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22% of healthcare executives say that culture is the biggest hurdle to their success in their patient clinical experience programs.

INTELLIGENCE REPORT

REENGAGING THE PATIENT CLINICAL EXPERIENCE

An Independent HealthLeaders Report Powered by:

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REENGAGING THE PATIENT CLINICAL EXPERIENCE

The COVID-19 pandemic put the push for patient clinical experience on the back burner, but a new survey from HealthLeaders suggests that this key component of value-based care has come back as a priority for providers. In truth, the need to focus on patient clinical experience never went away. It simply went into hibernation during the pandemic when providers had to address more pressing concerns, such as keeping the doors open.

With the nation's return to relative normalcy, and the expected renewed push to value-based care underway, the buzz about patient engagement—specifically the patient clinical experience—is back.

So, how are providers doing on their patient clinical experience efforts?

HealthLeaders' most-recent survey on patient clinical experience found that providers report making inroads on patient clinical experience metrics, while also acknowledging that more work remains.

John Commins
Senior Editor
HealthLeaders

The pandemic was "horribly destructive" for patient clinical experience efforts at United Medical Centers (UMC), says William Worrell, CEO of the nonprofit, federally qualified health center headquartered in Eagle Pass, Texas, whose 50 clinicians and support staff care for about 36,000 patients in three counties on the border with Mexico.

"It tanked our HCAHPS scores," he says.

But, like other providers, Worrell says UMC is committed to improving patient clinical experience, a critical component of successful value-based care programs.

When HealthLeaders asked respondents to name the top three patient clinical experience areas they want to improve (Figure 1), not surprisingly, clinical outcomes (72%) and patient satisfaction (71%) proved to be the top responses, with patient engagement in care coming in third (54%).

Clinical outcomes are supposed to be the end product of value-based care, Worrell notes, so it stands to reason that they would represent a primary and critical goal.
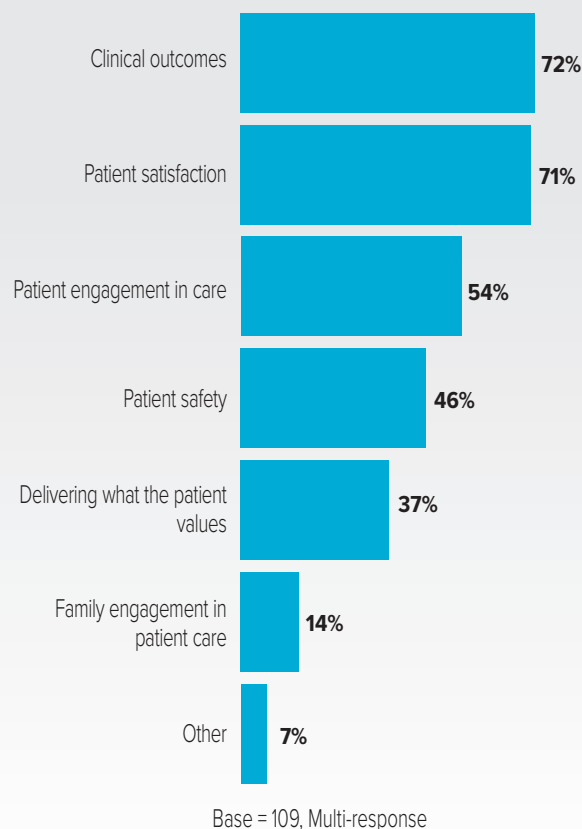
"In our realm, everything's moving towards clinical outcomes and value-based care," he says. "If you're not there, you're going to lose patients based on their bad experiences and otherwise."

Strength in patient clinical experience areas

When asked about their organization's strength in areas of patient clinical experience, combined survey responses of

Figure 1 | **What are the top three patient clinical experience areas that you want to improve?**

Clinical outcomes	72%
Patient satisfaction	71%
Patient engagement in care	54%
Patient safety	46%
Delivering what the patient values	37%
Family engagement in patient care	14%
Other	7%

Base = 109, Multi-response

"very strong" and "somewhat strong" highlighted four areas (Figure 2), including patient safety (95%), clinical outcomes (94%), patient satisfaction (86%), and delivering what the patient values (80%).

Worrell says that hubris could be playing a role in the responses.

"Sometimes people value themselves a little higher than they may actually be," he says. "With patient safety, there's always issues that arise and we can always improve."

The biggest area of improvement among respondents is family engagement in patient care, for which more than one-third (38%) graded themselves as "somewhat weak."

Worrell says family support for patient care is always a challenge but is critically important to outcomes.

"If you're not having family to buy in to change lifestyles, you're not going to change that patient," he says.
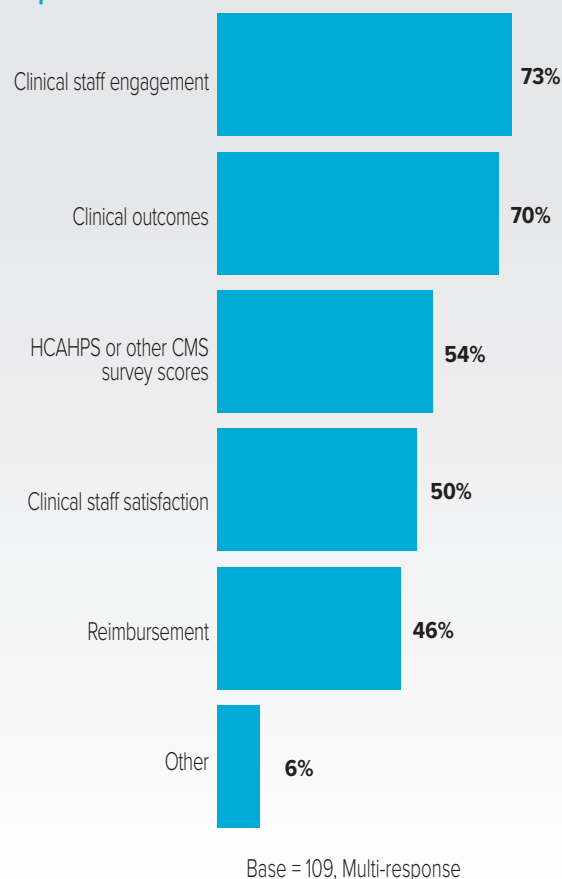
Figure 2 | **How would you rate your strength in these areas?**

	Very strong	Somewhat strong	Somewhat weak	Very weak
Patient satisfaction	36%	50%	14%	0%
Patient safety	54%	41%	5%	0%
Clinical outcomes	36%	58%	6%	0%
Patient engagement in care	15%	54%	31%	0%
Delivering what the patient values	20%	60%	20%	0%
Family engagement in patient care	11%	50%	38%	1%

Base = 109

Figure 3 | What are the top three organizational goals related to patient clinical experience that you hope to improve?

- Clinical staff engagement — 73%
- Clinical outcomes — 70%
- HCAHPS or other CMS survey scores — 54%
- Clinical staff satisfaction — 50%
- Reimbursement — 46%
- Other — 6%

Base = 109, Multi-response

At UMC, Worrell says they've started healthy eating classes for patients with diabetes and their families, "to help get them all on board, and that's helped a lot."

Patient clinical experience objectives

When asked to name the top three organizational goals related to patient clinical experience (Figure 3), clinical staff engagement (73%) and clinical outcomes (70%) topped the responses, which Worrell says are both common goals.

Worrell says UMC was particularly hard hit by high patient volumes during the height of the pandemic, and that led to burnout. "In our region, we were the only ones giving the COVID shots, and we were the only ones doing COVID testing. We were doing 100 tests a day and did almost 50,000 vaccines," he says.

To increase clinical staff buy-in at UMC and alleviate burnout, the physicians group provides performance bonuses and reduced administrative time for physicians, and gifts for support staff.

Figure 4 | How would you rate your strength in these organizational goals?

	Very strong	Somewhat strong	Somewhat weak	Very weak
HCAHPS or other CMS survey scores	18%	64%	17%	1%
Clinical outcomes	30%	65%	5%	0%
Clinical staff engagement	20%	48%	30%	2%
Reimbursement	17%	47%	32%	4%
Clinical staff satisfaction	16%	50%	33%	2%

Base = 109

However, Worrell was struck by the placement of reimbursement (46%) near the bottom of organizational goals.

"A lot of clinicians like to say that reimbursement isn't important, but whether we like it or not, reimbursement is necessary," he says. "During the pandemic a lot of insurance companies were delaying payments, denying them, or changing codes and going back and forth with us so they could keep the money a little bit longer."

Organizational goal strength

As for the relative strength of these organizational goals (Figure 4), 95% of respondents gave their clinical outcomes a very strong (30%) or somewhat strong (65%) grade, while 82% graded their HCAHPS and other CMS survey scores as very strong (18%) or somewhat strong (64%).

Figure 6 | **What level of improvement have you seen in your HCAHPS scores or similar metrics?**

- Major improvement: 7%
- Moderate improvement: 43%
- Minor improvement: 39%
- No improvement: 6%
- Don't know: 6%

Base = 109
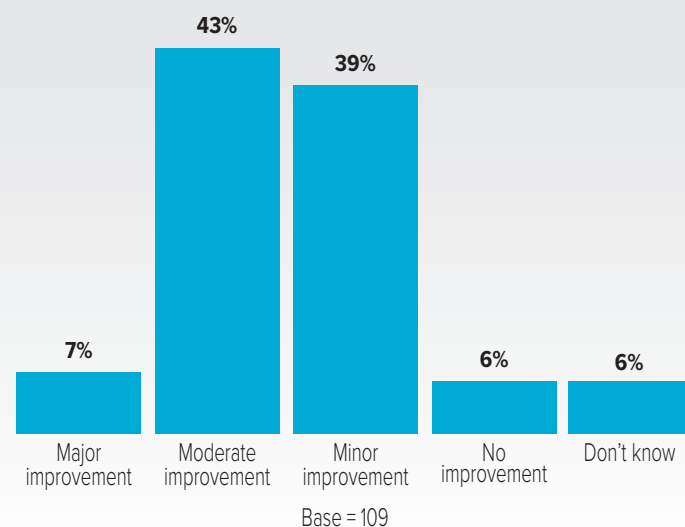
"The government is implementing these value-based care programs, but everybody is still up in the air about what they want," Worrell says.

To measure patient clinical experience (Figure 5), 72% of respondents said they use HCAHPS and other CMS surveys, and 68% said they rely on post-discharge communication with patients.
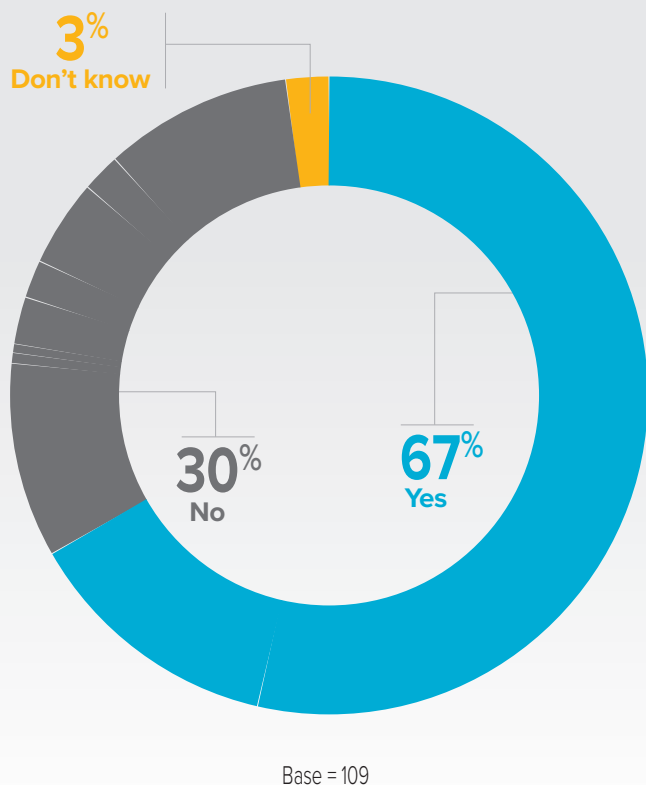
Worrell says UMC hired Press Ganey to survey patients, but is considering other options as well.

"Our board has told us that they want to get more into focus groups. They want to call patients and have actual focus groups about what patients want in our center," Worrell says.

"Our board is made up of community members who hear a lot from patients. So, now that they've heard those

Figure 5 | **How do you measure your patient clinical experience?**

- HCAHPS or other CMS survey: 72%
- Post-discharge communications: 68%
- Monitoring social media reviews: 45%
- Patient advisory councils: 28%
- Focus groups: 16%
- Other: 14%

Base = 109, Multi-response

Figure 7 | **Do you have a dedicated leader who is responsible for patient clinical experience?**

3%
Don't know

30%
No

67%
Yes

Base = 109

Level of improvement in HCAHPS scores

Eighty-two percent of respondents (Figure 6) report either moderate (43%) or minor (39%) improvements to their HCAHPS scores in the push to value-based care, with only 7% claiming major improvements.

Worrell says the pandemic was "horribly disruptive" for UMC because physicians were missing vital contacts with patients for preventive care, mammograms, and other cancer screenings.

Figure 8 | **What staff members get training for patient clinical experience?**

Staff	%
Nurses	77%
Front desk/registration staff	70%
Physicians	66%
Other clinical staff	56%
Case managers	52%
Executives	45%
Outpatient partners	28%
None of the above	10%

Base = 109, Multi-response

misgivings that the patients don't like, they've focused on that as an avenue. Plus, people sometimes may not be wholly truthful in a survey versus a focus group where they can share their experiences."
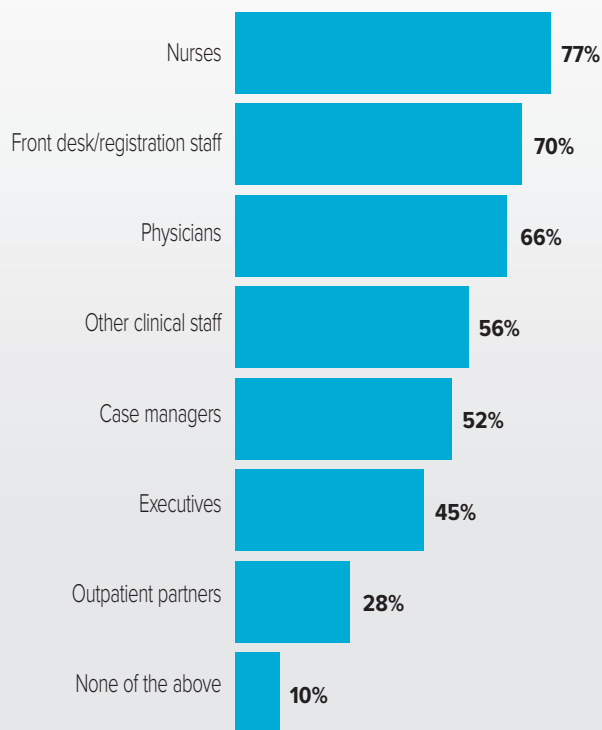
Nearly half (45%) of respondents say they also monitor social media reviews, but Worrell doesn't hold much stock in online feedback. "It may not be the best metric just because people are simply more overzealous online in one way or the other," he says.

Figure 9 | **Rate the success of your patient clinical experience training for the staff members below.**

	Highly effective	Slightly effective	Slightly ineffective	Highly ineffective	Not applicable
Nurses	23%	57%	11%	2%	6%
Case managers	16%	49%	9%	2%	23%
Physicians	20%	50%	9%	6%	14%
Executives	19%	48%	8%	3%	21%
Outpatient partners	10%	42%	11%	6%	31%
Front desk/registration staff	18%	58%	14%	4%	5%
Other clinical staff	14%	60%	9%	4%	12%

Base = 98, of those who train staff members

As for the 7% of respondents who reported major improvements, Worrell says "that's pie in the sky. I don't think they saw that."

On the question of whether their organization has a "dedicated leader" to monitor patient clinical experience (Figure 7), 67% said yes, while 30% said no.

Worrell says UMC relies on its compliance officer and a quality assessment team that "work together to improve the scores, but we don't have a dedicated person just based on clinical experience."

"In our current setup, that's how we've always done it, and also we're not quite large enough yet," he says. "Whereas as we grow, perhaps that's something we need to look at."

Training in patient clinical experience

Staff training for patient clinical experience for most respondents (Figure 8) was focused primarily on nurses (77%), front desk/registration (70%), and physicians (66%).

Worrell says the training UMC provides for administrative staff is not as rigorous as the training provided to clinicians.
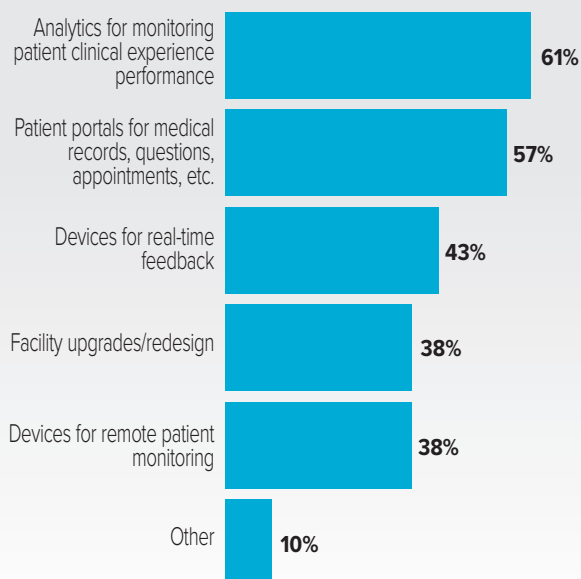
"Across the board, we get patient experience–, customer service–type training," he says. "As far as that, the nurses have been more diligent training and going through how to improve a patient's life, how to improve their outcomes, all the way through from visit through referrals to the entire process."

Patient clinical experience training was slightly or highly effective (Figure 9) for nurses (80%), front desk/registration staff (76%), other clinicians (74%), physicians (70%), and even executives (67%).

Worrell says he is not sure how you can measure the effectiveness of patient clinical experience training for executives because "they're not actually face to face with

Figure 10 | **How will you facilitate more meaningful interactions with inpatients over the next three years?**

Category	%
Analytics for monitoring patient clinical experience performance	61%
Patient portals for medical records, questions, appointments, etc.	57%
Devices for real-time feedback	43%
Facility upgrades/redesign	38%
Devices for remote patient monitoring	38%
Other	10%

Base = 109, Multi-response

Surprisingly, only 38% of respondents said they'll use remote patient monitoring devices.

"I don't know why that number is so low," Worrell says. "A lot of these programs are moving towards that. We implemented the remote patient monitoring for blood pressure. That's a big focus now especially from the insurance companies and otherwise. So, I'm surprised it's so low."

Patient clinical experience focus areas

Survey respondents were asked to prioritize three areas where positive patient clinical experience is most important (Figure 11). More than two-thirds (68%) of respondents identified discharge and follow-up as key encounter

patients," although he concedes that having a clinical background is an asset in the C-suite.

"I have a clinical background, so I like executives who know not only what their clinicians are going through, but also what patients are going through," he says. "For those who don't have that clinical background, I don't know how necessary [the training] would be."

Looking ahead, the survey asked respondents how they will improve inpatient interactions over the next three years (Figure 10), with 61% saying they'll rely on analytics to monitor clinical experience and 57% saying they will use patient portals to communicate directly with patients to answer questions, provide medical records, and schedule appointments.
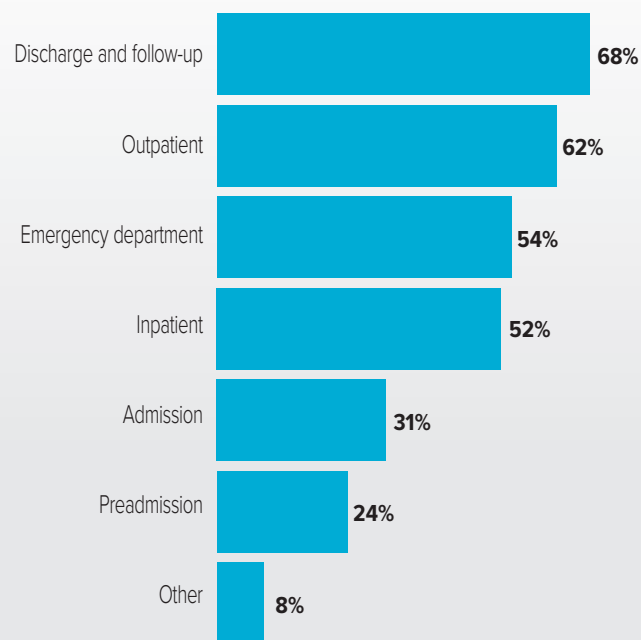
Figure 11 | **In what three areas is a positive patient clinical experience most important?**

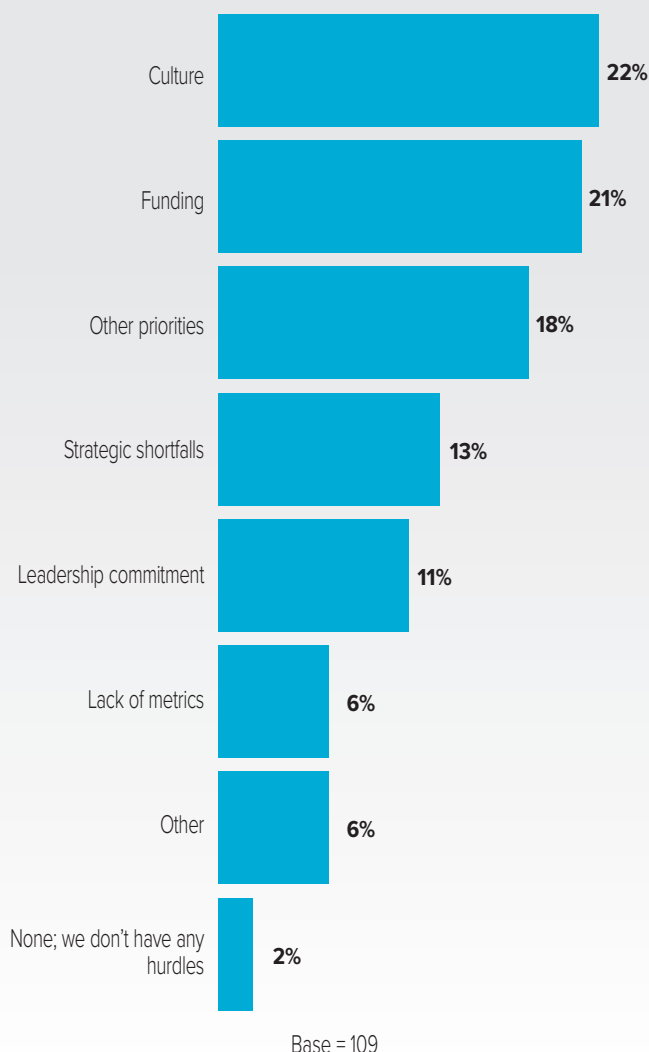| Category	%
Discharge and follow-up	68%
Outpatient	62%
Emergency department	54%
Inpatient	52%
Admission	31%
Preadmission	24%
Other	8%

Base = 109, Multi-response

Figure 12 | What is the biggest hurdle for your patient clinical experience program?

Category	Percentage
Culture	22%
Funding	21%
Other priorities	18%
Strategic shortfalls	13%
Leadership commitment	11%
Lack of metrics	6%
Other	6%
None; we don't have any hurdles	2%

Base = 109

"If you start off on the wrong foot, if you've already angered or upset the patient at admission, you're already starting a bad trend going forward," he says. "But I understand that a discharge could be highest because that's your last interaction. Plus, it's your opportunity to walk through everything that we went through in the visit and going forward, how they'll use that."

When asked to identify the biggest hurdle for their patient clinical experience program (Figure 12), 22% cited workplace culture, 21% said funding, and 18% said "other priorities."

At UMC, Worrell says culture includes "a smiling face at the front desk."

"It's the push for the employee to help the patient all the way through their experience and avoid that feeling of a cattle call," he says. "You want the patient to feel like their needs were met and everything was to their liking and [you are] trying to help them."

As with everything else in healthcare, Worrell says funding—or a lack thereof—is also a significant barrier.

"The more funding you have, the more you can focus on clinical outcomes," he says. "But labor costs and everything else have gotten so high that funding is a necessary evil."

areas, followed by outpatient (62%) and emergency department (54%).

Worrell was surprised that preadmissions (24%) and admissions (31%) weren't higher on the list.

John Commins is a senior editor for HealthLeaders. He can be contacted at jcommins@healthleadersmedia.com.

The HealthLeaders *2023 Patient Clinical Experience Survey* was conducted by the HealthLeaders Intelligence Unit, powered by the HealthLeaders Council. It is part of a series of thought leadership studies. In January 2023, an online survey was sent to the HealthLeaders Council and select members of the HealthLeaders audience at healthcare provider organizations. A total of 109 completed surveys are included in the analysis. The margin of error for a base of 109 is +/- 9.4% at the 95% confidence interval. Survey results do not always add to 100% due to rounding.

What Healthcare Leaders Are Saying

Here are selected comments from leaders who share how they will improve their organization's patient clinical experience within the next three years. As we reviewed the responses, we saw similar comments that stood out, which mentioned dedication to staff training and education, listening to patients, and acting on patient suggestions, wants, and needs. Here are some of the answers that differed from that trend.

"I believe patient navigators will play a huge role in improving patient clinical experience. Having the ability to assist patients in navigating the health system is very important for successful patient outcomes and patient satisfaction. In today's healthcare systems, patients are often left feeling overwhelmed with the decisions they have to make or even knowing where to start to make the decisions. Patient navigators can walk patients through these processes and enable them to make the right choices for their healthcare."

—VP of clinical services at a small physician organization

"Work on relationship-based care and change the culture."

—CNO at a small hospital

"More engagement with patient's families, etc., for appropriate discharge planning."

—VP of quality at a medium-sized health system

"Moving the priority of the clinical experience up in the strategic plan so that it receives the needed focus."

—CFO at a medium health system

"Hire the best people. Reward and celebrate their successes quarterly!"

—COO at a small hospital

About the HealthLeaders Intelligence Unit

The HealthLeaders Intelligence Unit, a division of HealthLeaders, 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.

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RESPONDENT PROFILE

TITLE

Base = 109

45% Clinical leadership

26% CEO, President

18% Operations leadership

6% Financial leadership

3% Marketing leadership
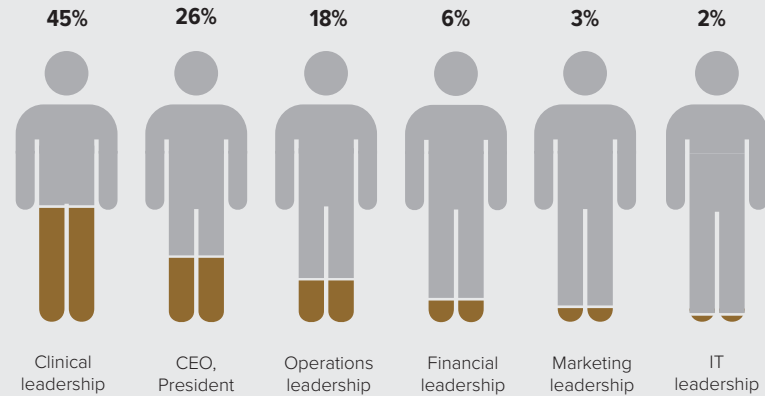
2% IT leadership

CEO, PRESIDENT
> CEO, President
> Chief Executive Administrator
> Chief Administrative Officer
> Board Member
> Executive Director
> Managing Director
> Partner

OPERATIONS LEADERSHIP
> Chief Operations Officer
> Chief Strategy Officer
> Chief Compliance Officer
> Chief Purchasing Officer
> VP/Director Operations Administration
> VP/Director of Compliance
> Chief Human Resources Officer
> VP/Director HR/People
> VP/Director Supply Chain/Purchasing

FINANCIAL LEADERSHIP
> Chief Financial Officer
> VP/Director Finance
> VP/Director Patient Financial Services
> VP/Director Revenue Cycle
> VP/Director Managed Care
> VP/Director Reimbursement
> VP/Director HIM

CLINICAL LEADERSHIP
> Chief Medical Officer
> Chief Nursing Officer
> Chief of Medical Specialty or Service Line
> VP/Director of Medical Specialty or Service Line
> VP/Director of Nursing
> Chief Population Health Officer
> Chief Quality Officer
> Medical Director
> VP/Director Ambulatory Services
> VP/Director Clinical Services
> VP/Director Quality
> VP/Director Patient Safety
> VP/Director Postacute Services
> VP/Director Behavioral Services
> VP/Director Medical Affairs/ Physician Management
> VP/Director Population Health
> VP/Director Case Management
> VP/Director Patient Engagement, Experience

IT LEADERSHIP
> Chief Information Technology Officer
> Chief Information Officer
> Chief Technology Officer
> Chief Medical Information Officer
> Chief Nursing Information Officer
> VP/Director IT/Technology
> VP/Director Informatics/Analytics
> VP/Director Data Security

TYPE OF ORGANIZATION

Base = 109

Hospital	**39%**
Physician organization (MSO/IPA/PHO/clinic)	**23%**
Health system (IDN/IDS)	**22%**
Ancillary services provider (diagnostic/therapeutic/custodial)	**5%**
Ambulatory surgical center	**3%**
Convenient care/retail clinic (including retail pharmacies with clinics)	**3%**
Urgent care center	**3%**
Payer/health plan/insurer (HMO/PPO/MCO/PBM)	**2%**
Third-party administrator, pharmacy benefits manager	**1%**

NUMBER OF PHYSICIANS

Base = 109

1–9	**13%**
10–49	**18%**
50+	**69%**
N/A	**0%**

NUMBER OF BEDS

Base = 109

1–199	**40%**
200–499	**17%**
500+	**13%**
Do not have a standard number of beds	**30%**

PROFIT STATUS

Base = 109

Nonprofit	**65%**
For-profit	**35%**

NET PATIENT REVENUE

Base = 109

$1 billion or more (large)	**13%**
$250 million–$999.99 million (medium)	**15%**
$249.9 million or less (small)	**59%**
None of above	**14%**

RESPONDENT REGIONS

Midwest **31%**
West **22%**
Northeast **27%**
South **20%**