equated to patient experience. But with the recent passage of the Patient Protection and Affordable Care Act, the government has defined patient experience in terms of very specific actions and interactions. Hospitals that traditionally scored as top performers when measuring patient satisfaction are finding that measuring patient experience is a tougher standard, one now closely linked to some serious financial implications.”

Beginning October 2012, the Centers for Medicare and Medicaid Services will introduce its value-based purchasing (VBP) program that will link payment to clinical care (the CMS core measures) and selected hospital-acquired infections and patient experience scores, which are reflected through the Hospital Consumer Assessment of Healthcare Providers and Systems survey, known as HCAHPS.

“Since the IOM report was published in 1999, hospitals have demonstrated their ability to focus on clinical performance improvement, but most are challenged by the concept of improving their HCAHPS scores. The dissemination of leading clinical practices across healthcare occurred when lower-performing hospitals followed the practices of the better performing hospitals. This formula for knowledge and process transfer, while still important, will prove to be more challenging as we look at the issue of patient experience, which is driven more by unique organizational and cultural elements and interpersonal interactions versus simple replicable processes,” says Wolf.

The patient experience element of the VBP program is proving to be enormously challenging for many hospitals. For almost every hospital, the introduction of VBP represents the potential loss of millions of Medicare reimbursement dollars beginning October 2012, and even though patient experience scores are weighted less heavily than clinical performance scores, they are a primary drag on hospital’s overall VBP scores.
Colleen Sweeney has three roles within her organization, but she has learned to capitalize on all three roles to look at patient experience. She trains facilitators and teaches in Memorial’s School of Innovation in South Bend, which searches for innovative approaches to improving healthcare, through technology, as well as changes in healthcare delivery processes. She is also directly responsible for improving the patient experience through management of the customer service program, and she runs the organization’s volunteer program, recruiting Memorial Ambassadors. Wearing three different hats is challenging, admits Sweeney, but through her work with volunteers and connections with healthcare innovators, she has managed to bring some new ideas to her patient experience work.

The catalyst for the creation of her role was the arrival of a new COO five years ago. One of the first things he implemented was putting someone in charge of the patient experience. That said, the organization had already been working to influence community perception of the hospital for many years. It was one of the first hospitals in the nation to tithe 10 percent of its bottom line back to the community to fund health improvement activities—the purpose being to get people to take responsibility for their health and to see the hospital as a partner in that process. It also started a Children’s Health Museum to entice children as young as five years old to begin thinking about taking responsibility for their own health. It also created the School of Innovation to unite area businesses and community leaders in order to think about ways to improve healthcare. Through all of these efforts, the organization sought to improve patient perception even before the patient actually experienced hospital care, acknowledgement that the patient experience starts well before the patient arrives.

Having been in her role for more than four years, Sweeney believes the task of improving patient experience is a very difficult one. This is true even though Memorial has established a solid foundation for her role—arranging for her to report to the COO and to the board and funding her work appropriately. She says Patient Experience leaders without these advantages have an even harder job.

“I spent my first two years in this role just building relationships that would later enable me to begin to implement changes in the organization to address patient experience. I worked in every single clinical unit in the hospital at least four hours so I could understand how the staff functioned and explore how patients are viewed and treated in each unit,” said Sweeney.

“When I finally decided I had learned enough to start the process of beginning to change how the organization addressed the patient experience, I started at the front door. I sat and watched for a day how we treated people when they walked in the front door. It took me 18 months to change the experience at the front door. The organization pretty much had to clean house and bring in new leaders over valet, parking services, and escort services in order to have people in place that had the right mindset. It was painful, and that was just to manage the first three seconds of the patient experience. It was worth it, though.”

In conjunction with her work to change how patients experienced the hospital at the front door, Sweeney began to train the rest of the employees about the importance of patient experience, starting first with all new employees, believing they would be easier to inoculate than employees with tenure. During new employee orientation, she had new employees sign a pledge to adhere to 86 behaviors she identified as essential to improving patient experience, such as letting visitors enter the elevator first. However, as soon as the new employees transitioned to their regular work spaces, they seemed to quickly adapt the embedded behaviors of their unit. In essence, the old-timers corrupted the newcomers. To address this, Sweeney began conducting as many as 30 in-services each month to introduce the key patient experience concepts to the entire employee base.

The patient experience at South Bend encompasses not only behaviors and how staff members interact with patients and family members, but elements such as the lighting, the furniture and the cleanliness of the building.
“When staff hear me say our physical environment impacts patient experience, and observe me picking up litter in the hallway, they know I’m seriously engaged with them in this effort. I pick up as much trash as housekeeping. Consistently modeling the right behavior reinforces the message and the credibility of the program. Then the staff members are willing to listen to me and take action. You can’t enter into this position thinking you are the queen or king in the organization.”

Sweeney also stated that the smells matter. One of the most impactful changes Sweeney made was addressing a common complaint and fear that people have about hospitals… the buildings always smell like antiseptic, which is disturbing for most people. To counteract this smell, Sweeney has cookie baking stations in the lobby and at the base of the elevators, ensuring that the first smell people encounter is the smell of freshly baked cookies. The hospital bakes approximately $30,000 worth of cookies annually. They bake the cookies close to the elevators so the smell wafts its way through the building.

“When it comes to the patient experience, we talk about the 3-second rule in every department. What you do in the first three seconds of any patient encounter may shape the patient’s long-term perception,” said Sweeney. “That is a performance standard that matters to us.”

To capture how patients feel about their inpatient experience, the hospital surveys 100% of its patients as part of its standard patient satisfaction survey. Embedded in this survey are the HCAHPS survey questions. However, 75 percent of patients receive calls following discharge from the nurse call center or directly from the clinical units. The organization has a 78% reach rate through the call program. Any positive or negative feedback is filtered back to the service line that treated the patient so they can take corrective action or recognize employees who are living out the organization’s customer care standards. 

Read more about Memorial South Bend’s Patient Experience Endeavors on page 13

Sweeney offered the following suggestions to any healthcare organization just starting on a journey to improve patient experience:

> Don’t hire an outsider to lead it because it takes too long for outsiders to build relationships that are key to implementing change, and time is working against healthcare organizations when it comes to Patient Experience improvement. The CMS October 1, 2012 deadline will be here soon.

> Be prepared to address cultural transformation needs and break down barriers. This activity is crucial in organizations that have many long-time employees.

> Develop a uniform understanding of what it means to improve the patient experience and share that vision across the organization. Educate every staff member and all physicians that practice in the hospital.

> Expect the patient experience improvement process to take as long as two years before measurable progress is achieved.

> Start in the parking lot, or at least the front door of the organization, where patients often build their first impression based on the sights, smells, sounds and people they first encounter.
In her role with Community Health Network (CHN), which is a five-hospital system, Nicole Nicoloff sits alongside the various hospital presidents and vice presidents across the organization as part of the system’s management team. She also manages volunteer services and guest relations; which includes concierge services for patients, patient’s families and employees alike. Community’s leadership team has historically been passionate about improving the patient experience, but the health system continued to grow and evolve, the work to consistently generate an exceptional patient and family experience became critical to all aspects of the organization’s priorities. The executive management team wanted to ensure that one individual within the organization was responsible for coordinating the focus on the patient experience. With that aim, Nicoloff’s position was created. The formation of a specific role to focus on patient experience came about because the health system’s standing rule, which was that “everyone” was responsible for improving the patient experience meant “no one” was actually being held responsible for managing it.

Another motivating factor to have one person responsible for managing the patient experience, admits Nicoloff, was the health system’s lower than desired patient satisfaction scores and the pending roll out of the CMS value-based purchasing program. “To really change, most organizations must bump up against some uncomfortable facts, such as seeing their HCAHPS scores publically reported next to their competition’s,” said Nicoloff.

The boundaries of the patient experience are broad, encompassing every encounter at the hospitals, as well as the non-acute care sites that are connected to the network, and virtual environments, such as online consultative chats with nurses. The expectations around the patient experience are fairly well defined, though. CHN says a good patient experience means:

> High quality, safe care, meaning no accidental harm
> Compassionate care, meaning the patient and family members sense empathy from the staff
> Special care, meaning the level of care causes the patient to become a brand ambassador
> Timely care, meaning the organization provides ready access to its services

The organization’s aim is to create an emotional, spiritual, intellectual and physical connection with the patient and the patient’s family.

Even with Nicoloff’s appointment, there is the recognition that one person cannot do it all. CHN leans on the handful of people at each primary care site who seem to “get it” in terms of the importance of improving the patient experience. “Getting it” means that these people understand what needs to happen to provide exceptional patient experiences and they have the passion, skill, talent, leadership and emotional intelligence to make it happen. They informally report in to Nicoloff, who believes any organization that wants to focus on improving the patient experience can harness the power of numbers by growing the number of people who are committed to the concept and meeting with these people on a regular basis to hold status checks and learning sessions.

“I grew up in this organization, starting at age 21,” said Nicoloff, “so I knew its culture and its blind spots. That’s made it easier to work within the organization to implement change. Until you gain some credibility with the staff by shadowing them and becoming one with the frontline care givers, even at 3 a.m., you won’t make progress in gaining buy-in.”
She added, “As important as it is to build credibility with clinical teams, you also need to spend time with operational leaders and learn their heartaches and headaches so you can engage them in this effort.”

One foundational element to CHN’s patient experience program is communications. Nicoloff spent the last 10 months focused on communications training with staff members. The program, centered on engaging patients in meaningful conversation, was designed to ensure that staff members cared for patients as individuals, not wristbands in rooms. To incorporate this training into everyday activities, Nicoloff rolled out a program called SMILE, which is meant to remind employees, especially frontline employees to:

Smile
Make eye contact
Introduce yourself
Let patient know what you are doing and why
End every conversation with, “Is there anything else I can do for you?”

“In every business, you have ‘thinking types’ and ‘feeling types.’ In healthcare, we have the challenge of getting the “thinking types,” who may be proficient at starting IVs, to understand that relational skills are part of improving the patient experience. “The “feeling types” approach patient experience issues naturally,” said Nicoloff. “Those differences in people’s personality styles pose a significant barrier to my work, so building acceptance for the SMILE program across all audiences has been a challenge.”

To understand more about the barriers to improving patient experience, Nicoloff surveyed the staff members at one of the system hospitals and asked them to describe the barriers from the employee perspective. The feedback described more than 800 barriers, but many of the issues were easily addressed by simple fixes that no one had bothered to address before. Central issues that were raised touched on communication problems, equipment issues, system and process breakdowns and not enough staffing to adequately meet patient expectations.

(See list of Top 10 barriers on page 14)

Nicoloff estimated that it took three years before the organization began to see noticeable differences in patient experience scores, defined in their HCAHPS survey. She believes having more than 11,000 employees across the system complicated the roll out of the patient experience improvement initiative and delayed their ability to generate improvement quickly.

“Once you get every layer of the employee population to understand that this ‘patient experience’ program isn’t going away, you can begin to see some change,” said Nicoloff. “For nearly a decade now, thanks to the initial Institute of Medicine report on patient safety and medical errors, the industry has focused on improving clinical quality, and this effort was brought about due to a significant shift in industry thinking. Rather than accepting that medical errors were part of healthcare delivery,

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we had to accept that we could do something about errors. That was significant. I think we need a similar transformational shift in industry culture to get everyone to acknowledge that we need to address the patient experience.”

“Over the last two years, we implemented an intense focus on improving patient safety. As a result, we reduced the number of medical errors by 65 percent in two years. However, it was a painful journey. We established the rules and we told people that if they couldn’t follow the rules every time, they wouldn’t work for the organization. Those are awkward conversations in an environment that’s supposed to have a “feel good” atmosphere. We have to have the same hard edge when it comes to managing patient experience, and many organizations may not be ready for that, especially if they’re still struggling with managing quality,” Nicoloff added.

She noted, “It’s taken a decade for the industry to embrace its accountability for patient safety. I worry it will take another decade for the entire industry to accept responsibility for the patient experience. Unfortunately, reimbursement rules don’t give us that much time.”

“Furthermore, some organizations mistakenly believe they are focusing on the patient experience by focusing on quality.
“ONCE YOU GET EVERY LAYER OF THE EMPLOYEE POPULATION TO UNDERSTAND THAT THIS ‘PATIENT EXPERIENCE’ PROGRAM ISN’T GOING AWAY, YOU CAN BEGIN TO SEE SOME CHANGE.”

Avoiding errors simply means you’ve not harmed the patient. It doesn’t mean the patient will reflect positively on the hospitalization. However, if you harm a patient, there is nothing you can do from a ‘niceness’ standpoint to fix that. We can’t forget that.

To measure patient satisfaction and patient experience, Community Health Network asks discharged patients to complete a 60-question survey, which includes the 27 HCAHPS survey questions in it. The hospital surveys about 40 percent of its patients.

“Historically our organization measured the ‘would recommend’ and ‘overall experience’ score to gauge patient loyalty. Our belief has always been centered on building patient loyalty and increasing market share by measuring our success based on ‘top box’ scores,” said Nicoloff. “Our efforts have yielded significant improvements in the past four years with 18 percent (top box) improvement for the “overall experience” and 20 percent (top box) improvement on ‘Would recommend.’ HCAHPS is a different story, it’s very challenging. The HCAHPS survey scale is ‘Always, usually, sometimes, never’. A response of ‘Always’ (the top box score) is much harder to attain than the second response category of ‘Usually’. Furthermore, the stereotypical outcome for many hospitals is to aggregate the two top box scores to report their experiences to the consumer, and now the government is only reporting the top box which is ‘Always.’

One effort the hospitals have established to improve patient perception is a post discharge call program to congestive heart failure patients to check on the patients’ status. As a result, their HCAHPS scores have improved in that patient population.

Nicoloff offered the following suggestions to any healthcare organization just starting on a journey to improve patient experience:

> For multi-hospital systems, create a system-level position to focus on improving patient experience, but connect that individual to champions at each hospital who can carry the torch for patient experience.

> Within each hospital, create cross-functional teams that include both operational leaders and clinicians to focus on patient experience.

> Examine the policies, processes, services and environmental improvements that can actually be implemented to influence the patient experience, and examine the barriers to improvement.

> Ensure that efforts to improve patient experience are a top priority in the organization’s mission, vision, goals and values.

> Create accountability for upper management, clinical and non-clinical management, physicians and front-line staff for improving patient experience.
A few years ago Halifax Health recognized it had a problem with patient satisfaction, so in 2008, it formed a cross-functional committee to address this issue. The committee included the CNO, the CIO, and representatives from education, HR, marketing, compliance, and patient relations. Its role was to provide oversight and direction for service excellence initiatives within Halifax Health. One outcome from this committee’s work was the creation of the Customer Experience Manager role, which Jennifer Wagner stepped into following her time on the Patient Experience committee.

Wagner believes early discussions around pay-for-performance in 2008 generated the initial interest by the organization’s CEO to focus on improving the patient experience. Senior management wanted to ensure that the healthcare organization was prepared for value-based purchasing after recognizing that the organization had fairly low patient satisfaction scores based on their survey results.

Because of the bridges Wagner built on the patient experience committee, she believes it has helped smooth the introduction of new ideas across the organization. However, her relative newness to the organization did pose some difficulties in crossing departmental barriers early on.

“Not having a clinical background has made it tougher for me to engage clinicians around patient experience. I encountered the attitude, ‘Who are you to tell us how we should be doing our jobs,’ she noted.

“The other challenging aspect to my role is that I’m accountable to so many other people in the organization, including the CEO, CNO, HR director, CMO, and CFO. By that, I mean I am influencing things that all those people are desperately interested in, and how patients view our organization. It’s a tough role.”

For Halifax, the patient experience encompasses not just the patient’s perspective, but the perceptions of family members and guests, so her work includes efforts that target each audience. Wagner says family members and friends may ultimately influence how patients feel about their stay, since they often help with recall efforts when it comes to completing patient surveys. The patient experience also encompasses the patient’s interaction with the call center, the Web site, and the discharge and billing offices, covering essentially every interaction with the organization.

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To evangelize the importance of the patient experience, Wagner initiated a series of face-to-face training sessions on the topic, which broke from the hospital’s standard online employee training format. The organization used a train-the-trainer model. The training consisted of five one-hour modules: Customer Service Basics, Teamwork, Professional Communication, Service Recovery and Problem-Solving, and Compassion. Wagner trained 30 trainers to deliver these courses, and every employee, from the CEO to the laundry staff, participates. The challenge hasn’t been participation, but creating accountability for what
Wagner offered the following suggestions to any healthcare organization just starting on a journey to improve patient experience:

> Create a budget devoted to improving patient experience, which would encompass some level of staff training.

> Connect the patient experience leader with the CEO, CNO, HR leader and a Patient Experience committee, which includes employees from across the organization.

> Acknowledge that downsizing of any kind could undermine or slow efforts to focus on improving patient experience, because the culture and processes must recalibrate and adjust to new workforce.

> Centralize expenses related to improving patient experience so you can calculate ROI.

> Consider implementing a post-discharge call program. Contacting patients after discharge may stimulate positive responses on HCAHPS survey.

“ODDLY, OUR INDUSTRY HAS NEVER BEEN CONSIDERED A SERVICE INDUSTRY, BUT WE ARE. THE WHOLE PARADIGM IS CHANGING NOW.”
MEMORIAL SOUTH BEND’S PATIENT EXPERIENCE EXPERIMENT
ELEVEN INITIATIVES TO ENHANCE PATIENT EXPERIENCE

Colleen Sweeney, Director of Innovation, Ambassador and Customer Services at Memorial South Bend Hospital, South Bend, IN, doesn’t know if the following initiative will individually make a significant difference in the patient experience, but she believes collectively they can make a difference over time.

1. Establish a pet therapy program, and allow dogs to help greet visitors.

2. Change the experience of smell by strategically baking cookies at the base of the elevators so that the smell goes to every unit.

3. Place white boards in each patient room and ask patients to write down what they fear most about their hospital stay and try to alleviate those fears by describing the steps employees will take to address the issues.

4. Provide “ID” cards of care providers in patient rooms to let them know who will be taking care of them and to create a personal connection – the cards should include photos, personal information, etc.

5. Following discharge, care providers should call patients and/or send handwritten notes to the patients wishing them well.

6. Increase your volunteer force, call them Ambassadors, and give them more accountability for helping manage the overall experience.

7. Offer free valet service to patients, guests and Ambassadors. Consider this at your ER entrance as well.

8. Provide easily visible way-finding guides, such as color-coded lines on floors and elevators. Use Ambassadors as guides at strategic locations.

9. Have your Senior Management Team become your front door greeters.

10. Build service improvement teams around the key HCAHPS domains.

11. Manage the first three seconds by having every department build a strategy for how it will address the first three seconds of a patient or guest experience in their area.
TEN BARRIERS TO IMPROVING PATIENT EXPERIENCE

Community Hospital South (one of five hospitals in the Community Health Network in Indianapolis) required all staff to attend customer services training to prepare them for a re-opening of the newly expanded hospital. As part of the training, staff members had the opportunity to provide feedback on the barriers (or things that get in the way) to delivering exceptional patient and family experiences. More than half of the 630 staff members responded and provided 851 individual barrier statements. The Top 10 were:

1. Poor personal communication skills
2. Lack of time to spend with patients/families and conflicting organizational priorities
3. Managers/Administration not prioritizing Patient Experience
4. Lack of staffing
5. Equipment/supply issues interrupted ability to provide care and frustrated the patient, especially on weekend and night shifts
6. Attitudes and mood of the staff affected ability to relate to patient
7. Ineffective systems and processes
8. Department to department communication breakdowns
9. Excessive e-mails (e.g., too many “all hospitals team member” e-mails) which interrupt patient care time
10. Teamwork breakdowns

As challenging as each of these issues is to address individually, the fact that the staff members were able to identify hundreds of barriers makes the task of addressing Patient Experience that much more challenging, according to Nicole Nicoloff, Director of Exceptional Patient and Family Experience at Community Health Network.
Where Do We Go from Here?
Jason A. Wolf, Ph.D.
Executive Director - The Beryl Institute

While we could look at the stories in this white paper as distinct, we would miss the parallel lessons. Through extended conversations during The Beryl Institute’s roundtable discussion, each individual expressed in many different ways the paradox of their roles. While their efforts were grounded in the critical nature of building relationships throughout their organizations, they acknowledged at times it seemed as if they were the lone torch-bearers for their important task. They each held up and stood for the ideals and actions that would have a positive impact on the service culture of their respective organizations.

What lessons can we absorb from their parallel experiences?

BUILD AND FEED A WEB OF RELATIONSHIPS
Patient experience leaders need to build the critical relationships to drive their efforts forward effectively. They should also consider what sort of structure will work best to lead improvement efforts focused on the patient experience. Should the leader build a series of personal relationships across clinical, administrative and medical staffs and drive the effort through individual channels, or consider forging a task force or work group to work jointly on this effort? Whichever option is most appropriate for a given organization’s culture would be the best choice. The key factor for each of our champion’s success was the relationships each both built AND maintained by consistently and continuously engaging others around the topic of patient experience.

LOOK BEFORE LEAPING
No recipe for success is perfectly transferable from place to place. Some basic practices may be replicable, but each tactic must be adapted to suit a given environment. Carefully consider the order in which you take action. Do not assume that one organization’s priorities can be adopted by another or that a specific check list will work everywhere. Take the time, like our subjects did, to look and listen. This may be the most challenging part of implementing a Patient Experience improvement program, especially when being pushed for quick results. Success requires patience and a longer term perspective. Identify where to act first and this will enable the organization to make better choices and achieve lasting improvements.

DISCOVER THE MOTIVATING FACTOR
Simply stated, what is the pain point for the organization? True, every organization is at risk with respect to value-based purchasing, but aside from regulatory pressures, patient experience leaders must ascertain the motivation for the organization to take on patient experience improvement as a key mission. Does the healthcare organization want to become the leading service provider in the community, or even the state? Have the leaders in the organization determined the real return on service for the organization? How will this motivation be shared across the organization?

“THE KEY FACTOR FOR EACH OF OUR CHAMPION’S SUCCESS WAS THE RELATIONSHIPS EACH BOTH BUILT AND MAINTAINED BY CONSISTENTLY AND CONTINUOUSLY ENGAGING OTHERS AROUND THE TOPIC OF PATIENT EXPERIENCE.”
REMAIN COMMITTED

Hospitals have been consistent in their commitment to improving clinical quality, especially around critical topics such as core measures. This is likely due to the fact that it is easier to collect hard metrics for these topics, so progress is easier to see. With a topic like service and patient experience, where perceptions, multiple touch points and innumerable variables are at play, the organization needs to stay focused, even when progress is harder to measure. All too often, improvement efforts are turned into “initiatives” (a label that equates to the kiss of death for most projects). But “initiatives” have a “shelf life,” meaning they not only have a beginning, they also must have an end. Hospital personnel are all too aware of this, with the volume of initiatives that seem to occur in healthcare settings and many times they hesitate to engage, choosing instead to play the waiting game and watch for the “initiative” to die off. Patient experience efforts cannot be initiatives; they are fundamental shifts in ways of being and they are often tough uphill climbs. Get the hospital’s board and senior management to stay focused and determine how progress will be demonstrated so that everyone can stay motivated. Each of the roundtable participants acknowledged that it took almost two years to even see significant progress in terms of the organizational and cultural changes, let alone actual improvements in patient experience.

REMEMBER THE POWER BEYOND FIRST IMPRESSIONS

The old adage, “There is nothing more important than a first impression,” is hard to dispute. It was also a common theme in our participants’ experiences. From the “three second rule” to consistent language in how they engaged patients, first impressions were depicted as having a significant impact on patient perceptions. The organizations also focused on the power of lasting impressions, e.g., what patients felt after they left the hospitals and what they told others about their experience. Therefore, focus on sustaining positive touch points not only at first encounter, but throughout a patient’s visit and beyond. The consideration of how to leave people with a lasting impression was central to the concepts our participants addressed through all of their efforts. It was not just one action, but a continuum of coordinated efforts that, in total, ensured a lasting positive result.
FOUR CRITICAL QUESTIONS

As healthcare organizations consider how to commence or refine patient experience improvement efforts, they must take into account different geographies, local economies and demographic challenges, to name just a few distinctions. Therefore in looking at how to move these ideas forward, consider how to adapt the experiences of three very devoted patient experience champions for your organization.

In doing so, ask:

> **Who will lead the Patient Experience efforts and how will they be supported?**
  All of our participants were supported by executive leaders and in some cases directly chartered by them.

> **What sort of support exists or needs to be created?**
  Engaging individuals at all levels in the organization ensures both broad and deep representation and expands the ownership of efforts into the very foundations of the organization. This support is also the engine for sustained positive results.

> **Where is the best starting point?**
  Find opportunities for quick wins and share these victories widely, not only internally, but also with the community.

> **How will success be measured?**
  Establishing metrics up front will ensure focus. The metrics need not be limited to the success measures of standard surveys if the organization has higher objectives beyond simply improving satisfaction scores (or HCAHPS outcomes). In fact, setting higher level objectives may be the surest way to achieve lasting change.
Colleen Sweeney RN, BS is currently the Director of Innovation, Ambassador and Customer Services at Memorial Hospital and Health System. Colleen first joined Memorial in 2000, as the creator of programming and a health educator for HealthWorks! Kids Museum. A background in critical care nursing, owning a design firm, and being a member of an improvisational comedy troupe have prepared her well for her current position. Sweeney earned her nursing degree from Cooper Medical Center School of Nursing in Camden, NJ, a business degree from Bethel College in Mishawaka IN, and a Master’s certificate in Project Management from the University of Notre Dame in Notre Dame, IN. She has recently completed two studies on Nosocomophobia (what patients fear about hospitals, healthcare and doctors) and bases much of her work on those studies.

Nicole Nicoloff is the Network Director of the Exceptional Patient and Family Experience for Community Health Network, the second largest healthcare network in Indiana. She has held this position since 2006 and has been with the organization for eleven years. With expertise in areas of culture change, strategic planning, performance improvement and outcomes, Nicoloff has been responsible for improving Community Health Network’s overall patient experience metric by 18 percent in four years. She leads the organization’s efforts achieving the 80th percentile nationally “Would Recommend” on HCAHPS. A graduate of Indiana University in Indianapolis, IN. Nicoloff holds a Bachelor of Fine Arts degree in Visual Communications.

Jennifer Wagner is the Customer Experience Manager for Halifax Health in Daytona Beach, Florida. Halifax Health is the area’s largest healthcare provider with a tertiary and community hospital with 944 licensed beds, more than 500 physicians on its medical staff representing 46 medical specialties. Halifax Health also offers psychiatric services, four cancer treatment centers, the area’s largest hospice organization, a health maintenance organization, and a preferred provider organization. Jennifer started her career with Halifax in 2007 as a service line Marketing Manager and transitioned into her current role in 2009. Her background is in marketing, sales and customer service. Wagner holds a Masters degree in International Business and a Bachelor’s degree in Management and Marketing from the University of Florida.


Also from The Beryl Institute

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.

June 2009

Customer Experience: A Generational Perspective

Michael Howe, former CEO of MinuteClinic, is an expert on retail healthcare. In this exciting new paper, Customer Experience: A Generational Perspective, he explores the social influences and characteristics of the four generations currently having the greatest impact on the healthcare system: Greatest Generation, Baby Boomers, Gen Xer’s, and Millennials. Howe discusses the challenges for healthcare providers in managing care for each generation. The paper includes a case study on MinuteClinic and concludes with customer service tips to improve the generational healthcare experience.

March 2009

Character Counts: Integrating Civility into the Healthcare Culture

Award-winning publisher and author Chuck Lauer explores the need for hospitals to incorporate a “civility initiative” into their customer service programs. Lauer addresses the prevailing climate of rude behavior in society at-large and offers solutions to healthcare providers seeking to provide consumers with outstanding healthcare experiences, including five secrets for bringing civility to healthcare.

October 2008

Balancing Consumer and Physician Influence: Finding the “Sweet Spot” in Healthcare Marketing

This paper is authored by Al Swinney, senior vice president of marketing communications for Meridian Health. The paper explores the history of marketing to consumers, the relationship between physicians and hospitals, the physician as the patient influencer, and physician-to-physician marketing programs. Swinney explains how physician-to-physician marketing programs work and the immediate impact they can have on hospital volume.

July 2008

Mystery Shopping the Patient Experience

This paper, written by Kristin Baird, Baird Consulting and a senior faculty member of The Beryl Institute, outlines how mystery shopping goes beyond satisfaction surveys to discover why patients leave before they ever engage a health care provider. This paper explores the value of mystery shopping, how the shopping is done, and how healthcare organizations can turn the results into actionable improvement opportunities.

November 2007

High Performing Organizations: Culture as a Bottom-Line Issue

This paper, written by adjunct faculty members Britt Berrett, CEO of Medical City, and Jason Wolf, Director of Organization Development for the Eastern Group of HCA, outlines the results of a ground-breaking study. It discusses “Seven Truths” about high performing organizations in case study format and provides actionable tips for hospital executives.

August 2007

Moments of Truth: Hospital Switchboards a Bottom-Line Issue

Switchboard operators and other hospital-based call centers are the front-line of the customer acquisition process. Individual healthcare organizations are losing significant dollars by providing poor customer service at this initial touch point. Savvy healthcare leaders will close this “service gap” and transform their switchboards into customer focused and outcomes oriented front-line acquisition centers.

May 2007

It’s Not Just a Call, It’s a Customer

Consumers are becoming more selective in making healthcare decisions and they are demanding convenience and accessibility from service providers. Data reveals that, contrary to popular belief, consumers are not willing to give providers a second chance if they are unable to make contact on the first try. This paper explores reasons why callers hang up before completing the call, the impact of lost revenue as a result of those abandoned attempts, and ways to decrease the number of callers who cannot get through.

March 2007

Ready or Not, Customer Service is Coming to Healthcare

Consumers are gaining more control of healthcare spending. This will lead to a new culture where cost, quality and service are all part of the value equation. With pricing transparency and quality reporting standards, the true differentiator in the future will be service. Savvy healthcare leaders will transform their institutions to be consumer rather than patient focused, leading to new standards in care and service delivery.