Patient Experience Learning Collaborative Report

June 2026

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Executive Summary

The Patient Experience Learning Collaborative, a partnership between the HSCRC and MHA, was formed to investigate strategies for improving Maryland hospital HCAHPS scores, which generally lag behind other states despite significant financial incentives. A survey revealed key challenges, including a mismatch between prioritizing improvement and dedicating resources, an over-reliance on HCAHPS outcome measures, and the limited impact of widespread best practices. The Collaborative concluded that more sustained success requires greater investment in consistency of teaching and coaching for these practices.

The Collaborative's work led to three key learnings, starting with the finding that HCAHPS is a quality and safety indicator, with high patient experience scores correlating to fewer safety events. Second, sustained improvement demands that hospitals invest in five foundational infrastructure elements: a Senior Patient Experience Leader, clear data strategy, supportive policies, best practice measurement tools, and staff coaching. Finally, the Collaborative found that state-wide data-driven decisions should be used to promote best practice adoption in the appropriate care setting as a part of cycles of learning.

The report discusses next steps, including implementing a state-wide HCAHPS Dashboard, establishing quarterly best-practice sharing meetings, and for the HSCRC to consider incentives for process-measure questions and sustainable best practice investments.

Introduction and Background

The Maryland Health Services Cost Review Commission (HSCRC) and the Maryland Hospital Association (MHA) partnered to create the Patient Experience Learning Collaborative. The Collaborative was co-chaired by Dr. Giora Netzer, Vice President at Chief Experience Officer for the University of Maryland Medical System and Jonathan Sachs, Patient Experience Consultant for the HSCRC.

The Collaborative’s membership included patient experience leaders from hospitals across the state of Maryland, Maryland’s health care regulatory bodies, and representatives from national survey vendors. The shared goal of the learning collaborative was to investigate strategies and practices to improve the patient experience at Maryland hospitals reflected through the Hospital Consumer Assessment of Healthcare Providers and Systems Hospital (HCAHPS) survey scores.

Maryland typically struggles compared to other states in HCAHPS performance. While the state of Maryland has been aggressive in incentivizing HCAHPS performance through the Quality Based Reimbursement (QBR) program, it has yet to yield significant improvement. For example, the National Value Based Purchasing (VBP) program incentivizes HCAHPS performance for FY 2027 through 2029 using six HCAHPS dimensions. Each HCAHPS measure will have equal weight and the score is based on

the percentage of a hospital's patients who chose the most positive, or top-box, survey response. HCAHPS measures make up 25% of the inventive[1].

In the Maryland QBR program, HCAHPS is weighted much more heavily. HCAHPS measures make up nearly 40% of the total incentive in the QBR program. The incentive includes HCAHPS Top Box, HCAHPS Consistency, and HCAHPS Linear Scores. This weight and mix is designed as a substantial incentive for Maryland hospitals to improve performance in HCAHPS measures[2].

The learning collaborative discussed the reasons performance has not matched the weight that the State of Maryland has added to incentivize patient experience, which is discussed in detail later in this report. In fact, this collaborative formed in an effort to improve Maryland hospitals' ranking through strategies that substantively improve the experience of receiving care in Maryland's hospitals.

The Collaborative met on a monthly basis from December 2024 through October 2025. During that time, the Collaborative heard from national leaders in patient experience, Maryland's hospitals, and Maryland's regulatory bodies including the HSCRC and Maryland Health Care Commission (MHCC) in an effort to better understand Maryland hospitals' historical HCAHPS performance and how to improve it.

For Maryland to transform its HCAHPS scores, State hospital leaders must continue to recognize and invest in improving the patient experience as an integral part of delivering high-quality, safe, and reliable hospital care.

Methods

Meetings

The Collaborative met monthly from December 2024 to December 2025. Each meeting featured a patient story to connect back to purpose. During the meetings, the group heard patient stories, presentations from national experts, hospital leaders across the state, and reviewed HCAHPS data from across the state of Maryland.

Data Review

The Collaborative reviewed data prepared and presented by the MHCC. The data sorted Maryland hospital HCAHPS data by geographic region, service line, academic vs. community medical center, and analyzed patient demographics. The data showed several interesting findings that helped the Collaborative

[1] https://qualitynet.cms.gov/files/674f1765fef025ccdcb3cea9?filename=VBP_FY2027_QRG.pdf and HCAHPS online

[2] https://hscrc.maryland.gov/Documents/Quality_Documents/QBR/RY2027/QBR%20RY%202027%20Final%20Recommendation.pdf

understand the characteristics of hospitals that perform the best in the state. Those presentations are presented for your review in Appendix A of this report.

Survey of Patient Experience Departments in Maryland

In addition to analyzing HCAHPS data, the Learning Collaborative also surveyed its membership, patient experience professionals from hospitals across the state. The goals of the survey included: understanding how hospital patient experience performance is prioritized at Maryland hospitals, understanding hospitals' investment in improving patient experience, discovering approaches that hospitals are using to improve performance, understanding the patient experience data being used to make decisions at hospitals, and learning more about best practices to bring to future learning collaborative meetings. The survey took place in March of 2025 and had 26 responses with all learning collaborative health systems represented in the data.

The full results of the survey are included in Appendix B of this report. The Learning Collaborative reached three conclusions based on the survey data.

1. There is a mismatch between prioritizing patient experience improvement and devoting resources to making the needed improvements.
2. Hospitals measure patient experience primarily through the HCAHPS survey, which are outcome measures only.
3. Hospitals across the state are largely trying to implement the same best practices and improvement strategies. The limited impact of best practices could be improved through investment in consistency of teaching and coaching to those practices.

Key Learnings

The HCAHPS Learning Collaborative members are united in the belief that it is possible for Maryland hospitals to improve the patient experience. With the right effort and investment over a sustained period of time, Maryland hospitals can significantly improve HCAHPS scores. As Thomas Jefferson once said, “If you want something you've never had, you must be willing to do something you've never done before.” With that important sentiment in mind, we present three key learnings from our work together over the last year.

1) HCAHPS Scores Are Quality Indicators

Patients perceive the quality of their care through their patient experience. In the vast majority of cases, patients are not trained clinicians. As a result, they often perceive the quality of their care in a hospital similarly to how they may perceive the quality of their food in a restaurant, the quality of service at a hotel, or the quality of customer service at their favorite store. A patient's feeling of safety is often a reflection not of the latest breakthrough in medical research, but of how they are treated by clinical staff, the coordination of the care team, and the environment where they receive care.

One health system in Maryland has taken the link between quality and patient experience one step further. Frederick Health, led by Jamie White, Chief Nursing Officer views service failures as harm, treating them just like any other type of harm that occurs at the hospital. Her team uses Six-Sigma tools to define, measure, analyze, improve and control processes that cause service failures and address patient dissatisfiers. Through pilot programs and Plan-Do-Study-Act (PDSA) cycles, Frederick Health has implemented several successful pilots that have improved HCAHPS scores in several domains. The mindset shift of viewing service failures as harm should be adopted by all hospitals.

The data and the research validates how quality, safety, and patient experience are intertwined. The Collaborative heard a presentation from Dr. Tejal Gandhi, Chief Safety and Transformation Officer for Press Ganey. Dr. Gandhi shared that being a top patient experience performer (75th percentile and above) on "Staff Worked Together" questions is associated with 10% fewer Total Falls and 10% fewer Injury Falls. In addition, top performers on "Staff provide care in a safe manner" questions are associated with 8% fewer Hospital-Acquired Pressure Injury (HAPI) and 16% fewer Total Falls.

As Dr. Gandhi shared additional data, it became clear that a patient's perception of how "Staff worked together" and "Provided care in a safe manner" are different from how a health care worker might answer similar questions. When patients feel safe, "Patients frequently mention that medical professionals are friendly, caring and professional, which helps them feel at ease and confident in the care they receive." On the other hand, patients that felt unsafe mentioned environmental cleanliness concerns like the cleanliness of the waiting room, patient room, and even parking lots.They also mentioned dismissive attitudes from staff or administrative errors. In summary, Dr. Gandhi shared, "These issues significantly impacted the patents' sense of security and trust in the healthcare environment."

Similarly, patients perceive the quality of the Emergency Department (ED) visit by the length of time that they wait for care. The Learning Collaborative received updates from the ED Department Length of Stay measure workgroup in an effort to improve HCAHPS scores of patients admitted to the hospital through the ED.

2) Invest in the Groundwork to Support Implementation of Best Practices

Improvement takes time. For lasting improvements in HCAHPS, hospitals should make Infrastructure investments to implement best practices that produce sustained results over a long period of time. The Learning Collaborative discussed a "Maslow's Hierarchy of Needs" for Patient Experience that appears here:

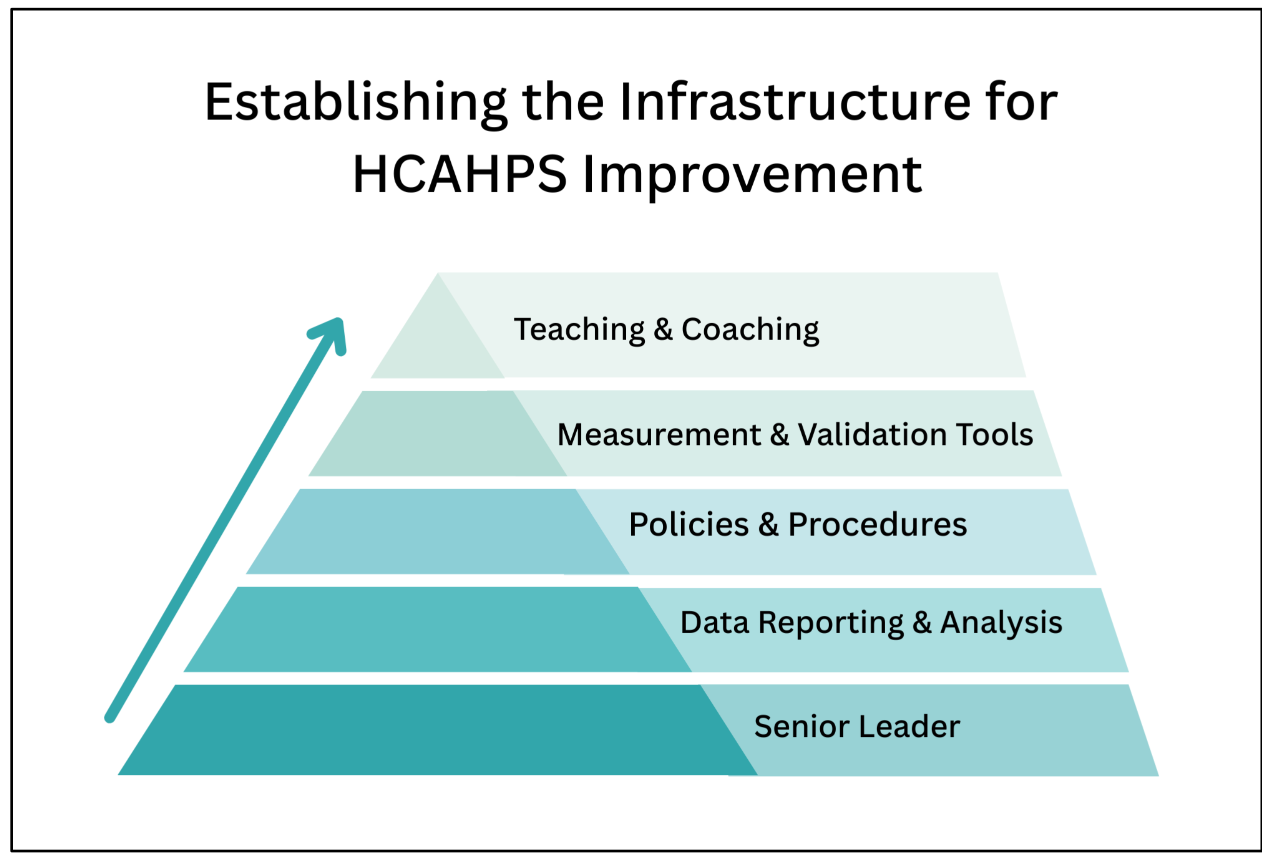


Figure 1. "Maslow's Hierarchy of Needs" for Patient Experience

First, **at the foundational level is a Senior Patient Experience Leader** who reports to the CEO and can create the strategy to deploy the needed infrastructure to implement best practices including data analysis, human capital, and technology unique to a particular hospital. This senior leader can bring the patient voice to the senior leadership table, encouraging new ways to meet patient needs specific to each hospital. According to the survey of Learning Collaborative members, the majority of hospitals in Maryland do not have a Chief Experience Officer or Vice President of Patient Experience to lead the creation of the infrastructure and deployment of best practices.

Second, a clear data reporting and analysis strategy is needed. HCAHPS data are an outcome measure and without the right listening methods and data systems to supplement the HCAHPS survey, it may not be clear what makes up a hospital's patient perception of what each question means to its particular population. For example, nurse courtesy and doctor courtesy are subjective measures answered based on a patient's definition of what is courteous and what is not. Additionally, data reporting can be misunderstood when it is not standardized, using nuanced differences like adjusted or unadjusted data or reporting by discharge date or survey received date, must be standardized to effectively track progress. There are already several systems in Maryland that have deployed this step including the University of Maryland Medical System (UMMS), Greater Baltimore Medical Center (GBMC), and Adventist HealthCare.

Third, systems should adopt policies and procedures that support patient experience improvement. These include clear policies on improving support for both the patient and a support person in the hospital setting. Additionally, policies pertaining to standardized discharge paperwork containing explanations in plain language and responses to patient complaints should also be adopted.

Fourth, measurement and validation tools are needed to assess implementation of best practices. Patient experience best practices, like bedside shift report and hourly rounding requires validation and measurement to understand if those best practices are, in fact, taking place. Some hospitals validate this through supplemental questions on the patient survey but that does not always tell the whole story. Hospitals should invest in and deploy infrastructure to measure how consistently these behaviors are taking place. The Learning Collaborative has seen several presentations that show that these best practices do work in Maryland, but only when the practices are measured to ensure that they are taking place.

Hospitals should invest in infrastructure to track best practices like hourly rounding and bedside shift report. This could come in the form of simple and effective validation tools like kamishibai boards. Hospital technology systems that include digital monitoring to confirm hourly visits to patient rooms is another helpful tool. Whatever the mechanism, being able to measure these best practices beyond self-validation is essential to being able to manage to the desired result.

Fifth, teaching and coaching are necessary to educate clinicians on the social skills and emotional quotient (EQ) involved in caring for human beings. Social skills, customer service skills, and emotional intelligence are core solutions for improving HCAHPS scores. Being able to anticipate a patient's needs, be responsive to family members' needs, and show empathic concern are vital to the patient experience. For many, these skills are not intuitive. Practicing in a hospital environment can also impact a person's psychology, making caregivers more jaded, skeptical, and impatient. From the patient's perspective, a clinician's attitude and bedside manner can shape the patient's perception of the clinician's clinical acumen.

Having staff who can help select, educate, simulate, monitor, and coach clinicians on how to behave towards patients is essential. Most hospitals in Maryland have small patient experience teams. Many of them focus on producing data or responding to patient complaints. Patient experience teams should be staffed enough to be able to engage in the proactive work of best practice implementation, including education and coaching for both clinical leaders and bedside staff. A patient experience department should be more than the "Complaint Department" or data analysts. They should be strategic partners in helping to fully deploy best practices by engaging hospital leadership, bedside staff, patients, and family members.

Furthermore, clinical leaders must be coached on how to foster cultures of employee engagement. According to Press Ganey, Organizations with high engagement are three times more likely to be top

performers for patient experience. Helping clinical leaders engage their teams is a vital part of this work and can be done by high-functioning and strategically oriented patient experience professionals.

With the right infrastructure in place, best practices can be deployed successfully in Maryland. We know this works because it is being done in many hospitals across our state with positive results. When hospitals invest in the infrastructure to improve, they can see rapid improvement in patient experience scores.

3) Identify Trends Using State-Wide Data

Data-driven decisions should be used to promote best practice adoption in the appropriate care setting as a part of cycles of learning. The learning collaborative looked for trends in state-wide HCAHPS in service lines, geographic location, size of hospital and patient demographics, which helped systems dialogue and learn from each other. In fact, several leaders went for site visits at other hospitals to learn and collaborate based on the data analysis.

In addition to HCAHPS outcome measures, the Learning Collaborative identified a need for understanding, measurement, and analysis of process measures, in addition to outcome measures, as a part of improving patient experience scores over time. Process measures are a leading indicator for HCAHPS results. The more hospitals across Maryland can identify process measures that successfully move outcome measures, the more progress the state can make on improvement.

The Collaborative is excited about the state-wide HCAHPS data dashboard being launched by the MHCC, which we discuss later in this report. Phase 1 adoption is scheduled to include visualizations on unadjusted HCAHPS top-box scores, starting with January to June 2025 patient-level data with high-priority filters for stratification and comparisons to State benchmarks.

Best Practices That Improve Scores

During the course of the Learning Collaborative's meetings, we were fortunate to hear from several hospitals in Maryland who have adopted and deployed best practices to improve HCAHPS scores. Below is a summary of some of the best practices that hospitals can learn from and adopt quickly to improve HCAHPS scores.

Adventist HealthCare: Shady Grove Medical Center - Hourly Rounding

At Adventist HealthCare: Shady Grove Medical Center, hospital leadership has focused on improving hourly rounding, achieving their highest HCAHPS scores in five years. By investing in teaching nursing leaders how to observe, coach, and document hourly rounding through an electronic rounding platform, Marcello Khattar, the System's Patient Experience leader, was able to track what was working and how the hospital system could do more of it. He noticed that higher coaching levels on nursing units

correlated with increased patient-reported hourly rounding. Furthermore, the greatest hourly rounding improvement was linked to the highest HCAHPS gains by unit.

By fostering a coaching culture to develop their team and enhance results, Adventist HealthCare: Shady Grove Medical Center has successfully deployed a nurse-rounding best practice and has seen HCAHPS scores improve.

Lifebridge Health - Strategic Planning

Joann Cox, Chief Experience Officer of LifeBridge Health presented the hospital system's 2025-2026 patient experience strategic plan. LifeBridge is investing in making sure people are connected to their work and have a deep understanding of why patient experience best practices are both important and work to achieve patient satisfaction goals. As a first step, LifeBridge is investing in improving their staff's organizational identity so that they feel connected to investing time in improving patient experience.

Through staff engagement, education, and coaching, LifeBridge is focusing its strategy on making the case for improvement for everyone that gives care at a LifeBridge facility.

University of Maryland Medical System - Get to Know Me Boards, and Interdisciplinary Bedside Rounds

Giora Netzer, Learning Collaborative Co-Chair and Chief Experience Officer for the University of Maryland Medical System (UMMS) shared best practices that are working at hospitals in the largest health care system in Maryland. All UMMS member organizations use Get to Know Me Boards, with specialty boards for different service lines. The data showed that patients that respond "always" to the "Care Team uses the Get To Know Me Board" question on the survey also respond more favorably on the Nurse Communication survey questions.

UMMS is also standardizing Interdisciplinary Bedside Rounds (IBR) as a core tactic in addition to nurse leader rounding and bedside shift handoff. They created standard work for IBR based on best practice and oversight group consensus. The system found that IBR was positively correlated with physician and nurse communication scores and patient-perceived frequency of rounding.

GBMC - Data Monitoring and Reporting

Rebecca Stein, Health Data Operations Analyst shared GBMC's process for reporting HCAHPS outcomes data to the HCAHPS Learning Collaborative Data Subcommittee. GBMC utilizes a monthly internal dashboard that tracks results compared to previous fiscal year top box scores and the QBR achievement threshold scores. Rebecca also designs and reports leadership slides, consultant dashboards tracking risk-adjusted data, and a weekly report from the Press Ganey database.

In addition, Rebecca compiles and publishes a straightforward internal snapshot and unit infographic sheet to simplify unit specific key drivers for improvement and unit specific patient comments for

unit leaders. Taking patient experience scores and simplifying the data so it is easy to absorb and understand for staff at the unit-level allows staff-members to take ownership for the needs of patients specific to their unit.

Frederick Health - Treat Patient Dissatisfaction as Harm

As mentioned earlier in the report, At Frederick Health, Chief Nursing Officer Jamie White's team treats service failures as a form of harm, applying LEAN tools and Plan-Do-Study-Act (PDSA) cycles to define, analyze, and control processes that lead to patient dissatisfaction. This approach has resulted in successful pilot programs and improved HCAHPS scores across several areas, underscoring a vital mindset shift that could benefit other hospitals in the state as well.

Johns Hopkins Health - Emergency Department Wait Times

Steve Meth, Chief Experience Officer for Johns Hopkins Medicine as well as Neysa Ernst, Director of Patient Experience at Johns Hopkins Howard County Medical Center and Stacy Colimore, Director of Patient Experience at Johns Hopkins Bayview Medical Center presented on their efforts to improve patient perception and experience when facing long Emergency Department (ED) wait times.

The team at Johns Hopkins noticed that likelihood to recommend scores drop most significantly after the patient spends nine hours in the ED, but being informed about care delays can help earn higher likelihood to recommend scores. John Hopkins added technology to improve communication with patients and patient support people through event messaging. Patients can also use the Bedside Mobile app in the ED to get summaries based on the step the patient is in for their overall ED visit, such as “Initial Assessment”, “Waiting for Treatment Area” and “Care in Progress”. Johns Hopkins also saw improvement when they started to use a Discharge Hospitality Suite in July of 2024 and ED fast track expanded their hours and bed capacity to help reduce ED wait times.

Luminis Health - Bringing More Stakeholders in For Decision Making

Kali Milgate, System Director of Patient Experience presented on Luminis Health’s effort to build a sustainable patient experience vision and function beyond implementing best practices. Luminis has taken the approach of being more inclusive when it comes to their approach to patient experience, broadening impact beyond the bedside. She emphasized that expanding the Patient Experience Steering Committee to include Human Resources, Marketing, Performance Improvement, Quality/Safety, Operations, and Clinical leaders has strengthened their ability to treat patient experience as a multi-dimensional, system-wide priority.

MedStar Health - Human Experience Systemwide Summit

Allison Profili, System Director, Patient Experience launched an annual Human Experience Systemwide Summit to educate and train leaders on improving HCAHPS scores. This annual summit

helped leaders at MedStar Health understand the direction, mindset, best practices, planning and leadership required to improve HCAHPS scores across the hospital system.

Next Steps

There are a few areas that the Learning Collaborative thought would merit further discussion and consideration by members of the HSCRC, the HSCRC's senior leadership, and hospital leaders.

1) Implement Maryland Hospital HCAHPS Dashboard

This report highlighted the unique collaboration that took place during the Learning Collaborative meetings. One tool that would help continue this effort is a Maryland patient experience dashboard. Establishing a data dashboard that can be viewed by hospital patient experience leaders can help encourage them to identify and learn from high performing hospitals in the state. The MHCC has created a working dashboard prototype with phase 1 expected to launch shortly after the release of this report.

2) Meet Quarterly To Share Best Practices

Among the most valuable work that Learning Collaborative participants highlighted was the networking and community created by meeting together regularly. For patient experience leaders, the opportunity to share best practices and ideas, discuss challenges, and work together to achieve performance goals was welcome. The meetings featured a high degree of engagement and excitement. The group intends to stay together to work to improve HCAHPS scores across the state of Maryland.

As hospitals across Maryland work together, different hospitals can deploy and learn from different best practice implementations. As the collaborative continues to meet and share information, hospitals can learn from multiple best practices deployments simultaneously rather than one at a time, leading to rapid-cycle learning and improvement.

3) Consider State-Wide Best Practice Incentives

The HSCRC should consider incentives for adopting specific supplemental questions on the survey that measure process measures. These additional questions will facilitate the sharing of best practices in implementing initiatives that are well-documented for their success but have been challenging in Maryland.

In addition, the HSCRC should consider incentives for hospitals who make investments in sustainable implementation of best practices.

Conclusion and Thank You

On behalf of the entire HCHAPS Learning Collaborative, we wanted to thank the leadership of the HSCRC and MHA for convening this group. Specifically, thank you to John Kromm, Allan Pack, and Alyson Schuster from the HSCRC for recognizing the opportunity and asking for our guidance to improve

Maryland's HCHAPS scores. We have also appreciated the MHA's leadership and involvement in forming this collaborative, identifying members, and guiding the sessions. Specifically we want to thank Melony Griffith, Tequila Terry, and Amanda Wright for their leadership and partnership during the work of the Learning Collaborative. We also wanted to extend our gratitude to our partners at the MHCC, specifically Theressa Lee, Courtney Carta, and Teresa Brown for their assistance on providing analyses on state-wide HCHAPS data.

We submit this report as a starting point as a part of a broader discussion of how Maryland hospitals can transform into national leaders in HCAHPS outcomes and overall patient experience.

Sincerely,

Giora Netzer *Jonathan Sachs*

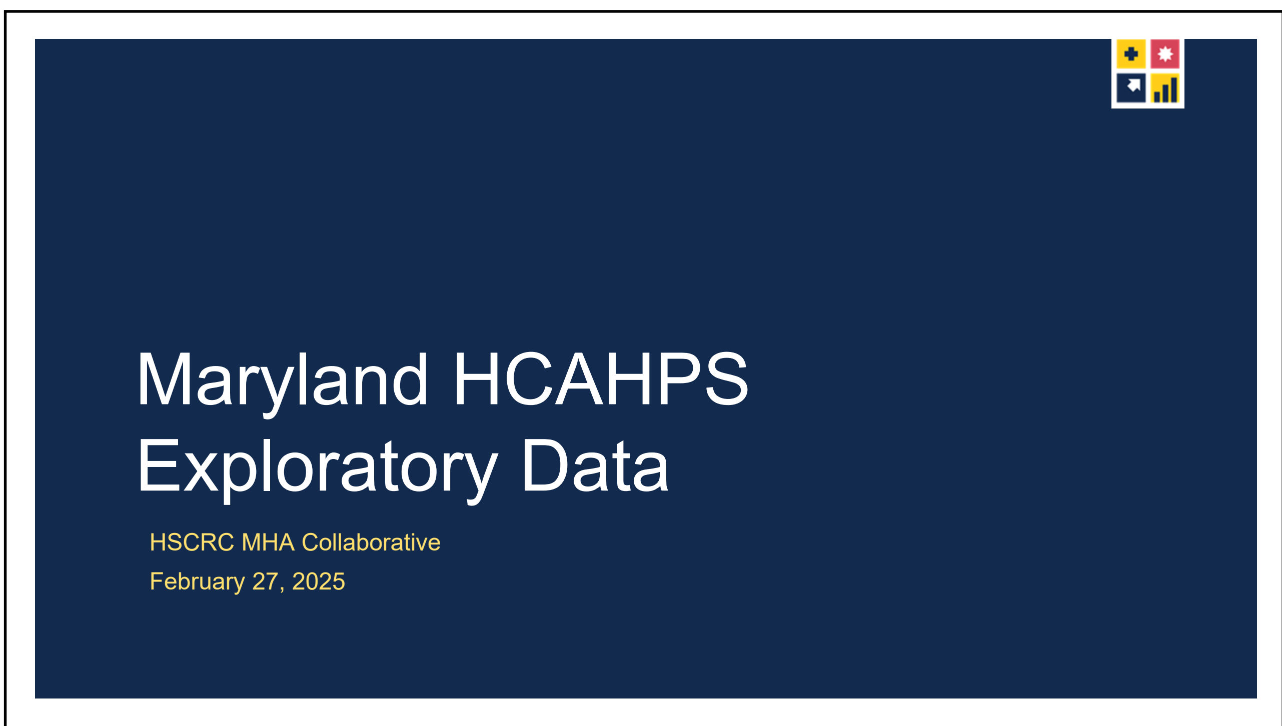
Dr. Giora Netzer, Co-Chair Jonathan Sachs, Co-Chair

HSCRC MHA HCAHPS Collaborative Participants

Organization	Contact Name	Title
Adventist HealthCare	Marcello Khattar, MBA	Director of Patient Experience
Frederick Health	Jamie White	VP Patient Care Services & Chief Nursing Officer
GBMC	Dr. Melvin Blanchard	Chair, Medicine
	Rebecca Stein	Health Data Operations Analyst
Garrett Regional Medical Center	Angela Maule	Regional Senior Director of Performance Improvement and Quality
HSCRC	Princess Collins Taylor	Chief II, Quality Initiatives
	Jonathan Sachs	Patient Experience Consultant
	Alyson Schuster	Deputy Director, Quality Methodologies
	Tina Simmons	Associate Director, Quality Methodologies
Johns Hopkins Health System	Steve Meth, JD, MS	Vice President, Chief Patient Experience Officer
Johns Hopkins Hospital	Shanne Keeny	Director of Patient & Family Experience
Johns Hopkins Howard County Medical Center	Neysa P. Ernst, DNP, RN	Director, Patient Experience
LifeBridge Health	Joan Cox, CPXP	Chief Experience Officer
Luminis Health	Kali Milgate	System Director, Patient Experience
MHA	Tequila Terry	Senior Vice President, Care Transformation & Finance
	Amanda Wright	Director, Quality & Clinical Care
MHCC	Teresa Brown	Methodologist, Center for Quality Measurement and Reporting
MedStar Health	Tony Calabria	Senior Director, Hospital Quality Programs and Clinical Quality
	Allison Profili	Director Performance Improvement/Patient Experience
Mercy	Conor Sullivan	Sr. Director, Quality Assurance
Mount Washington Pediatric Hospital	Justina Starobin	VP, Outpatient Services
NRC	Ryan Kalkwarf	Regional Director
Press Ganey	Jennifer Lux	Vice President, Atlantic Market
Suburban Hospital	Kris Hakanson	Director of Patient & Family Experience

Organization	Contact Name	Title
UMMS	Giora Netzer	Vice President and Chief Experience Officer
UPMC Western Maryland	Zane Leydig	Improvement Specialist – Patient Experience
Union Hospital	Julie MoDavis	Director of Customer Experience Reporting & Insight
	Wren Lester	Chief Experience Officer
UM Baltimore Washington Medical Center	Dan Cashman	Director, Quality and Safety
UM Capital Region Medical Center	Lisa Jibril	Director, Patient Experience
UM Charles Regional Medical Center	Anne Weekley	VP, Quality and Safety
UM Medical Center	Jasmine Arfaa	VP Patient Experience
UM Rehabilitation and Orthopedic Institute	Amanda Rabinowitz	Director, Patient Experience
UM Shore Regional Medical Center	Sherri Hobbs Messick	VP, Chief Quality Officer
UM St. Joseph Medical Center	Brenda Johnson	VP Patient Experience
UM Upper Chesapeake Medical Center	Jo Anne Thomson	VP Patient Experience

Appendices



Background

- MHCC publishes HCAHPS data by hospital on the consumer website in alignment with CMS methodology
  - https://healthcarequality.mhcc.maryland.gov/
- Additionally, MHCC began requiring detailed level HCAHPS data starting January 2022 (Q3 2021 discharges)
  - Joint memo with HSCRC
  - Allows for more timely and detailed analysis into race, ethnicity, service line, etc.
  - Potential for targeted approaches for quality improvement (e.g., patient populations, domains)
  - Reporting requirements, updates, and results are also available on the provider side of the website
    - https://healthcarequality.mhcc.maryland.gov/Hospital/ProviderResources/HCAHPS

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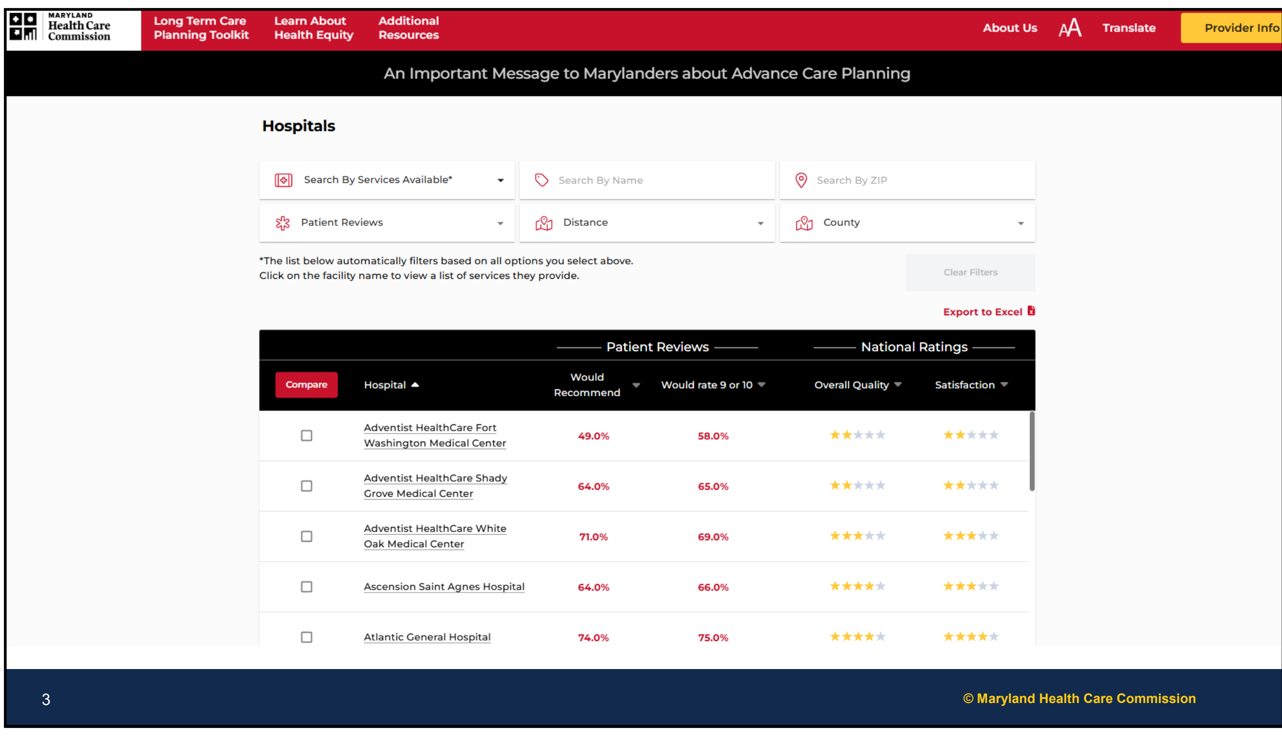
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Distance
County
*The list below automatically filters based on all options you select above.
Click on the facility name to view a list of services they provide.
Clear Filters
Export to Excel
Patient Reviews
National Ratings
Compare
Hospital
Would Recommend
Would rate 9 or 10
Overall Quality
Satisfaction
Adventist HealthCare Fort Washington Medical Center 49.0% 58.0%
Adventist HealthCare Shady Grove Medical Center 64.0% 65.0%
Adventist HealthCare White Oak Medical Center 71.0% 69.0%
Ascension Saint Agnes Hospital 64.0% 66.0%
Atlantic General Hospital 74.0% 75.0%
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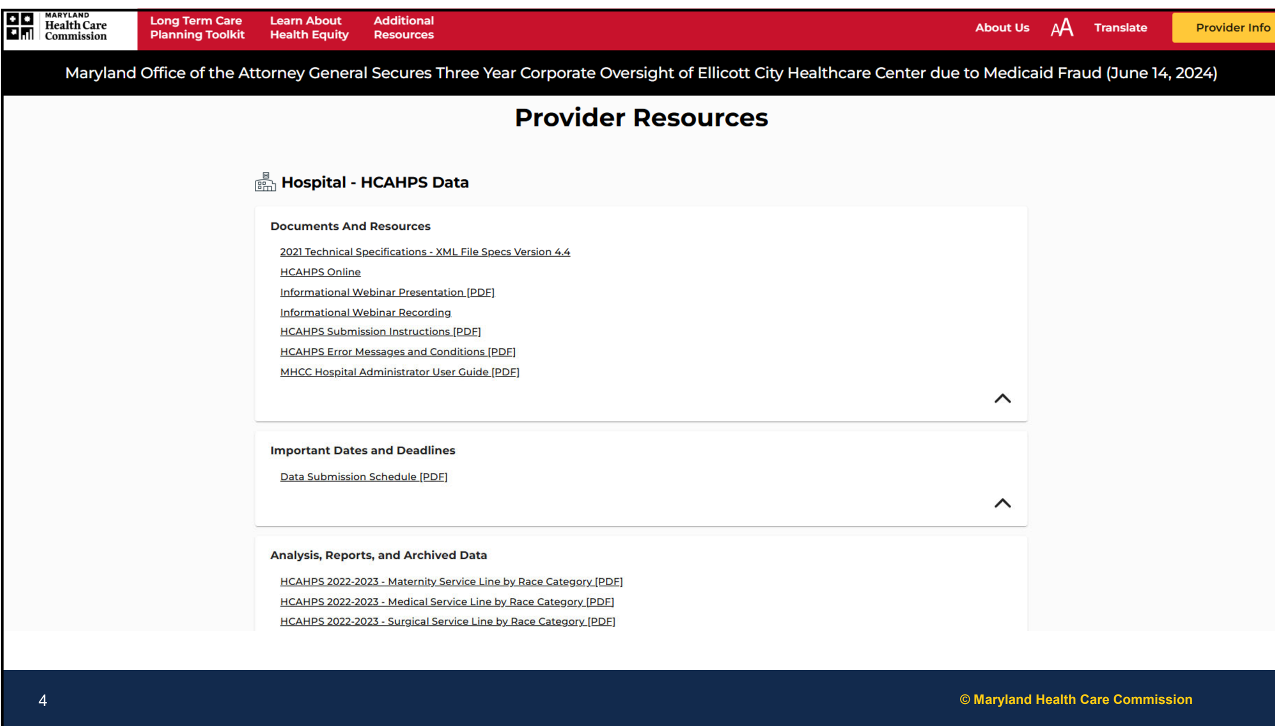
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Maryland Office of the Attorney General Secures Three Year Corporate Oversight of Ellicott City Healthcare Center due to Medicaid Fraud (June 14, 2024)
Provider Resources
Hospital - HCAHPS Data
Documents And Resources
2021 Technical Specifications - XML File Specs Version 4.4
HCAHPS Online
Informational Webinar Presentation [PDF]
Informational Webinar Recording
HCAHPS Submission Instructions [PDF]
HCAHPS Error Messages and Conditions [PDF]
MHCC Hospital Administrator User Guide [PDF]
Important Dates and Deadlines
Data Submission Schedule [PDF]
Analysis, Reports, and Archived Data
HCAHPS 2022-2023 - Maternity Service Line by Race Category [PDF]
HCAHPS 2022-2023 - Medical Service Line by Race Category [PDF]
HCAHPS 2022-2023 - Surgical Service Line by Race Category [PDF]
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Methodology

- Review of state-wide, patient-level HCAHPS responses with a focus on improvement opportunities
- Total denominator ~106k over 13 quarters
- Time period
  - 2021 Q2 – 2024 Q3
- Top-Box Responses
  - Analysis includes only the most positive responses to each prompt
  - Focused on overall responses and key drivers
    - Overall Rating: 9 or 10
    - Recommendation: Definitely Yes
    - Doctor Courtesy: Always
    - Nurse Courtesy: Always
- Adjustment difference compared to CMS data: Overall rating and recommendation
  - In general, CMS-adjusted rates are lower than unadjusted rates
  - Median difference by hospital is 1%
  - Range is -9% to 3%
  - 88% are within +-3%
- Cross-sections include:
  - Region
  - Service Line
  - Generational Grouping
  - Race
  - Denominators by category vary by quarter, hospital, vendor

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Regions				
Baltimore Area	**Baltimore City**	**Northern DC Suburbs**	**Southern Maryland**	**Eastern Shore**
Anne Arundel Medical Center	Johns Hopkins Bayview Medical Center	Adventist HealthCare Shady Grove Adventist Hospital	Adventist HealthCare Fort Washington Medical Center	Atlantic General Hospital
Carroll Hospital	Johns Hopkins Hospital	Adventist HealthCare White Oak Medical Center	CalvertHealth Medical Center	TidalHealth Peninsula Regional
Greater Baltimore Medical Center	MedStar Good Samaritan Hospital	Frederick Health Hospital	Doctors Community Medical Center	University of Maryland Shore Medical Center at Chestertown
Howard County General Hospital	MedStar Harbor Hospital	Holy Cross Germantown Hospital	MedStar Southern Maryland Hospital Center	University of Maryland Shore Medical Center at Easton
MedStar Franklin Square Medical Center	MedStar Union Memorial Hospital	Holy Cross Hospital	MedStar St. Mary's Hospital	
Northwest Hospital	Mercy Medical Center	MedStar Montgomery Medical Center	University of Maryland Capital Region Medical Center	
Union Hospital	Sinai Hospital	Suburban Hospital	University of Maryland Charles Regional Medical Center	**Western Maryland**
University of Maryland Baltimore Washington Medical Center	St. Agnes Hospital			Garrett Regional Medical Center
University of Maryland St. Joseph Medical Center	University of Maryland Medical Center			Meritus Medical Center
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical Center Midtown Campus			UPMC Western Maryland

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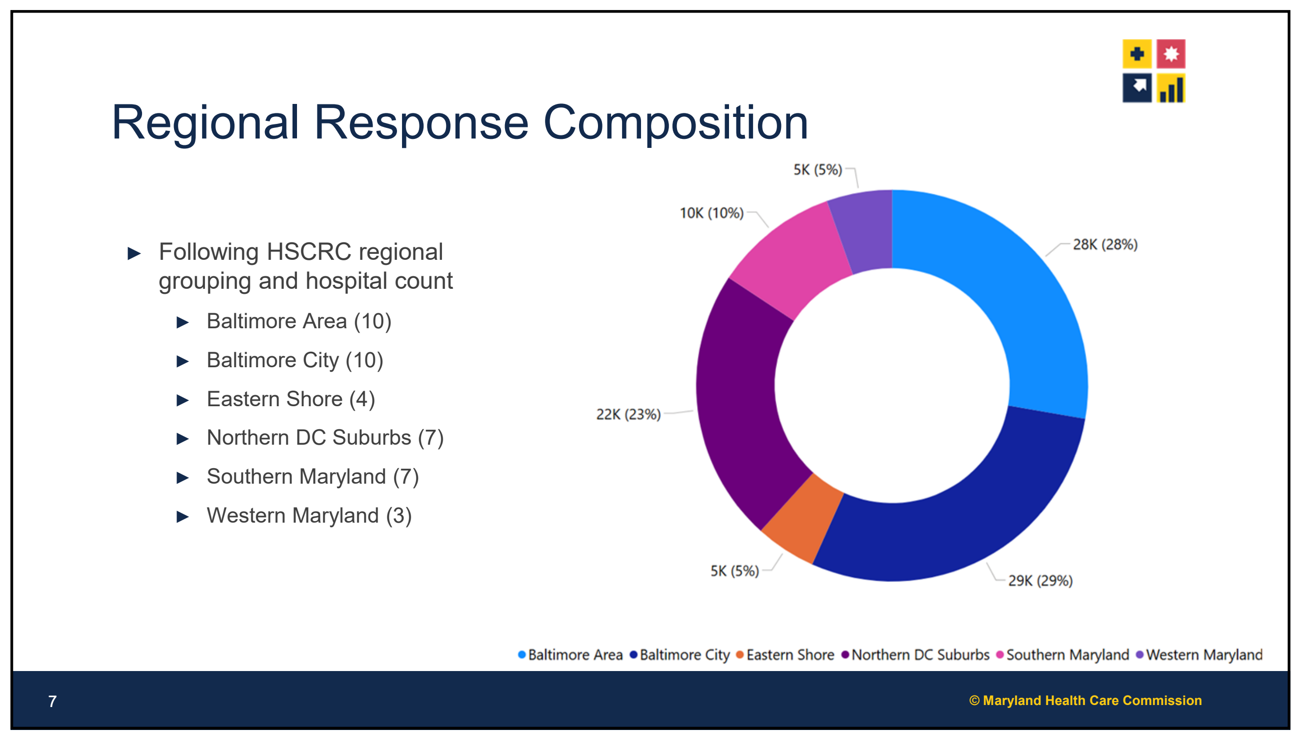
Regional Response Composition
Following HSCRC regional grouping and hospital count
Baltimore Area (10)
Baltimore City (10)
Eastern Shore (4)
Northern DC Suburbs (7)
Southern Maryland (7)
Western Maryland (3)
5K (5%)
10K (10%)
28K (28%)
22K (23%)
5K (5%)
29K (29%)
Baltimore Area Baltimore City Eastern Shore Northern DC Suburbs Southern Maryland Western Maryland
7
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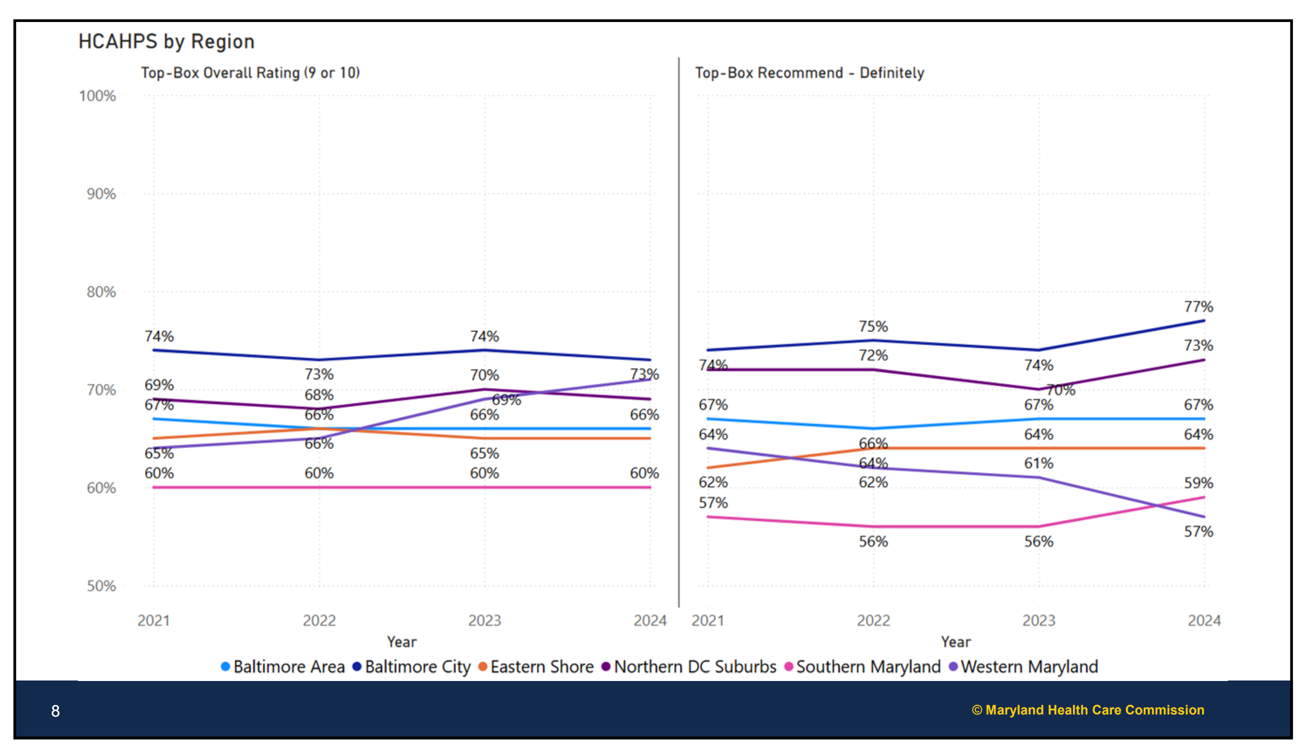
HCAHPS by Region
Top-Box Overall Rating (9 or 10)
Top-Box Recommend - Definitely
100%
90%
80%
70%
60%
50%
2021 2022 2023 2024
Year
Baltimore Area Baltimore City Eastern Shore Northern DC Suburbs Southern Maryland Western Maryland
8
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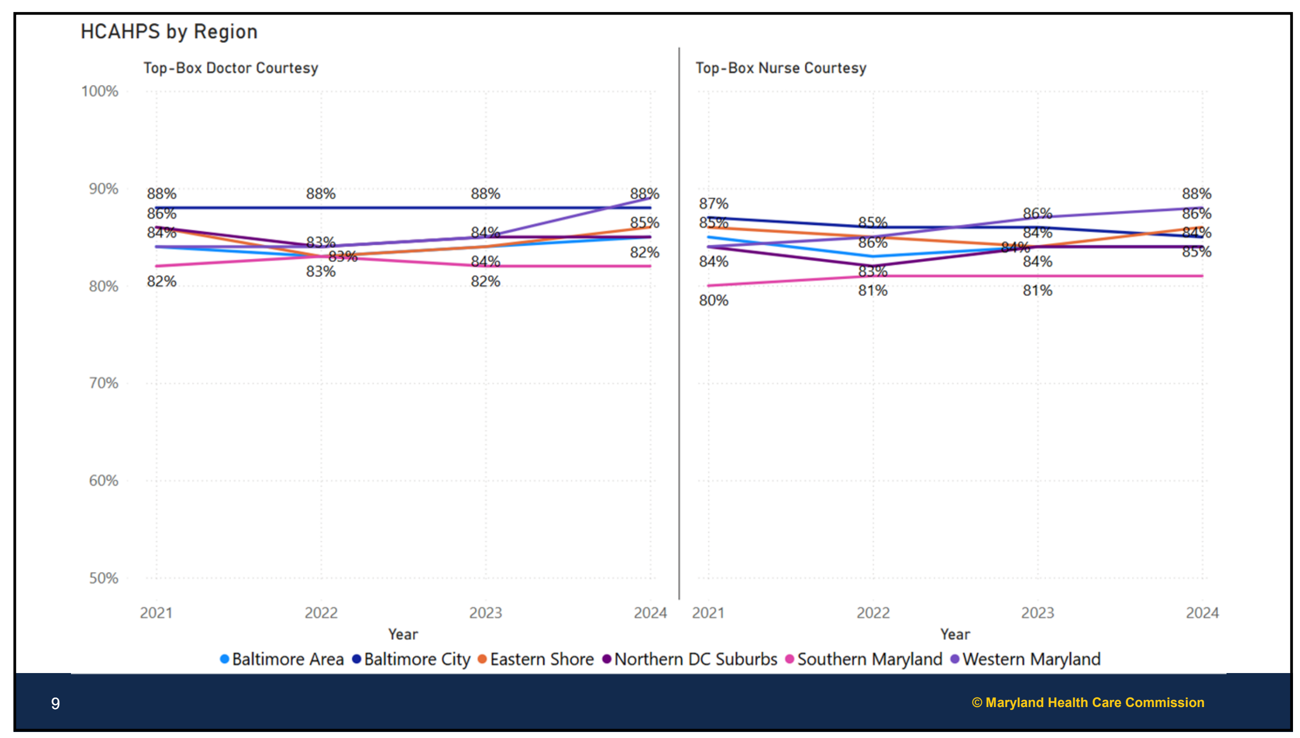
HCAHPS by Region
Top-Box Doctor Courtesy
Top-Box Nurse Courtesy
100%
90%
80%
70%
60%
50%
2021
2022
2023
2024
Year
Baltimore Area
Baltimore City
Eastern Shore
Northern DC Suburbs
Southern Maryland
Western Maryland
9
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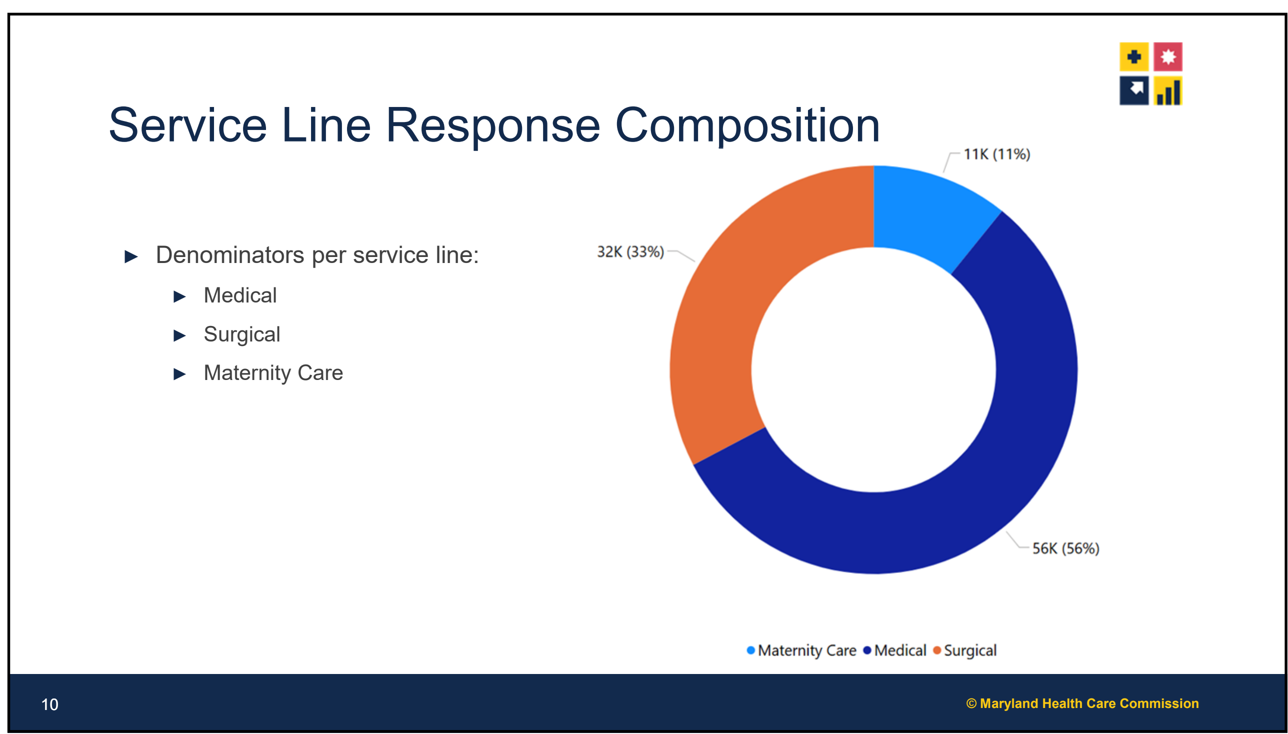
Service Line Response Composition
Denominators per service line:
Medical
Surgical
Maternity Care
11K (11%)
32K (33%)
56K (56%)
Maternity Care
Medical
Surgical
10
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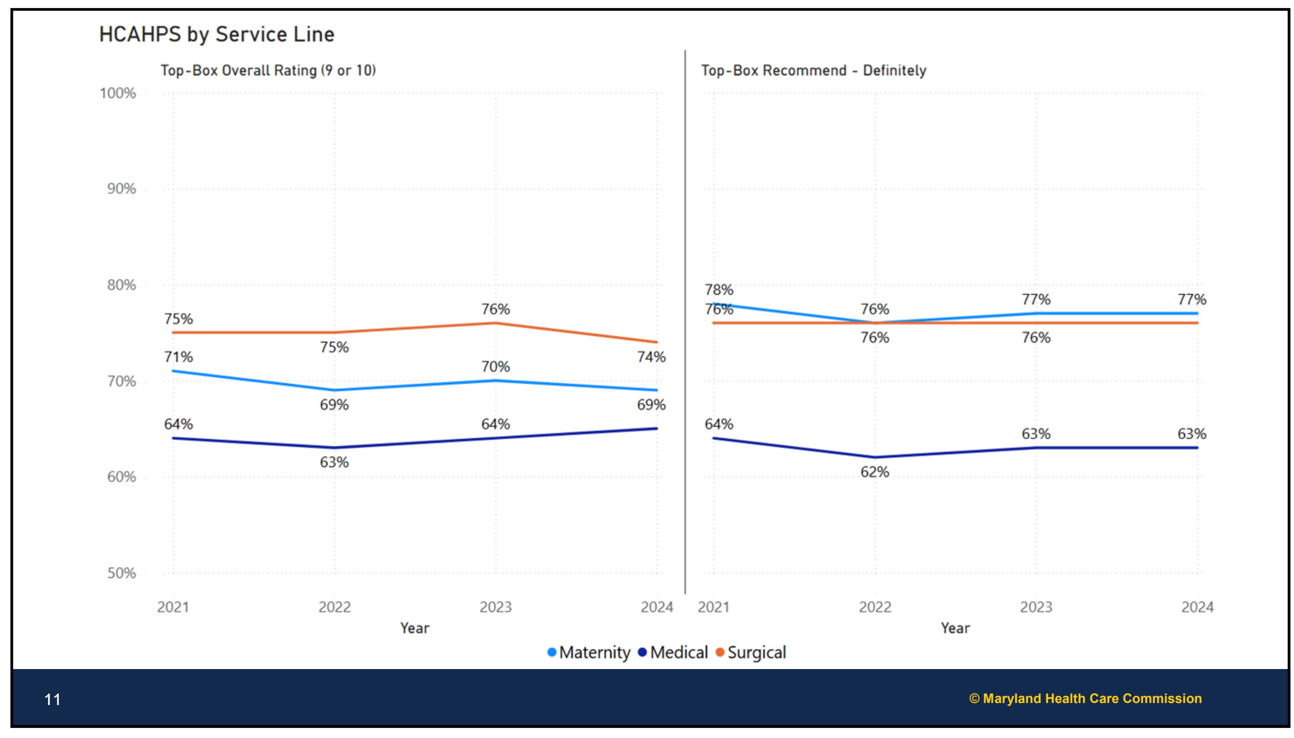
HCAHPS by Service Line
Top-Box Overall Rating (9 or 10)
Top-Box Recommend - Definitely
100%
90%
80%
70%
60%
50%
75%
76%
75%
74%
71%
70%
69%
69%
64%
64%
63%
78%
76%
76%
77%
77%
76%
76%
64%
63%
63%
62%
2021
2022
2023
2024
Year
Maternity
Medical
Surgical
11
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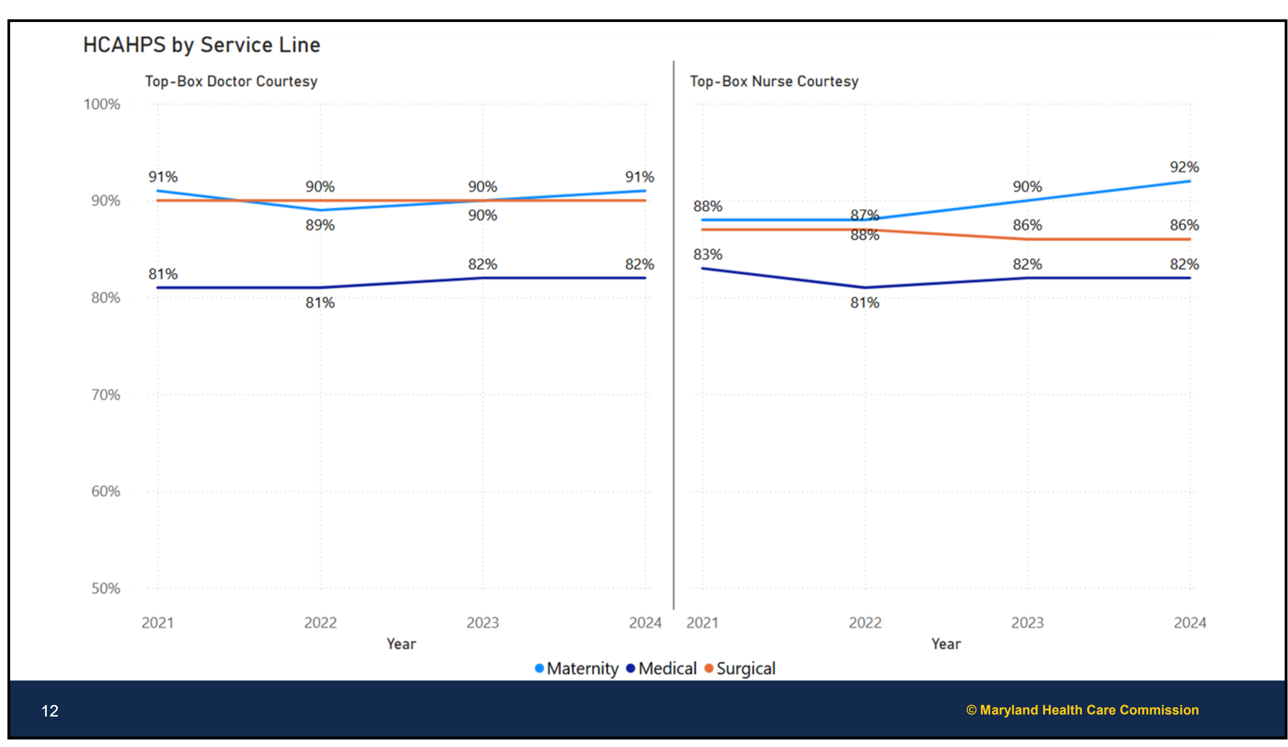
HCAHPS by Service Line
Top-Box Doctor Courtesy
Top-Box Nurse Courtesy
100%
90%
80%
70%
60%
50%
91%
90%
90%
91%
89%
90%
81%
82%
82%
81%
92%
90%
88%
87%
88%
86%
86%
83%
82%
82%
81%
2021
2022
2023
2024
Year
Maternity
Medical
Surgical
12
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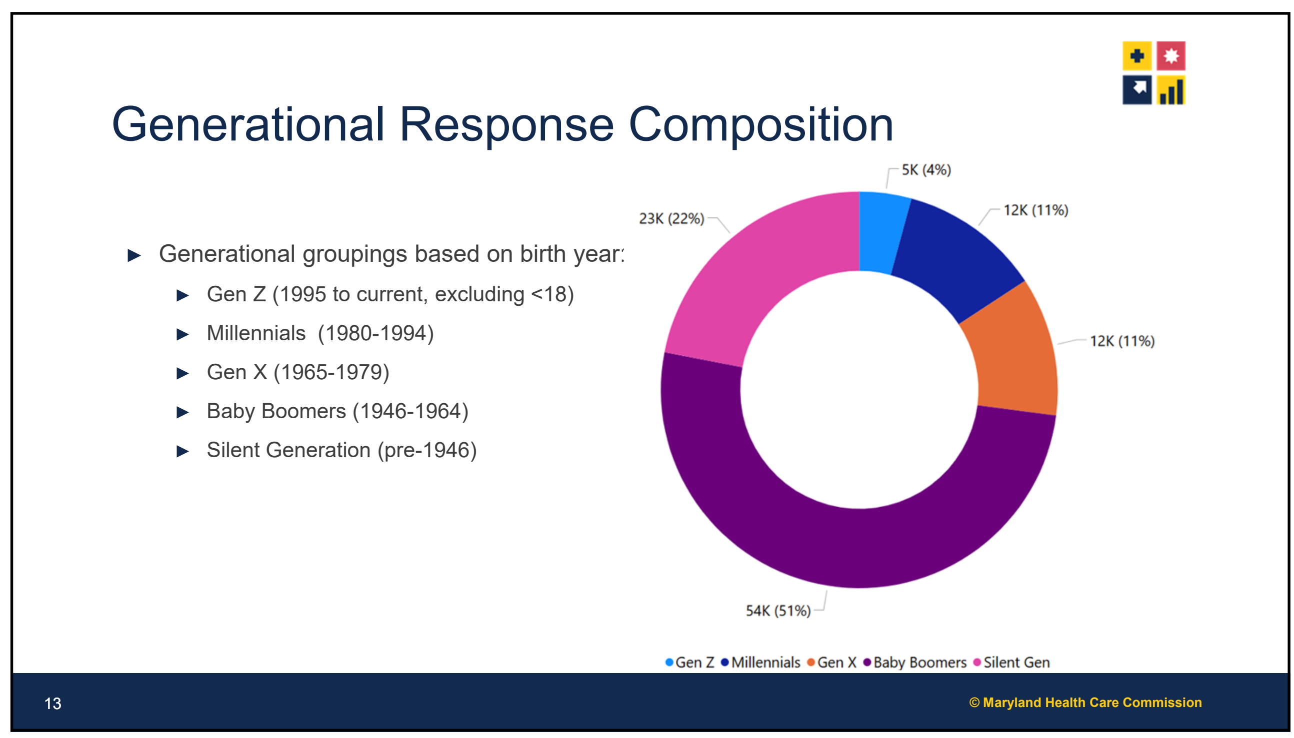
Generational Response Composition
Generational groupings based on birth year:
Gen Z (1995 to current, excluding <18)
Millennials (1980-1994)
Gen X (1965-1979)
Baby Boomers (1946-1964)
Silent Generation (pre-1946)
5K (4%)
12K (11%)
12K (11%)
54K (51%)
23K (22%)
Gen Z
Millennials
Gen X
Baby Boomers
Silent Gen
13
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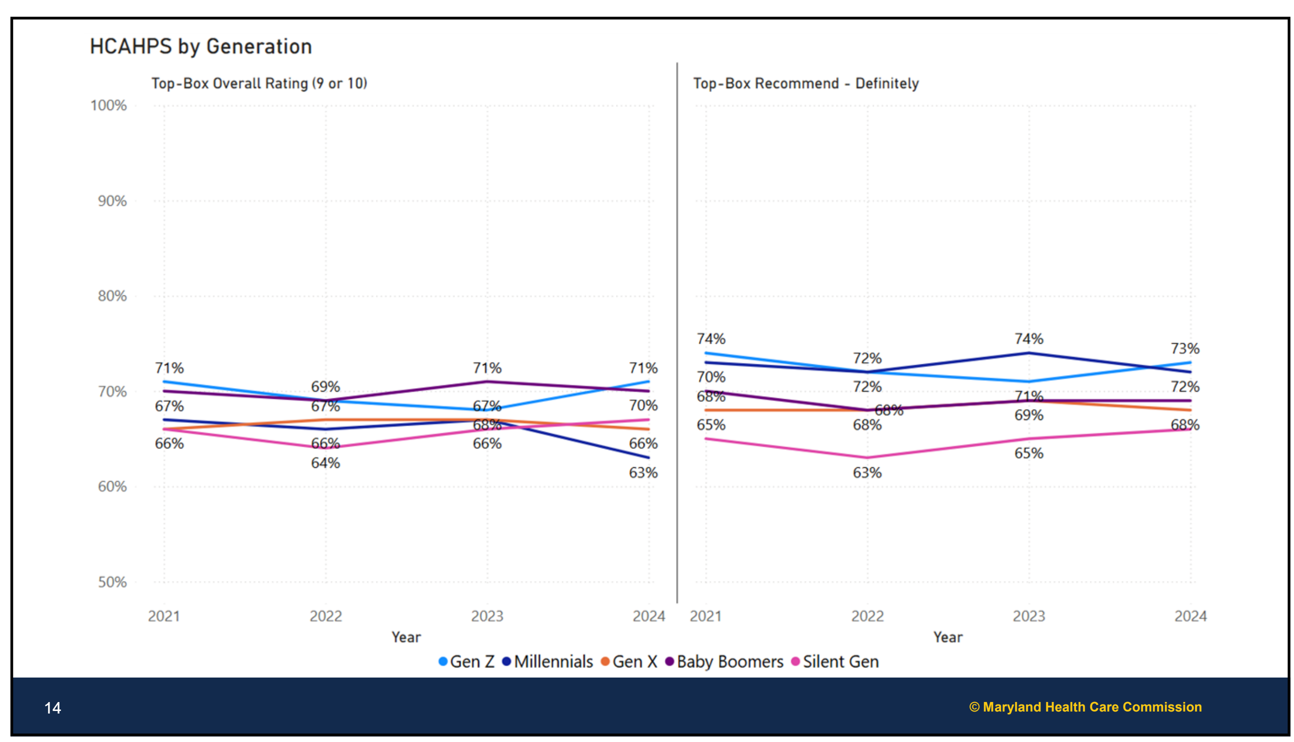
HCAHPS by Generation
Top-Box Overall Rating (9 or 10)
Top-Box Recommend - Definitely
100%
90%
80%
70%
60%
50%
2021
2022
2023
2024
Year
Gen Z
Millennials
Gen X
Baby Boomers
Silent Gen
14
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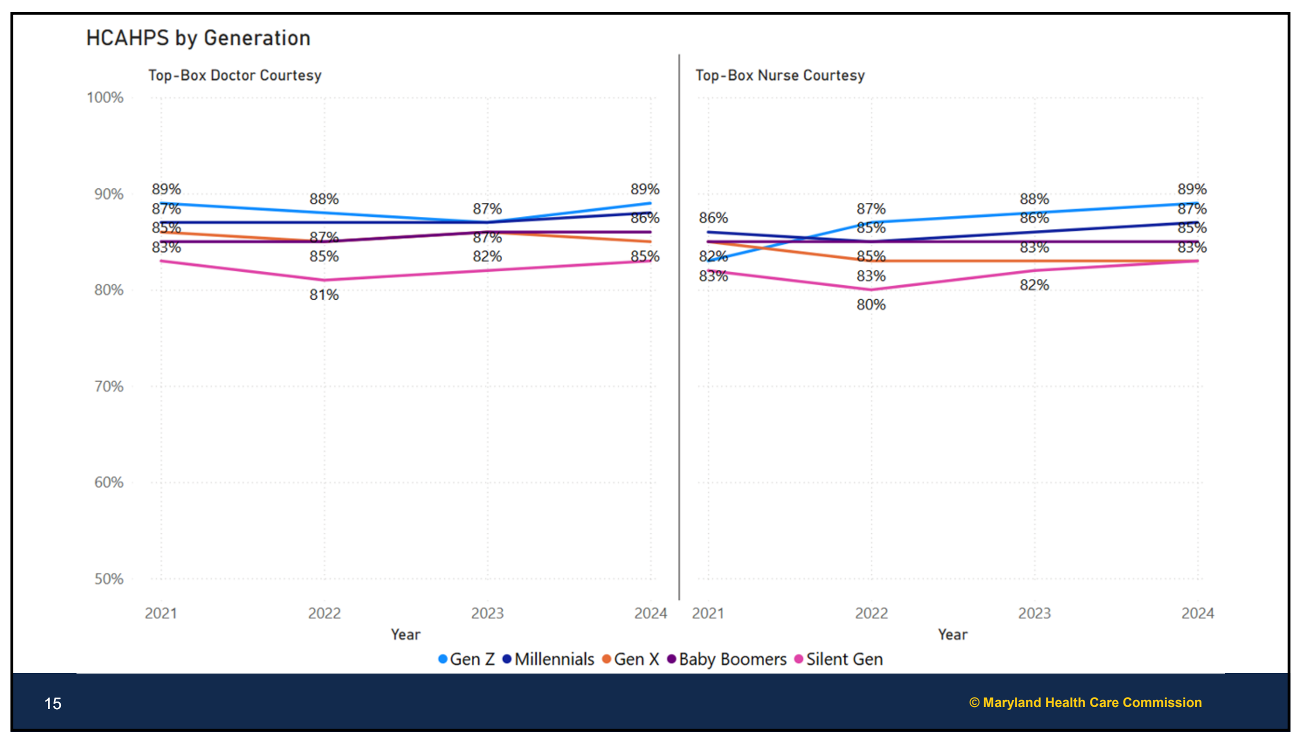
HCAHPS by Generation
Top-Box Doctor Courtesy
Top-Box Nurse Courtesy
100%
90%
80%
70%
60%
50%
89%
87%
85%
83%
88%
87%
85%
81%
87%
87%
82%
89%
86%
85%
86%
82%
83%
87%
85%
85%
83%
80%
88%
86%
83%
82%
89%
87%
85%
83%
2021
2022
2023
2024
Year
Gen Z
Millennials
Gen X
Baby Boomers
Silent Gen
15
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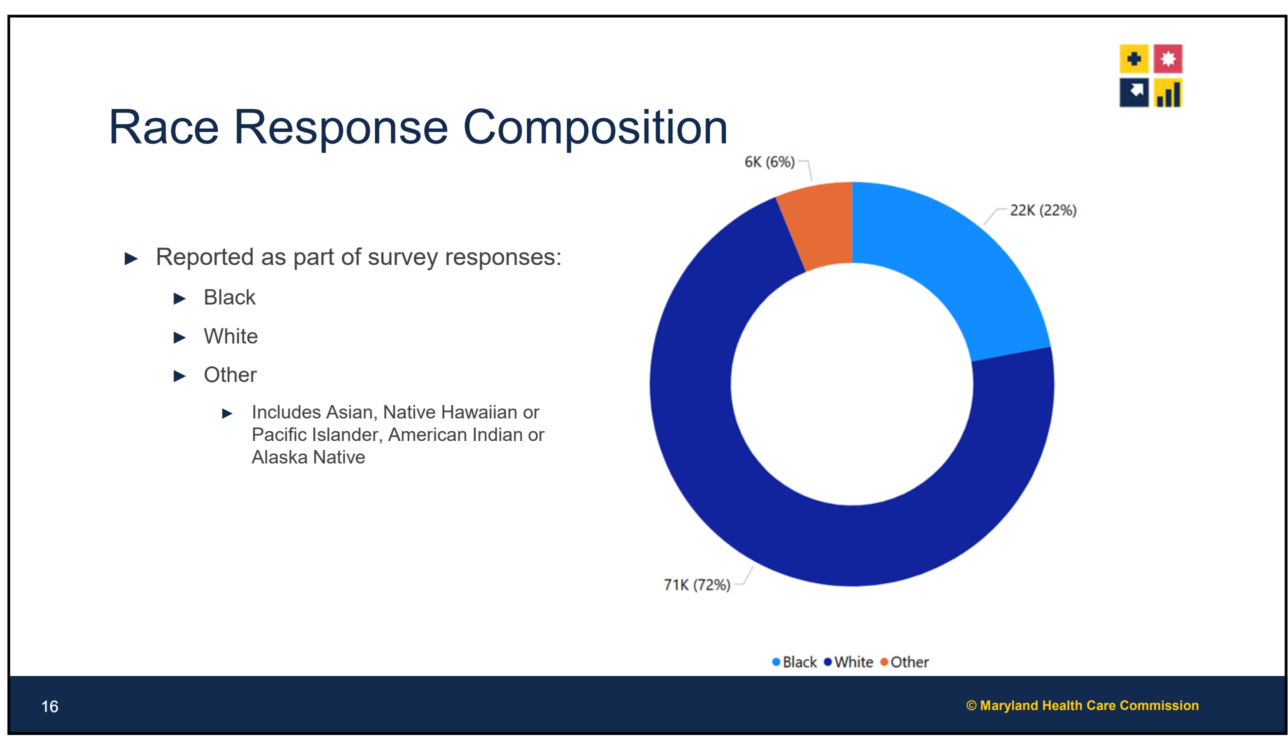
Race Response Composition
Reported as part of survey responses:
Black
White
Other
Includes Asian, Native Hawaiian or Pacific Islander, American Indian or Alaska Native
6K (6%)
22K (22%)
71K (72%)
Black
White
Other
16
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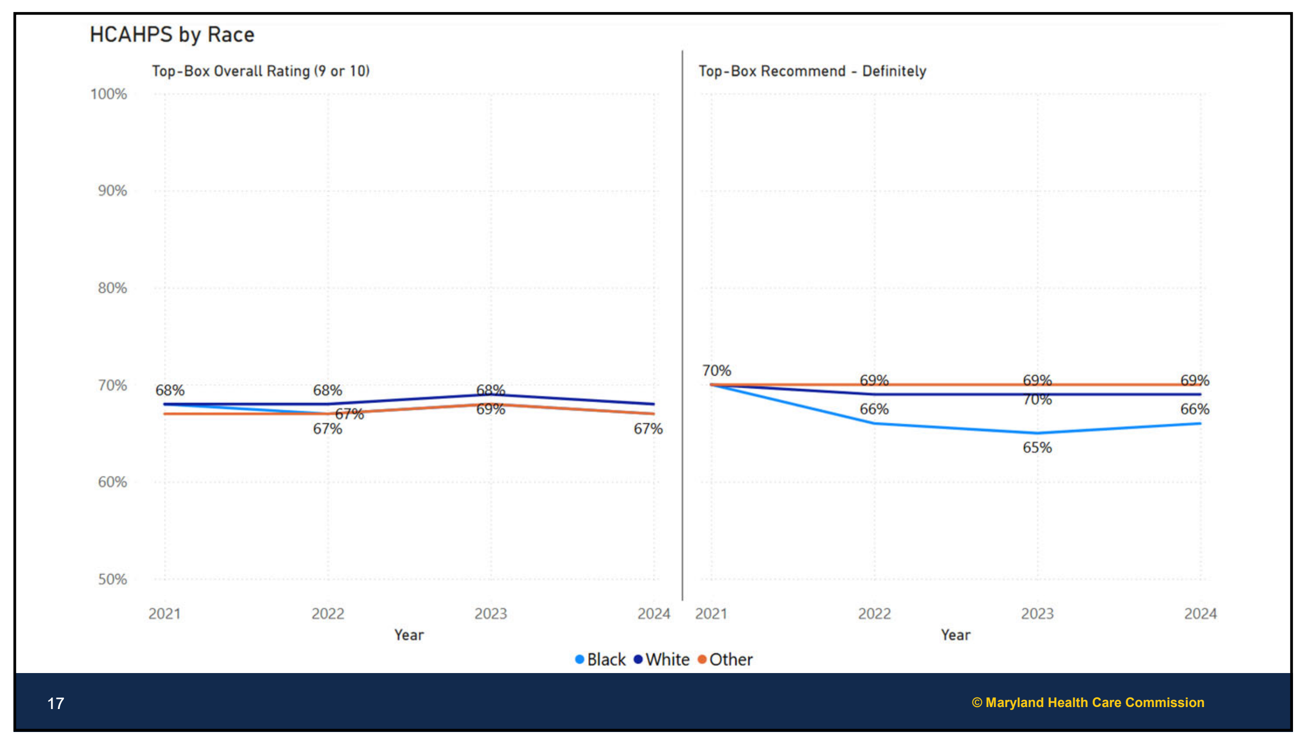
HCAHPS by Race
Top-Box Overall Rating (9 or 10)
Top-Box Recommend - Definitely
100%
90%
80%
70%
60%
50%
68%
68%
67%
67%
68%
69%
67%
70%
69%
66%
69%
70%
65%
69%
66%
2021
2022
2023
2024
Year
Black
White
Other
17
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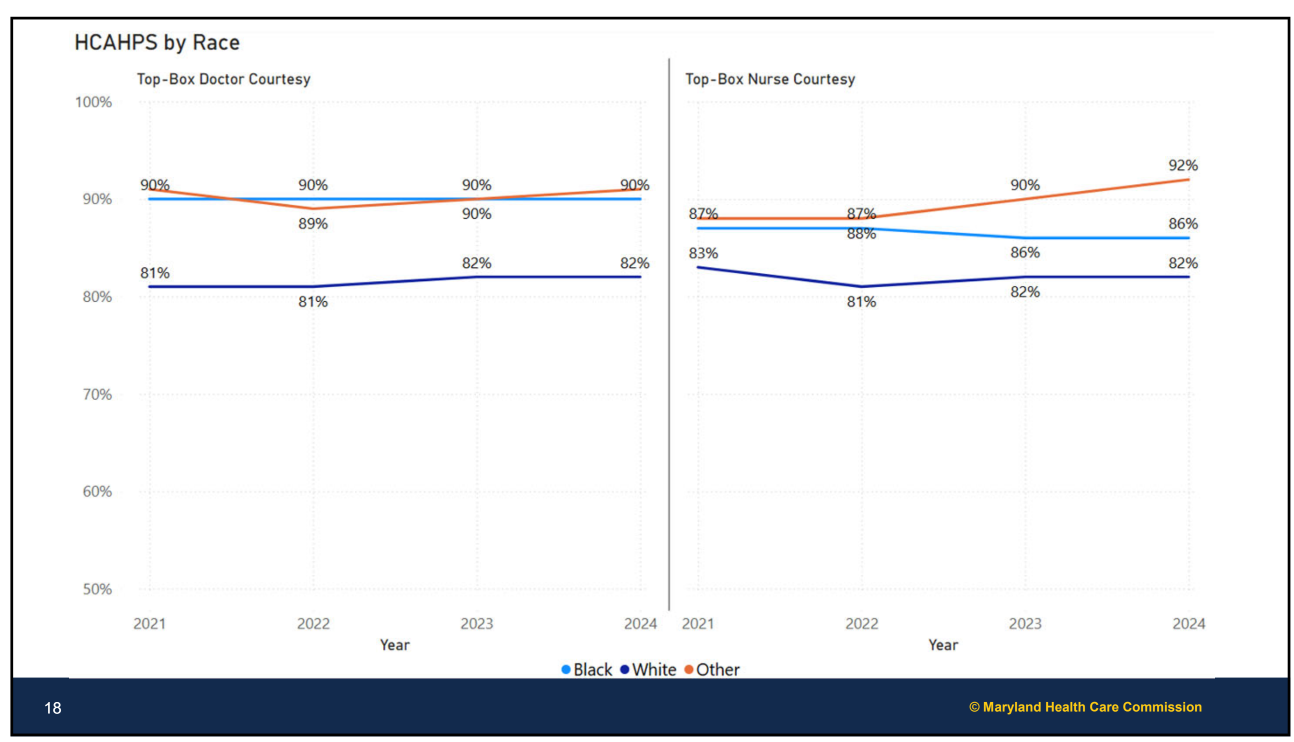
HCAHPS by Race
Top-Box Doctor Courtesy
Top-Box Nurse Courtesy
100%
90%
80%
70%
60%
50%
90%
90%
89%
90%
90%
90%
81%
81%
82%
82%
87%
87%
88%
83%
81%
90%
86%
82%
92%
86%
82%
2021
2022
2023
2024
Year
Black
White
Other
18
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Key Takeaways & Discussion

- Potential further areas of exploration:
  - Region: Southern Maryland
  - Service Line: Medical
  - Race: Black Respondents
  - Generation: Silent Generation (pre-1946)
  - Doctor & Nurse Courtesy: White respondents, medical service line
- There may be a relationship between survey size and results
- 2024 Q4 submission due to MHCC April 9
- Upcoming changes for XML submission for new 2025 survey

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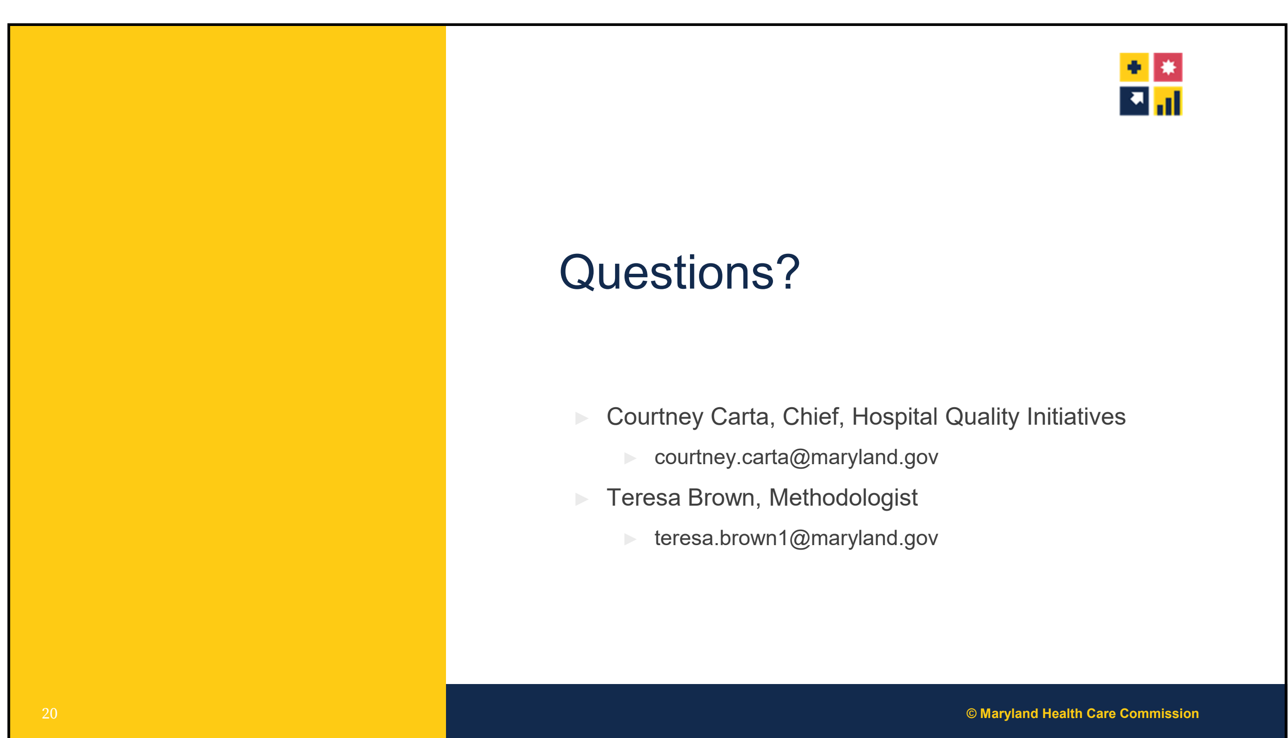
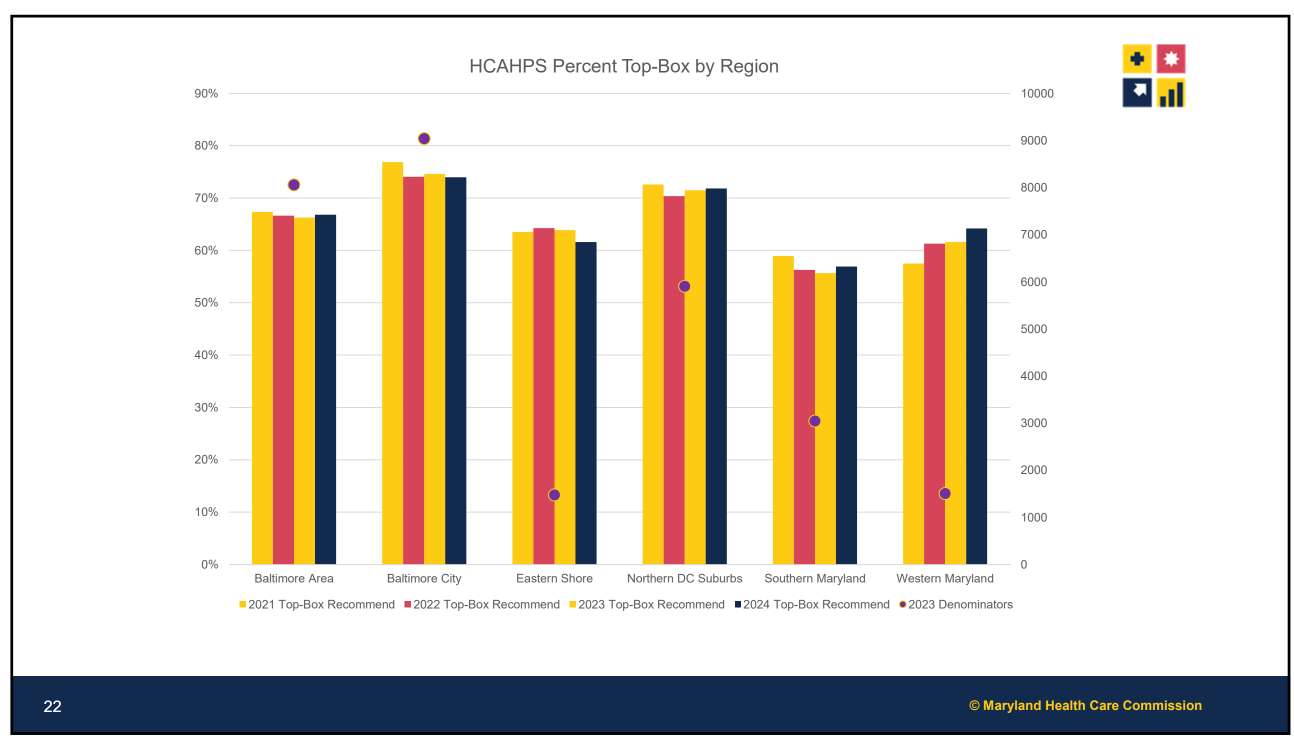


Appendix
21


HCAHPS Percent Top-Box by Region
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
Baltimore Area
Baltimore City
Eastern Shore
Northern DC Suburbs
Southern Maryland
Western Maryland
2021 Top-Box Recommend
2022 Top-Box Recommend
2023 Top-Box Recommend
2024 Top-Box Recommend
2023 Denominators
22
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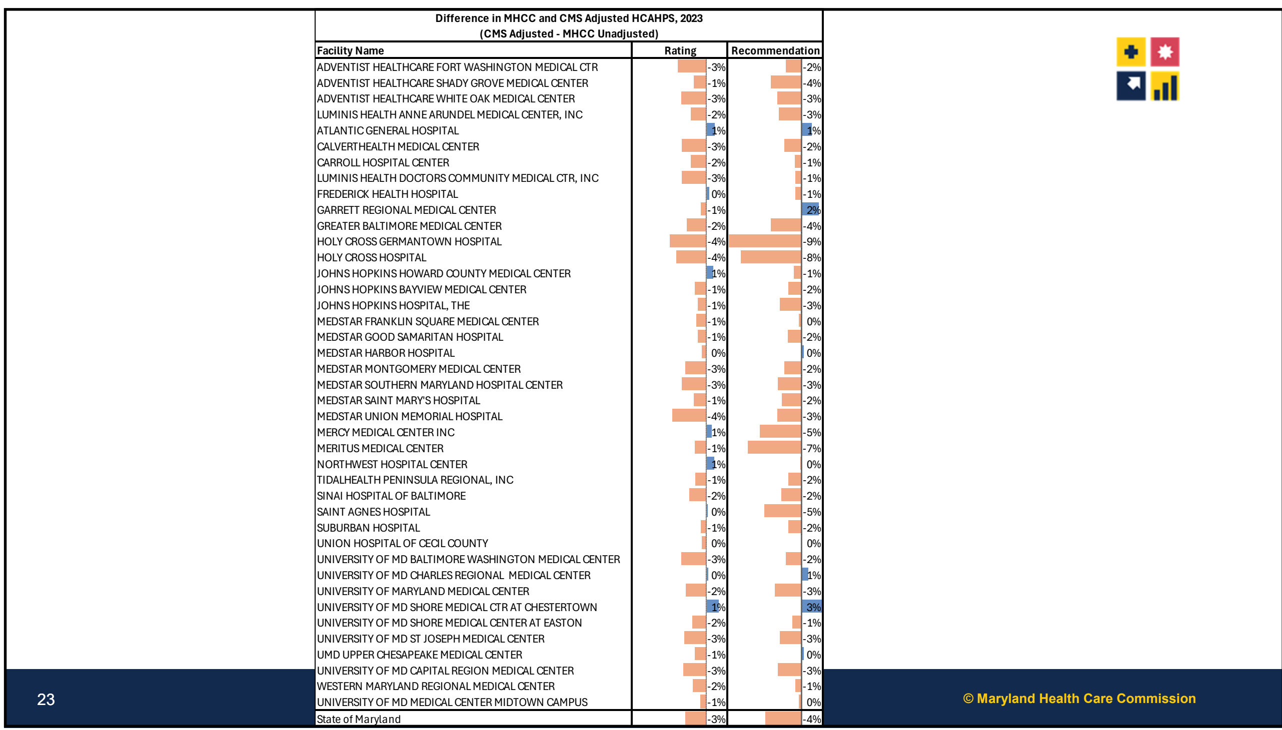
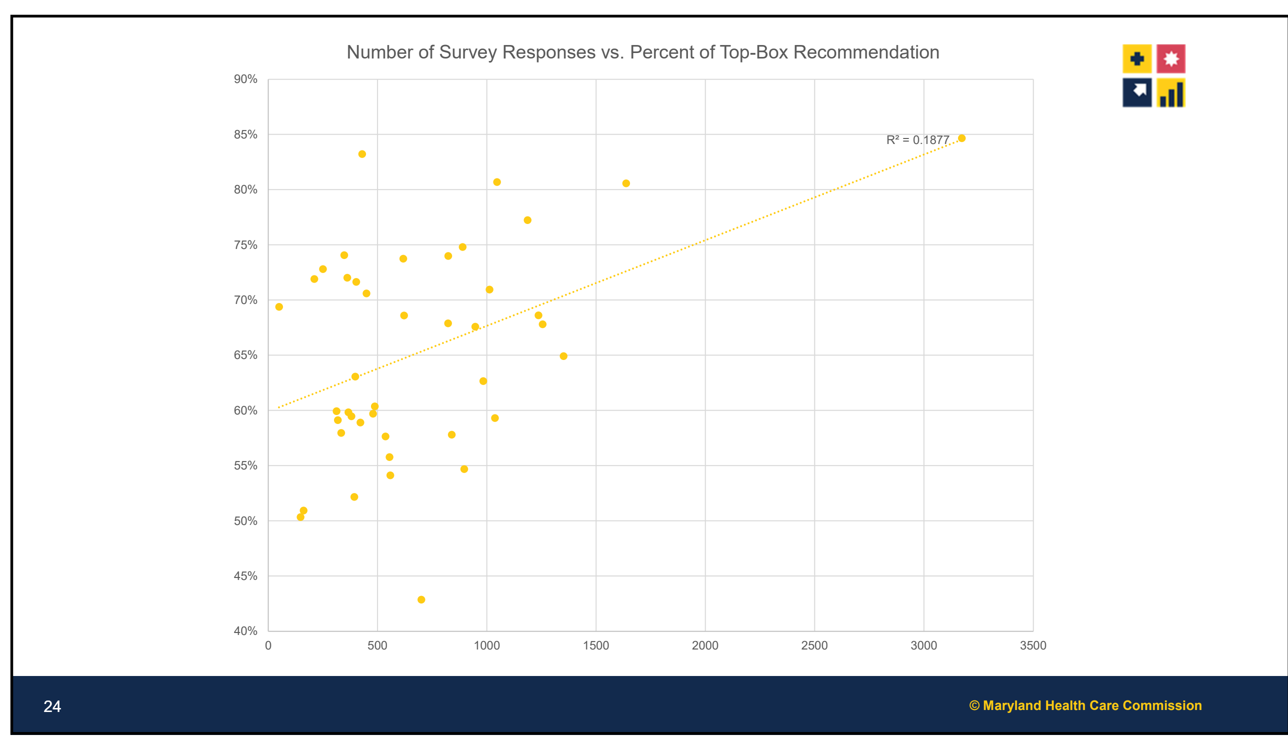
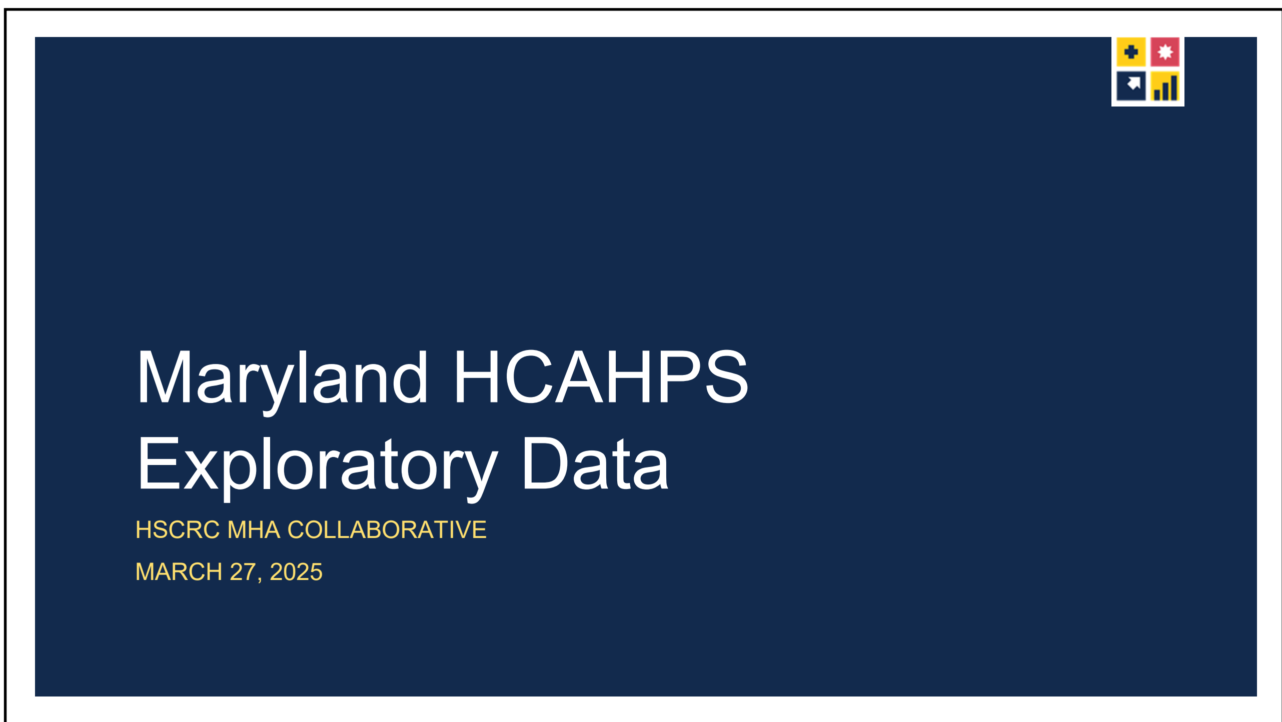


Difference in MHCC and CMS Adjusted HCAHPS, 2023
(CMS Adjusted - MHCC Unadjusted)

Facility Name	Rating	Recommendation
ADVENTIST HEALTHCARE FORT WASHINGTON MEDICAL CTR	-3%	-2%
ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	-1%	-4%
ADVENTIST HEALTHCARE WHITE OAK MEDICAL CENTER	-3%	-3%
LUMINIS HEALTH ANNE ARUNDEL MEDICAL CENTER, INC	-2%	-3%
ATLANTIC GENERAL HOSPITAL	1%	1%
CALVERTHEALTH MEDICAL CENTER	-3%	-2%
CARROLL HOSPITAL CENTER	-2%	-1%
LUMINIS HEALTH DOCTORS COMMUNITY MEDICAL CTR, INC	-3%	-1%
FREDERICK HEALTH HOSPITAL	0%	-1%
GARRETT REGIONAL MEDICAL CENTER	-1%	2%
GREATER BALTIMORE MEDICAL CENTER	-2%	-4%
HOLY CROSS GERMANTOWN HOSPITAL	-4%	-9%
HOLY CROSS HOSPITAL	-4%	-8%
JOHNS HOPKINS HOWARD COUNTY MEDICAL CENTER	1%	-1%
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	-1%	-2%
JOHNS HOPKINS HOSPITAL, THE	-1%	-3%
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	-1%	0%
MEDSTAR GOOD SAMARITAN HOSPITAL	-1%	-2%
MEDSTAR HARBOR HOSPITAL	0%	0%
MEDSTAR MONTGOMERY MEDICAL CENTER	-3%	-2%
MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	-3%	-3%
MEDSTAR SAINT MARY'S HOSPITAL	-1%	-2%
MEDSTAR UNION MEMORIAL HOSPITAL	-4%	-3%
MERCY MEDICAL CENTER INC	1%	-5%
MERITUS MEDICAL CENTER	-1%	-7%
NORTHWEST HOSPITAL CENTER	1%	0%
TIDALHEALTH PENINSULA REGIONAL, INC	-1%	-2%
SINAI HOSPITAL OF BALTIMORE	-2%	-2%
SAINT AGNES HOSPITAL	0%	-5%
SUBURBAN HOSPITAL	-1%	-2%
UNION HOSPITAL OF CECIL COUNTY	0%	0%
UNIVERSITY OF MD BALTIMORE WASHINGTON MEDICAL CENTER	-3%	-2%
UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	0%	1%
UNIVERSITY OF MARYLAND MEDICAL CENTER	-2%	-3%
UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	1%	3%
UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	-2%	-1%
UNIVERSITY OF MD ST JOSEPH MEDICAL CENTER	-3%	-3%
UMD UPPER CHESAPEAKE MEDICAL CENTER	-1%	0%
UNIVERSITY OF MD CAPITAL REGION MEDICAL CENTER	-3%	-3%
WESTERN MARYLAND REGIONAL MEDICAL CENTER	-2%	-1%
UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	-1%	0%
State of Maryland	-3%	-4%



Patient Experience Learning Collaborative Report



Background

- MHCC publishes HCAHPS data by hospital on the consumer website in alignment with CMS methodology
  - https://healthcarequality.mhcc.maryland.gov/
- Additionally, MHCC began requiring detailed level HCAHPS data starting January 2022 (Q3 2021 discharges)
  - Joint memo with HSCRC
  - Allows for more timely and detailed analysis into race, ethnicity, service line, etc.
  - Potential for targeted approaches for quality improvement (e.g., patient populations, domains)
  - Reporting requirements, updates, and results are also available on the provider side of the website
    - https://healthcarequality.mhcc.maryland.gov/Hospital/ProviderResources/HCAHPS

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Methodology

- Review of state-wide, patient-level HCAHPS responses with a focus on improvement opportunities
- Total denominator ~106k over 13 quarters
- Time period
  - 2021 Q2 – 2024 Q3
- Top-Box Responses
  - Analysis includes only the most positive responses to each prompt
  - Focused on overall responses and key drivers
    - Overall Rating: 9 or 10
    - Recommendation: Definitely Yes
    - Doctor Courtesy: Always
    - Nurse Courtesy: Always
- Adjustment difference compared to CMS data: Overall rating and recommendation
  - In general, CMS-adjusted rates are lower than unadjusted rates
  - Median difference by hospital is 1%
  - Range is -9% to 3%
  - 88% are within +-3%
- Cross-sections include:
  - Region
  - Service Line
  - Admission Source
  - Hospital Bed Size
  - Denominators by category vary by quarter, hospital, vendor

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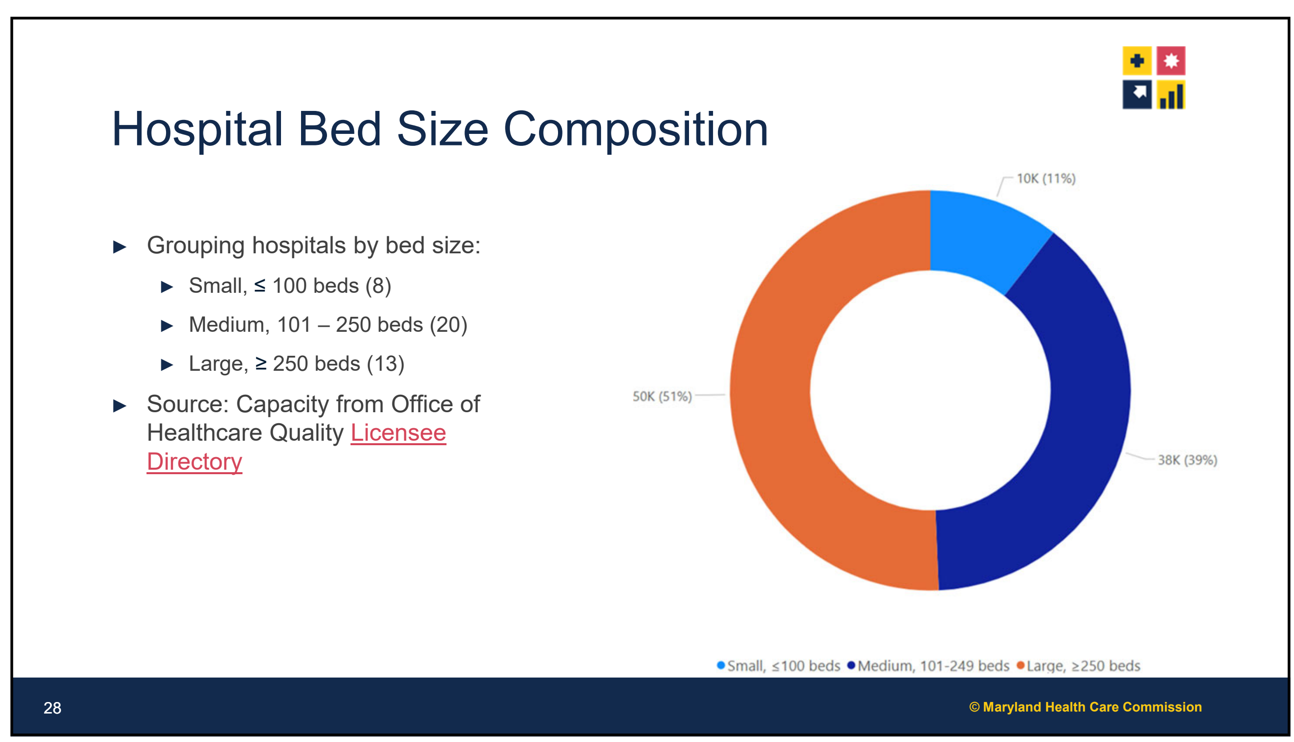

Hospital Grouping by Bed Size				
Small, ≤100 beds	**Medium, 101-250 beds**		**Large, ≥ 250 beds**	
University of Maryland Shore Medical Center at Chestertown	MedStar Montgomery Medical Center	MedStar Southern Maryland Hospital Center	Suburban Hospital	Adventist HealthCare Shady Grove Adventist Hospital
Garrett Regional Medical Center	University of Maryland Charles Regional Medical Center	Northwest Hospital	Frederick Health Hospital	Anne Arundel Medical Center
Adventist HealthCare Fort Washington Medical Center	University of Maryland Medical Center Midtown Campus	UPMC Western Maryland	Howard County General Hospital	Johns Hopkins Bayview Medical Center
Atlantic General Hospital	MedStar Harbor Hospital	Greater Baltimore Medical Center	TidalHealth Peninsula Regional	Sinai Hospital
CalvertHealth Medical Center	University of Maryland Shore Medical Center at Easton	Adventist HealthCare White Oak Medical Center	University of Maryland Baltimore Washington Medical Center	University of Maryland Medical Center
MedStar St. Mary's Hospital	Mercy Medical Center	University of Maryland St. Joseph Medical Center	Holy Cross Hospital	Johns Hopkins Hospital
Holy Cross Germantown Hospital	MedStar Good Samaritan Hospital	Doctors Community Medical Center	MedStar Franklin Square Medical Center	
Union Hospital	Carroll Hospital	University of Maryland Upper Chesapeake Medical Center		
	St. Agnes Hospital	University of Maryland Capital Region Medical Center		
	MedStar Union Memorial Hospital	Meritus Medical Center		

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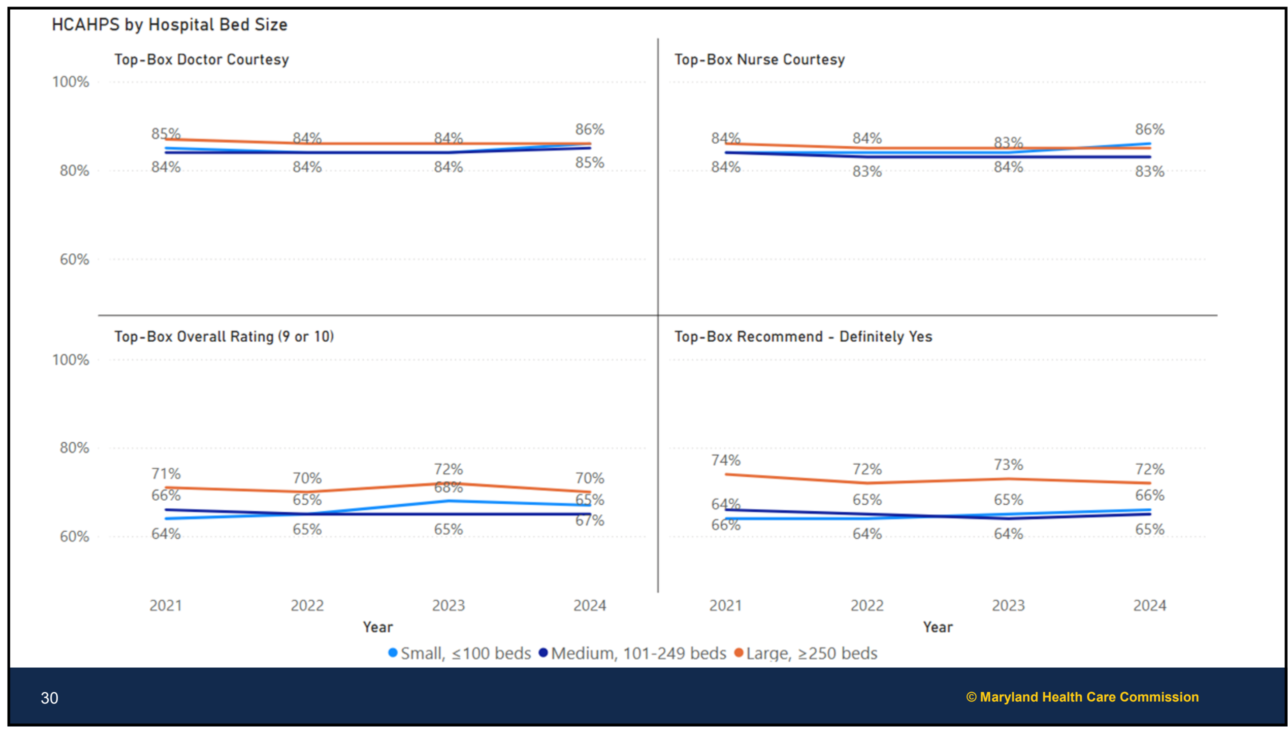

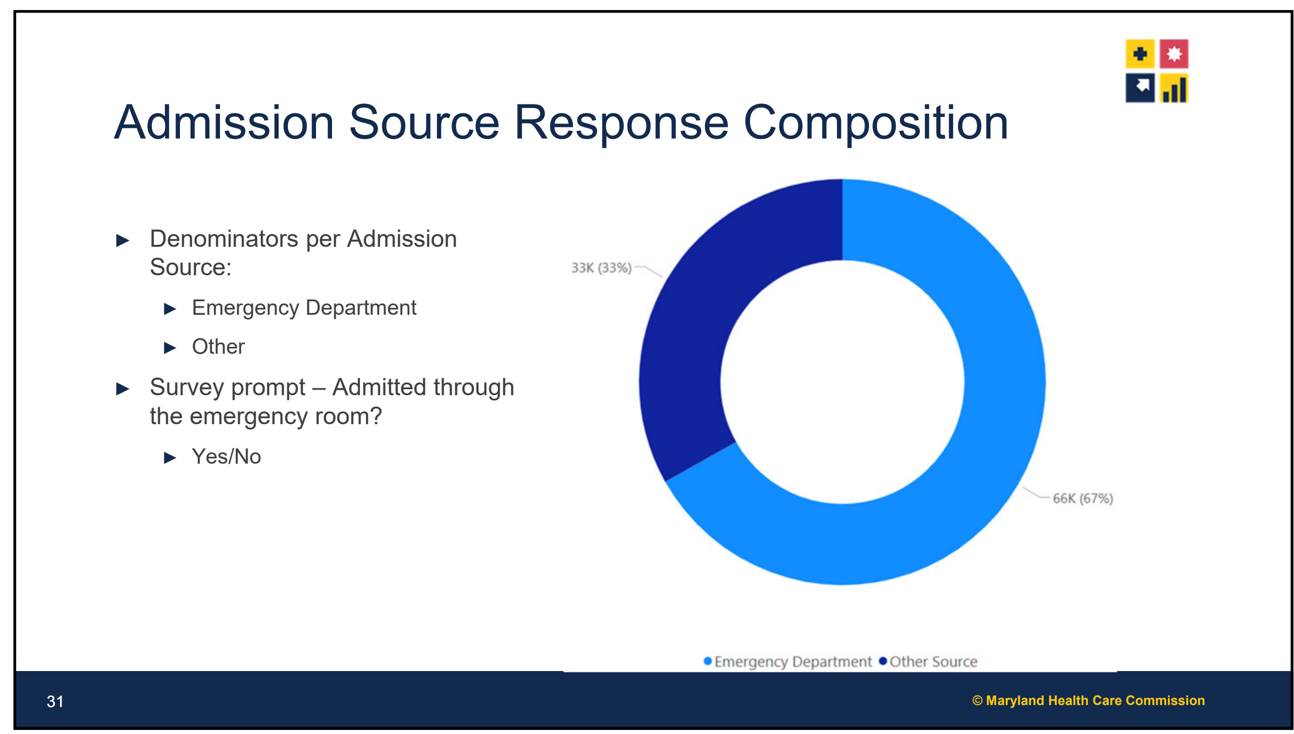
Admission Source Response Composition
Denominators per Admission Source:
Emergency Department
Other
Survey prompt – Admitted through the emergency room?
Yes/No
33K (33%)
66K (67%)
Emergency Department
Other Source
31
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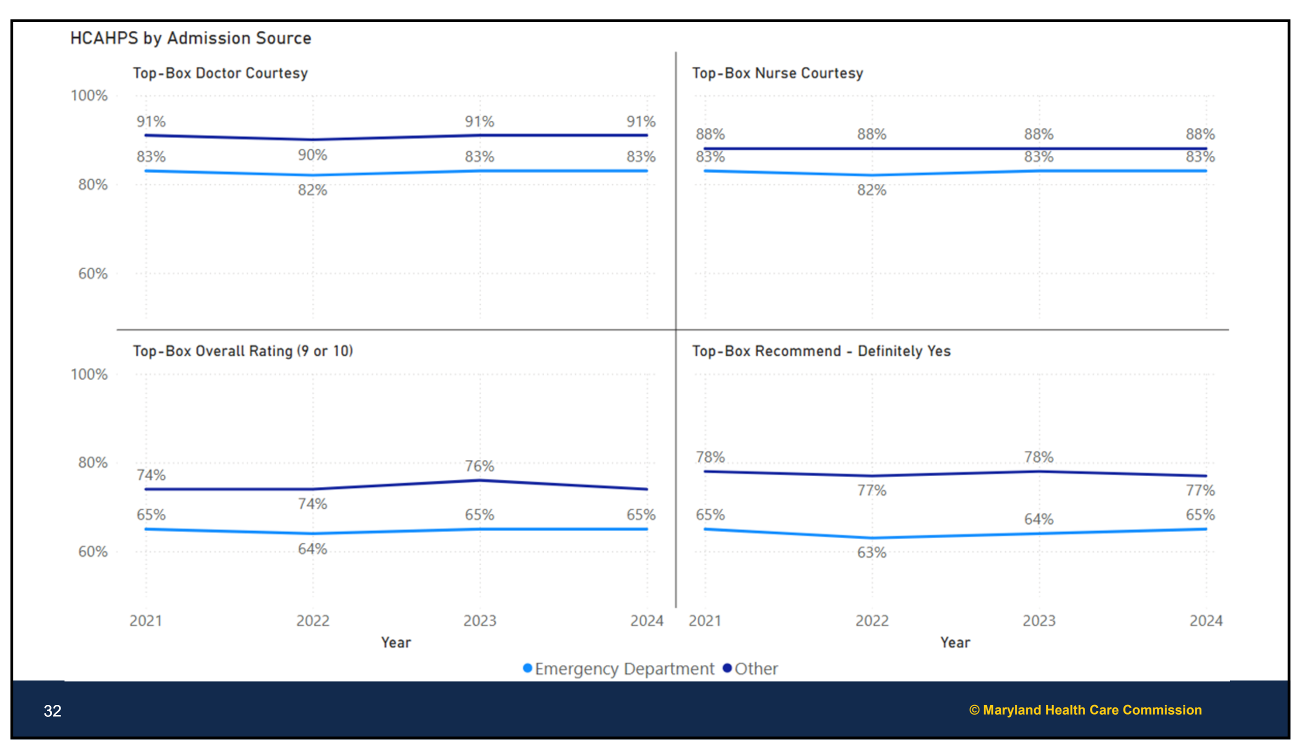
HCAHPS by Admission Source
Top-Box Doctor Courtesy
Top-Box Nurse Courtesy
Top-Box Overall Rating (9 or 10)
Top-Box Recommend - Definitely Yes
100%
80%
60%
91%
90%
91%
91%
83%
82%
83%
83%
88%
88%
88%
88%
83%
82%
83%
83%
74%
74%
76%
65%
64%
65%
65%
78%
77%
78%
77%
65%
63%
64%
65%
2021
2022
2023
2024
Year
Emergency Department
Other
32
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Regions				
Baltimore Area	**Baltimore City**	**Northern DC Suburbs**	**Southern Maryland**	**Eastern Shore**
Anne Arundel Medical Center	Johns Hopkins Bayview Medical Center	Adventist HealthCare Shady Grove Adventist Hospital	Adventist HealthCare Fort Washington Medical Center	Atlantic General Hospital
Carroll Hospital	Johns Hopkins Hospital	Adventist HealthCare White Oak Medical Center	CalvertHealth Medical Center	TidalHealth Peninsula Regional
Greater Baltimore Medical Center	MedStar Good Samaritan Hospital	Frederick Health Hospital	Doctors Community Medical Center	University of Maryland Shore Medical Center at Chestertown
Howard County General Hospital	MedStar Harbor Hospital	Holy Cross Germantown Hospital	MedStar Southern Maryland Hospital Center	University of Maryland Shore Medical Center at Easton
MedStar Franklin Square Medical Center	MedStar Union Memorial Hospital	Holy Cross Hospital	MedStar St. Mary's Hospital	
Northwest Hospital	Mercy Medical Center	MedStar Montgomery Medical Center	University of Maryland Capital Region Medical Center	
Union Hospital	Sinai Hospital	Suburban Hospital	University of Maryland Charles Regional Medical Center	**Western Maryland**
University of Maryland Baltimore Washington Medical Center	St. Agnes Hospital			Garrett Regional Medical Center
University of Maryland St. Joseph Medical Center	University of Maryland Medical Center			Meritus Medical Center
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical Center Midtown Campus			UPMC Western Maryland

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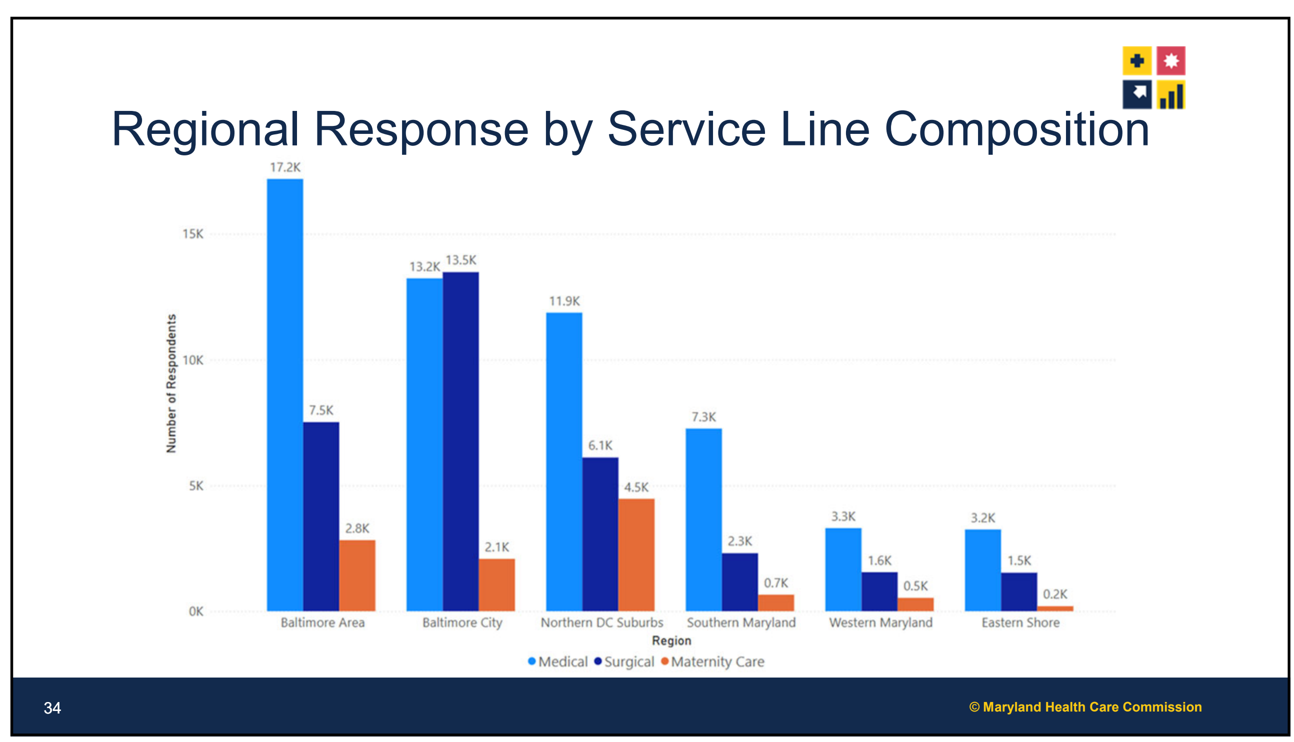

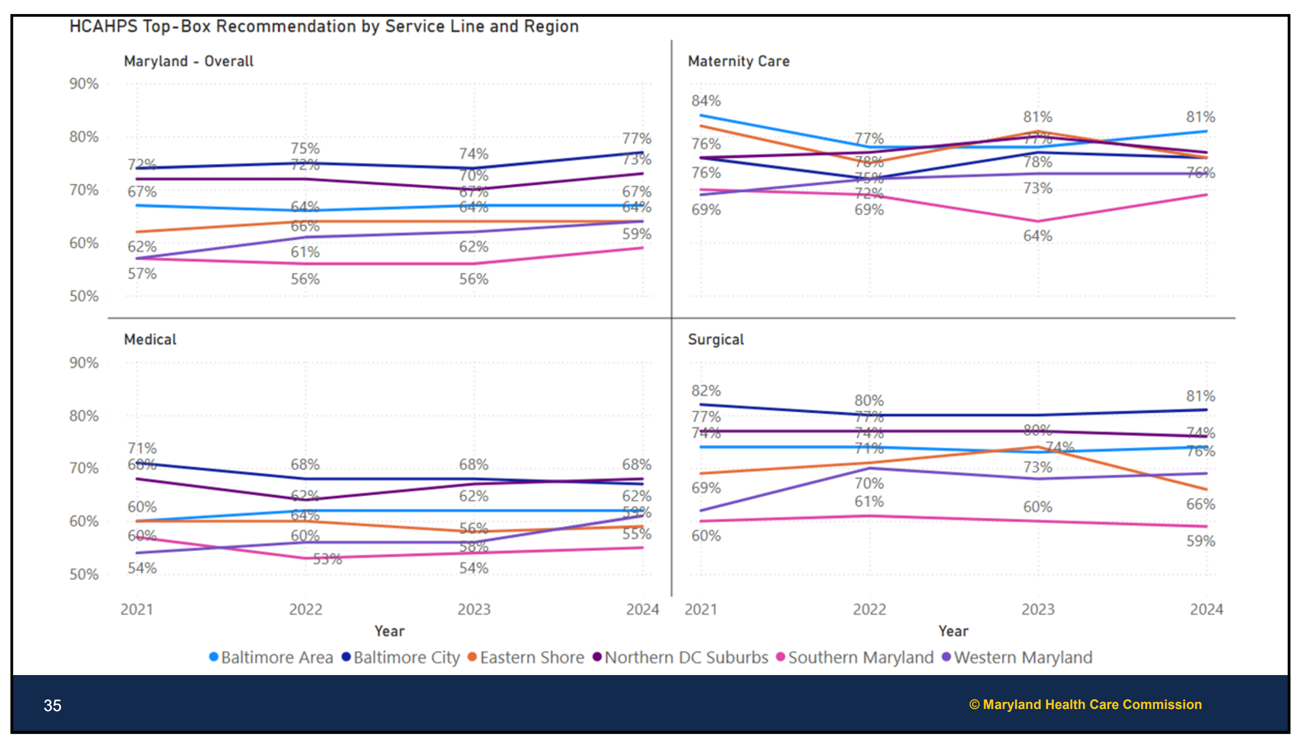
HCAHPS Top-Box Recommendation by Service Line and Region
Maryland - Overall
Maternity Care
Medical
Surgical
90%
80%
70%
60%
50%
2021
2022
2023
2024
Year
Baltimore Area
Baltimore City
Eastern Shore
Northern DC Suburbs
Southern Maryland
Western Maryland
35
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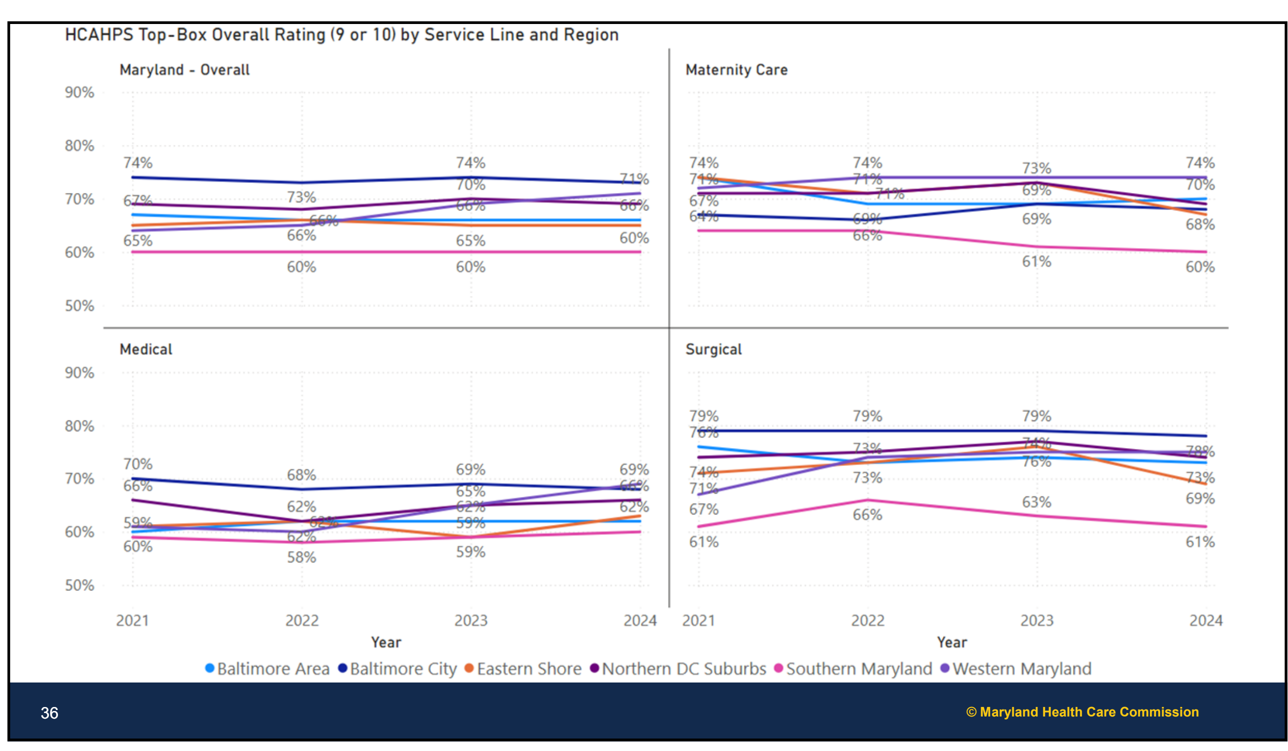
HCAHPS Top-Box Overall Rating (9 or 10) by Service Line and Region
Maryland - Overall
Maternity Care
Medical
Surgical
90%
80%
70%
60%
50%
2021
2022
2023
2024
Year
Baltimore Area
Baltimore City
Eastern Shore
Northern DC Suburbs
Southern Maryland
Western Maryland
36
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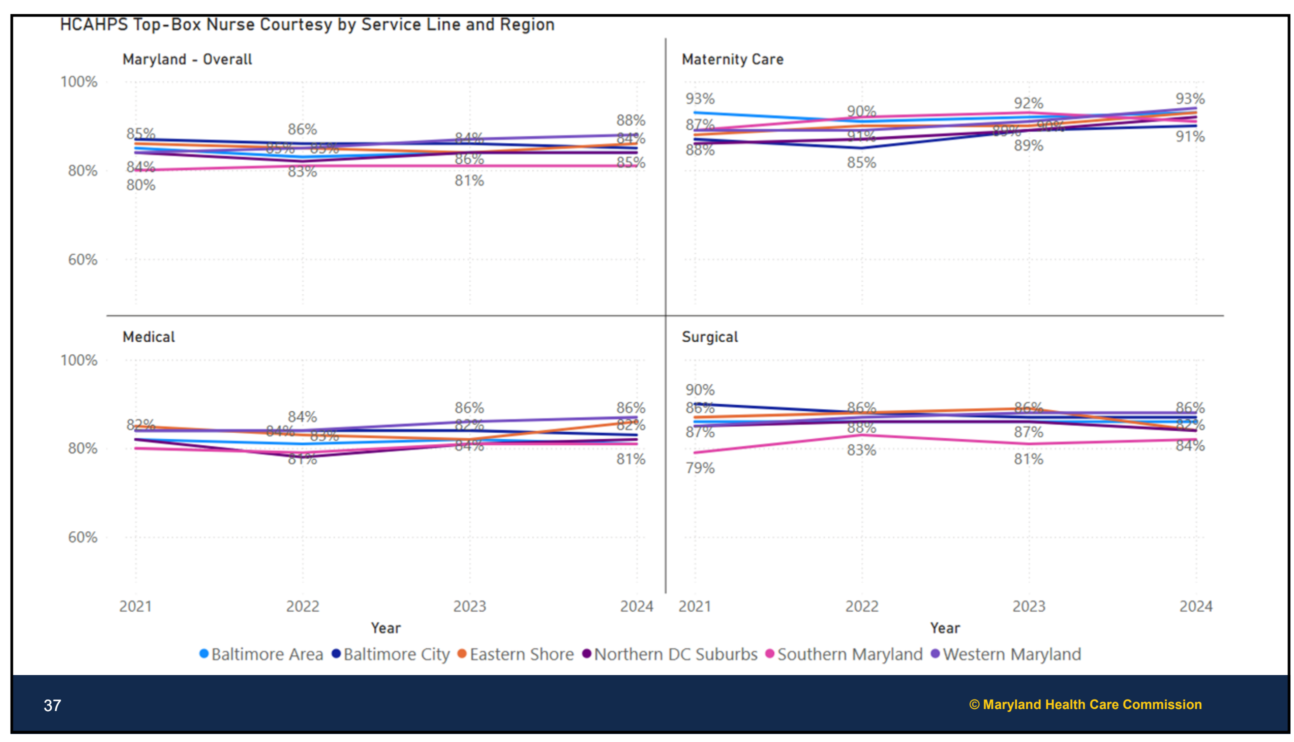
HCAHPS Top-Box Nurse Courtesy by Service Line and Region
Maryland - Overall
Maternity Care
Medical
Surgical
100%
80%
60%
2021
2022
2023
2024
Year
Baltimore Area
Baltimore City
Eastern Shore
Northern DC Suburbs
Southern Maryland
Western Maryland
37
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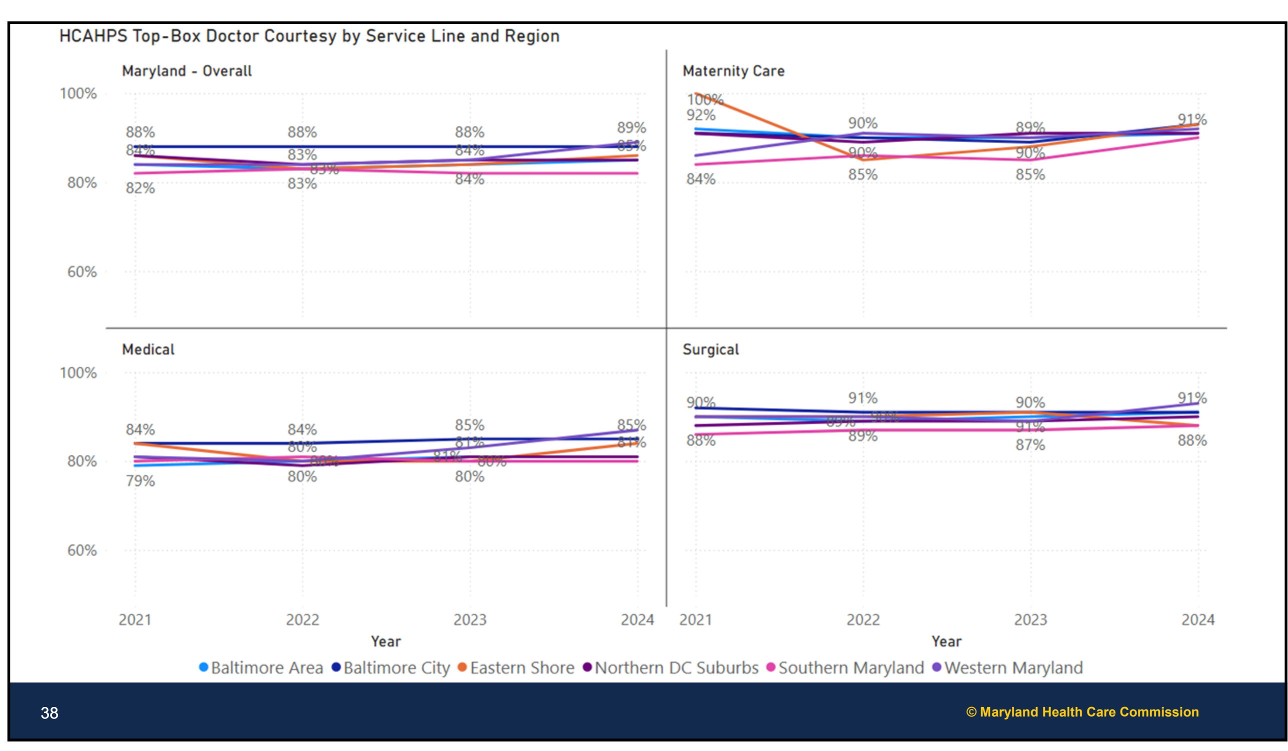
HCAHPS Top-Box Doctor Courtesy by Service Line and Region
Maryland - Overall
Maternity Care
Medical
Surgical
100%
80%
60%
2021
2022
2023
2024
Year
Baltimore Area
Baltimore City
Eastern Shore
Northern DC Suburbs
Southern Maryland
Western Maryland
38
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Key Takeaways & Discussion

- Potential further areas of exploration:
  - Relationship between Maryland and neighboring state surgical volumes
  - Criteria for urban/rural, academic medical centers
  - Other ways to support best practices
- 2024 Q4 submission due to MHCC April 9
- Upcoming changes for XML submission for new 2025 survey
  - Call for volunteers: Early submission of 2025 survey responses for programming

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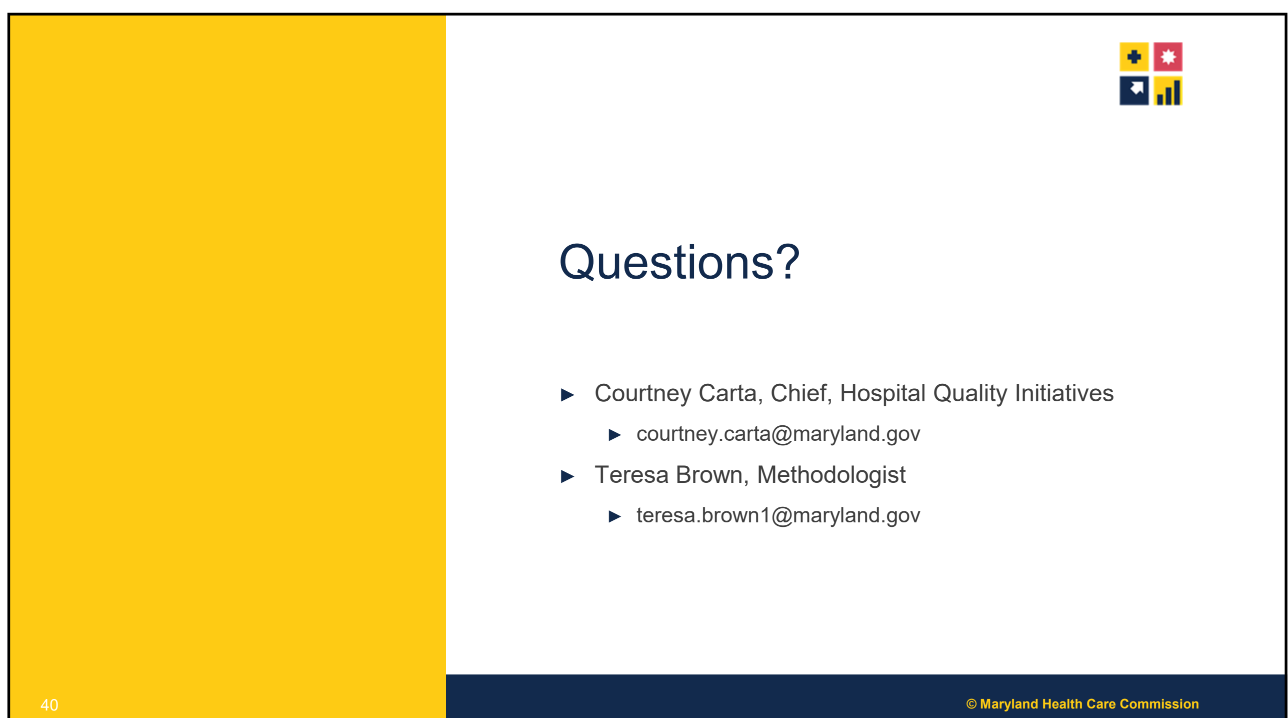
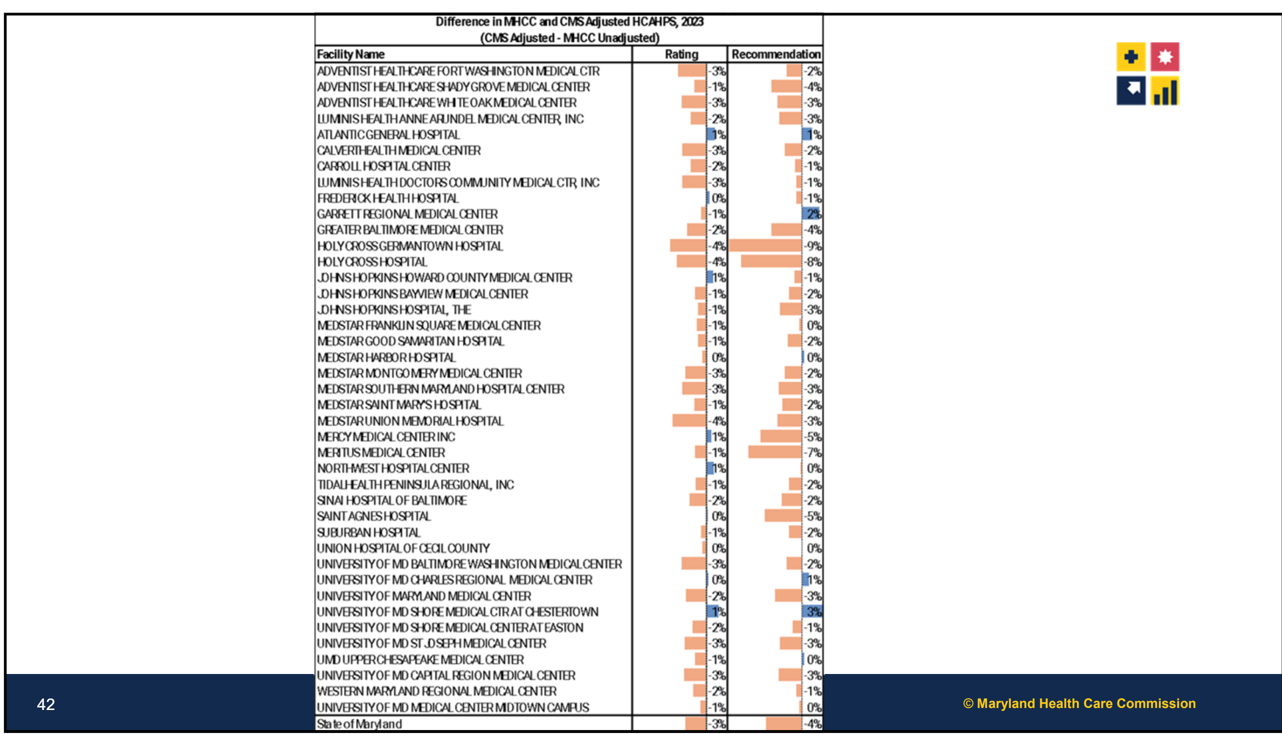




Difference in MHCC and CMS Adjusted HCAHPS, 2023
(CMS Adjusted - MHCC Unadjusted)

Facility Name	Rating	Recommendation
ADVENTIST HEALTHCARE FORT WASHINGTON MEDICAL CTR	-3%	-2%
ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	-1%	-4%
ADVENTIST HEALTHCARE WHITE OAK MEDICAL CENTER	-3%	-3%
LUMINIS HEALTH ANNE ARUNDEL MEDICAL CENTER, INC	-2%	-3%
ATLANTIC GENERAL HOSPITAL	1%	1%
CALVERTHEALTH MEDICAL CENTER	-3%	-2%
CARROLL HOSPITAL CENTER	-2%	-1%
LUMINIS HEALTH DOCTORS COMMUNITY MEDICAL CTR, INC	-3%	-1%
FREDERICK HEALTH HOSPITAL	0%	-1%
GARRETT REGIONAL MEDICAL CENTER	-1%	2%
GREATER BALTIMORE MEDICAL CENTER	-2%	-4%
HOLY CROSS GERMANTOWN HOSPITAL	-4%	-9%
HOLY CROSS HOSPITAL	-4%	-8%
JOHNS HOPKINS HOWARD COUNTY MEDICAL CENTER	1%	-1%
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	-1%	-2%
JOHNS HOPKINS HOSPITAL, THE	-1%	-3%
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	-1%	0%
MEDSTAR GOOD SAMARITAN HOSPITAL	-1%	-2%
MEDSTAR HARBOR HOSPITAL	0%	0%
MEDSTAR MONTGOMERY MEDICAL CENTER	-3%	-2%
MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	-3%	-3%
MEDSTAR SAINT MARY'S HOSPITAL	-1%	-2%
MEDSTAR UNION MEMORIAL HOSPITAL	-4%	-3%
MERCY MEDICAL CENTER INC	1%	-5%
MERITUS MEDICAL CENTER	-1%	-7%
NORTHWEST HOSPITAL CENTER	1%	0%
TIDALHEALTH PENINSULA REGIONAL, INC	-1%	-2%
SINAI HOSPITAL OF BALTIMORE	-2%	-2%
SAINT AGNES HOSPITAL	0%	-5%
SUBURBAN HOSPITAL	-1%	-2%
UNION HOSPITAL OF CECIL COUNTY	0%	0%
UNIVERSITY OF MD BALTIMORE WASHINGTON MEDICAL CENTER	-3%	-2%
UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	0%	1%
UNIVERSITY OF MARYLAND MEDICAL CENTER	-2%	-3%
UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	1%	3%
UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	-2%	-1%
UNIVERSITY OF MD ST JOSEPH MEDICAL CENTER	-3%	-3%
UMD UPPER CHESAPEAKE MEDICAL CENTER	-1%	0%
UNIVERSITY OF MD CAPITAL REGION MEDICAL CENTER	-3%	-3%
WESTERN MARYLAND REGIONAL MEDICAL CENTER	-2%	-1%
UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	-1%	0%
State of Maryland	-3%	-4%

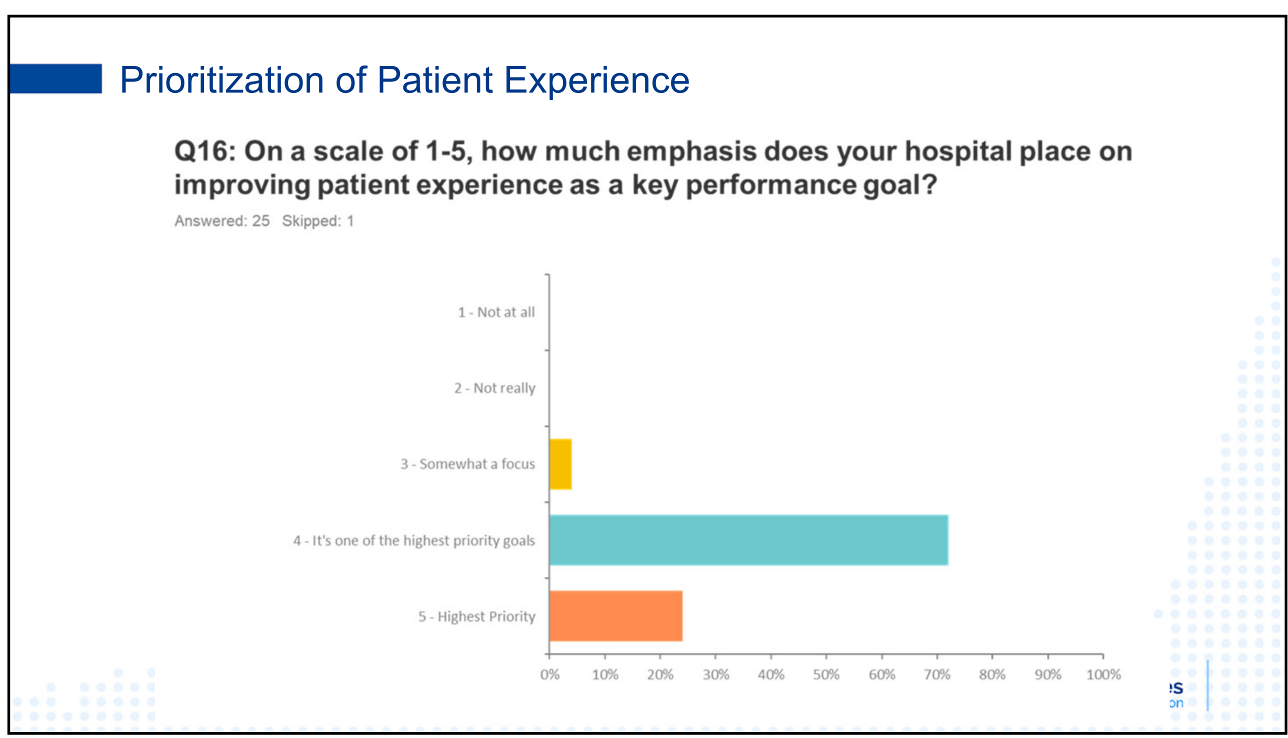
Survey Goals

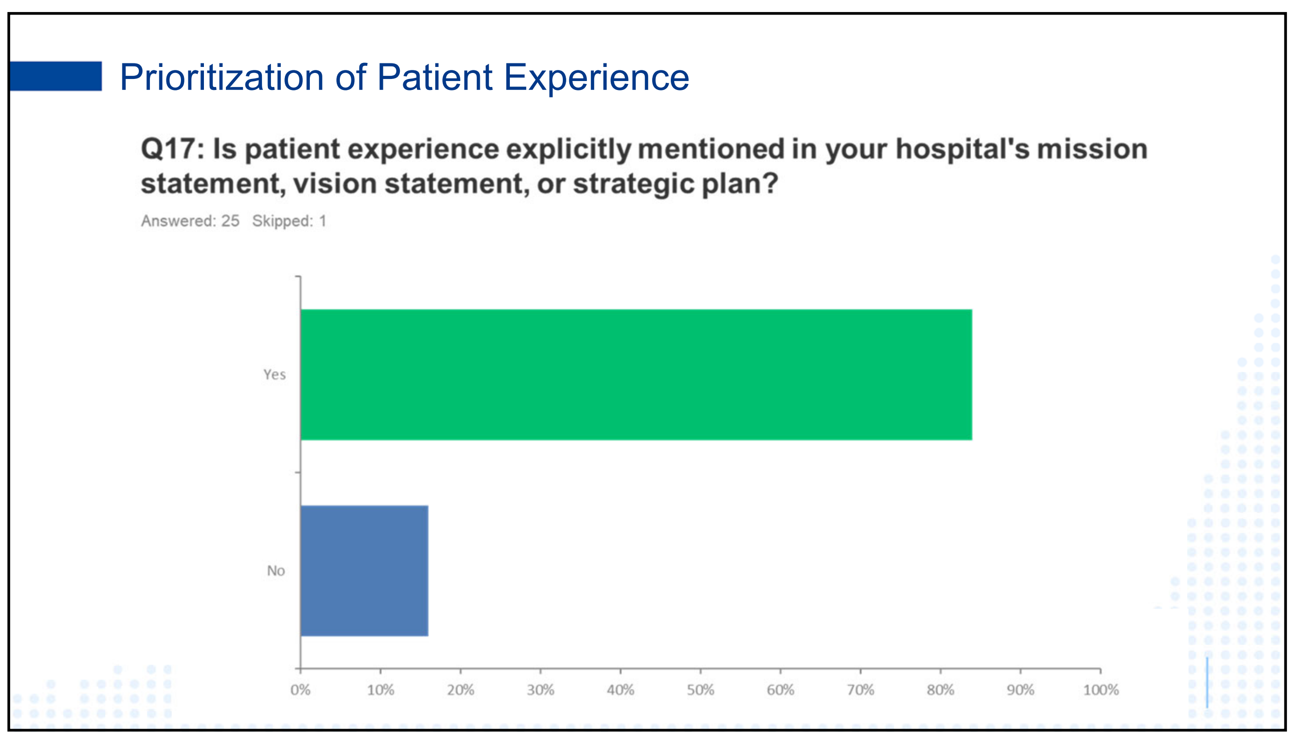
- Understand how hospital patient experience performance is prioritized at Maryland hospitals.
  - Understand hospital's investment in improving patient experience
- Discover approaches that hospitals are using to improve performance.
- Understand the patient experience data used to make decisions.
- Learning more about best practices to bring to future learning collaborative meetings

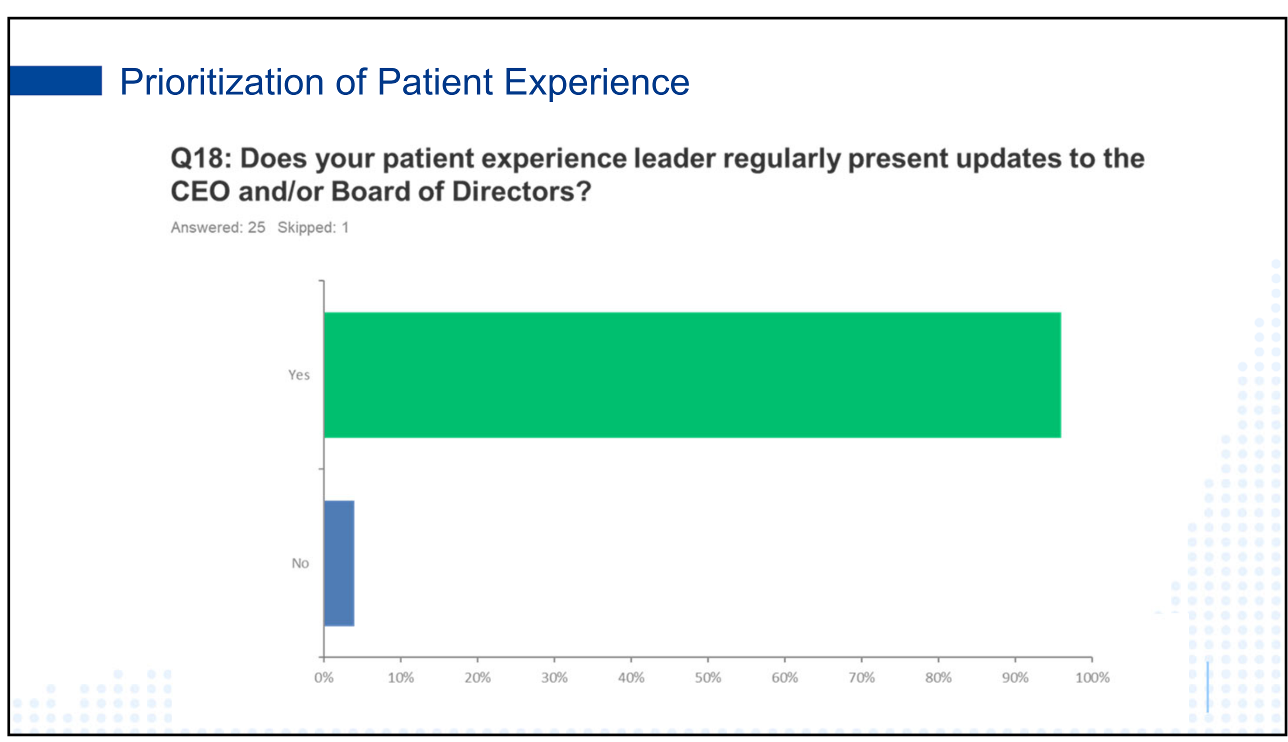
Responses

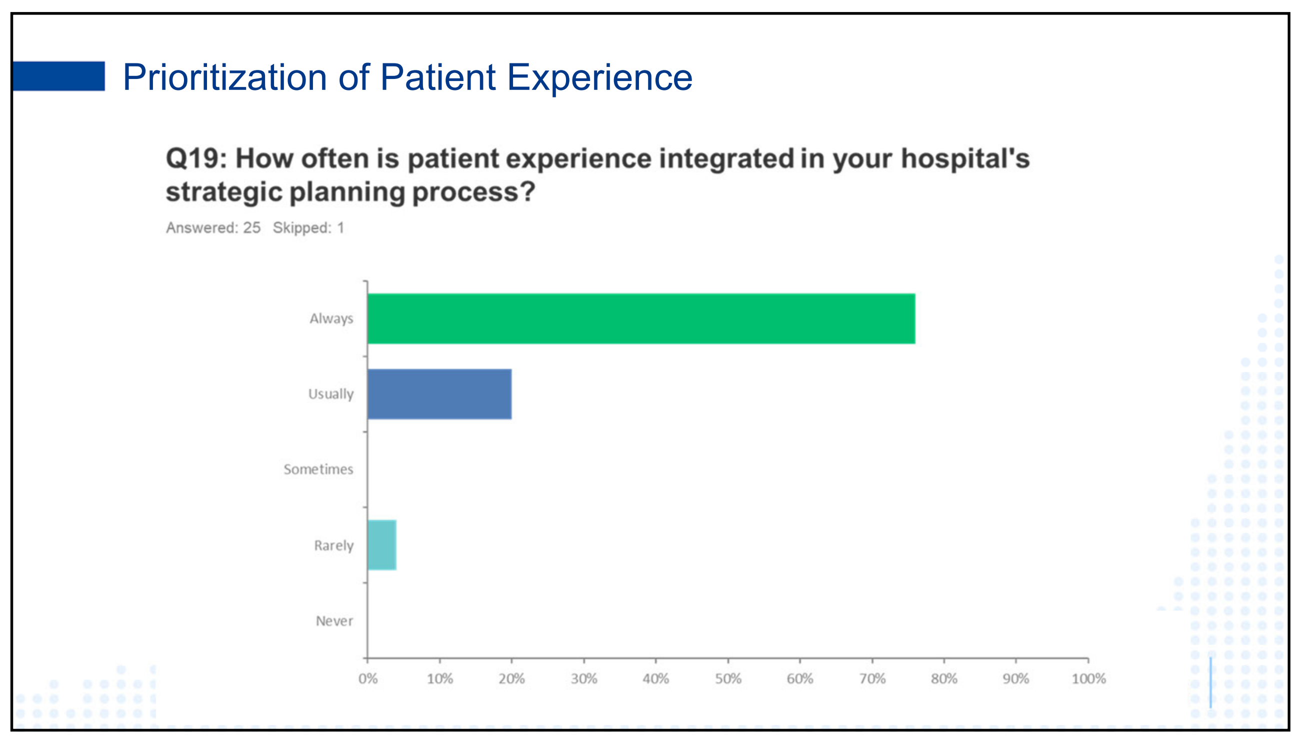
- 26 responses
- All learning collaborative health systems represented
- Survey took place over survey monkey in March 2025

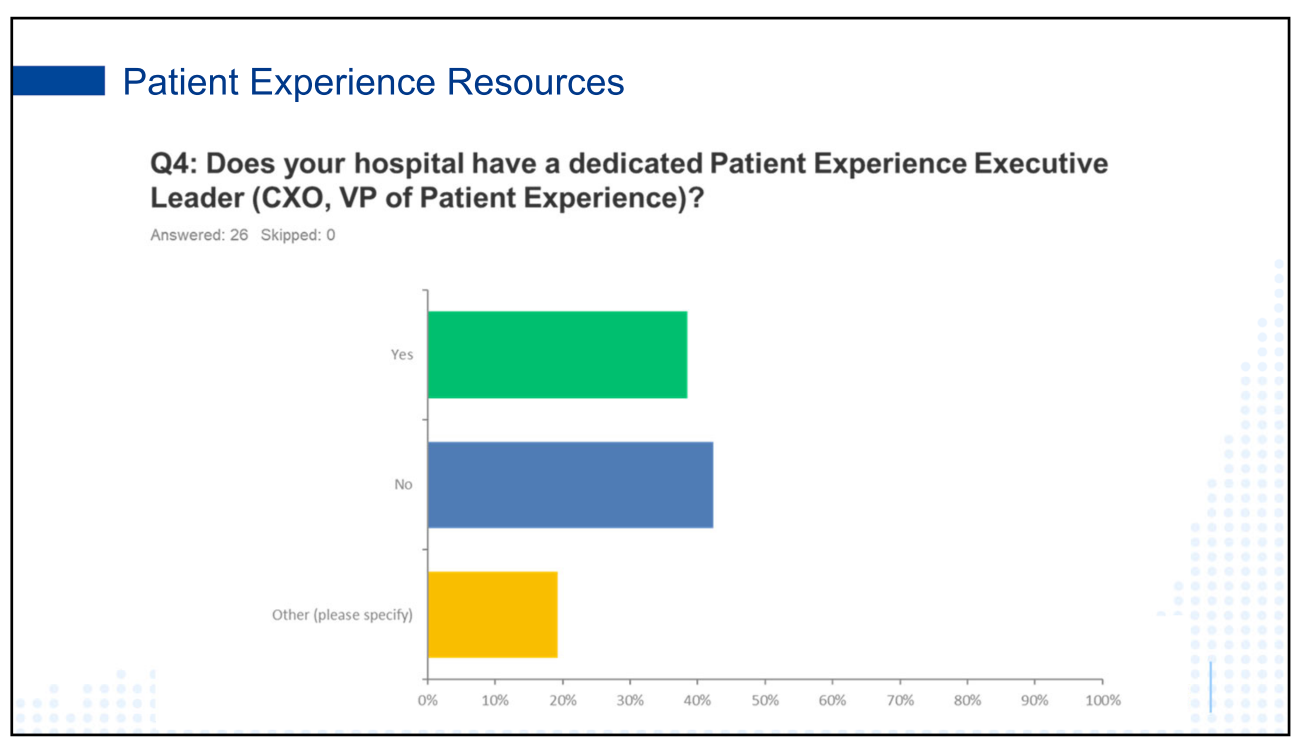
maryland health services cost review commission

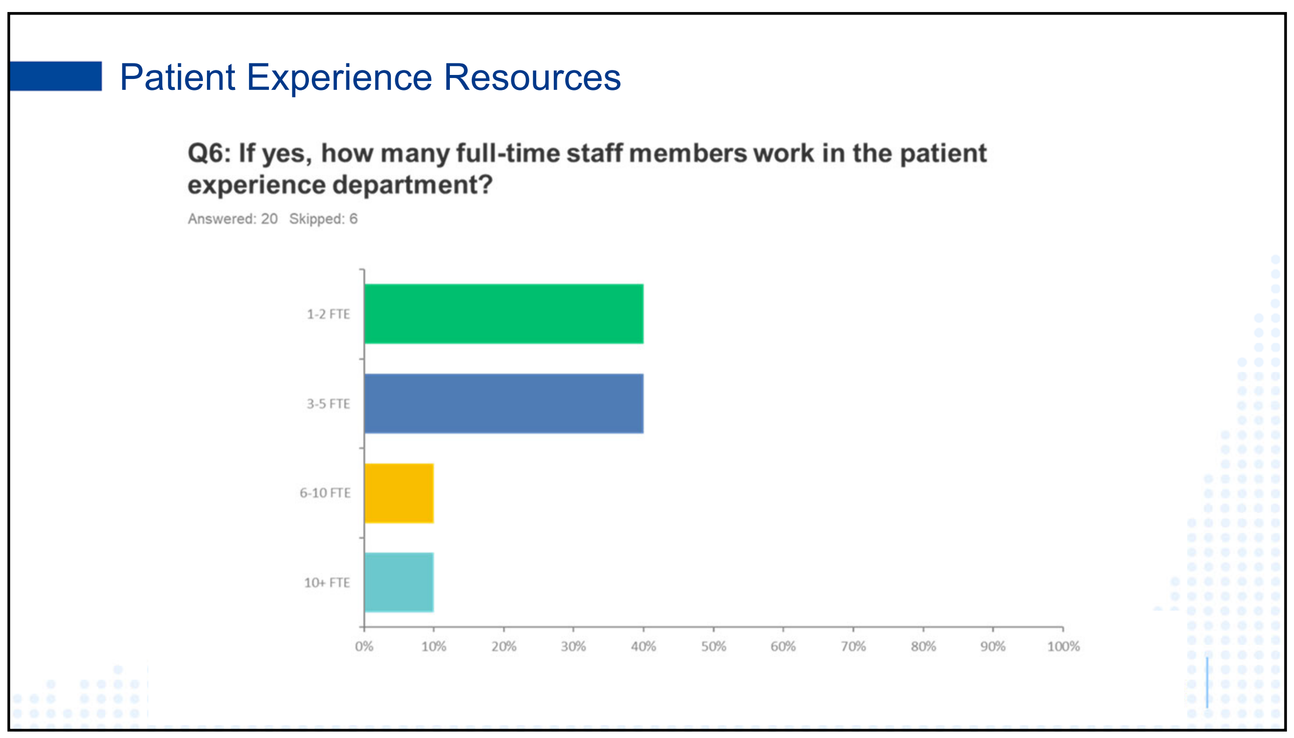


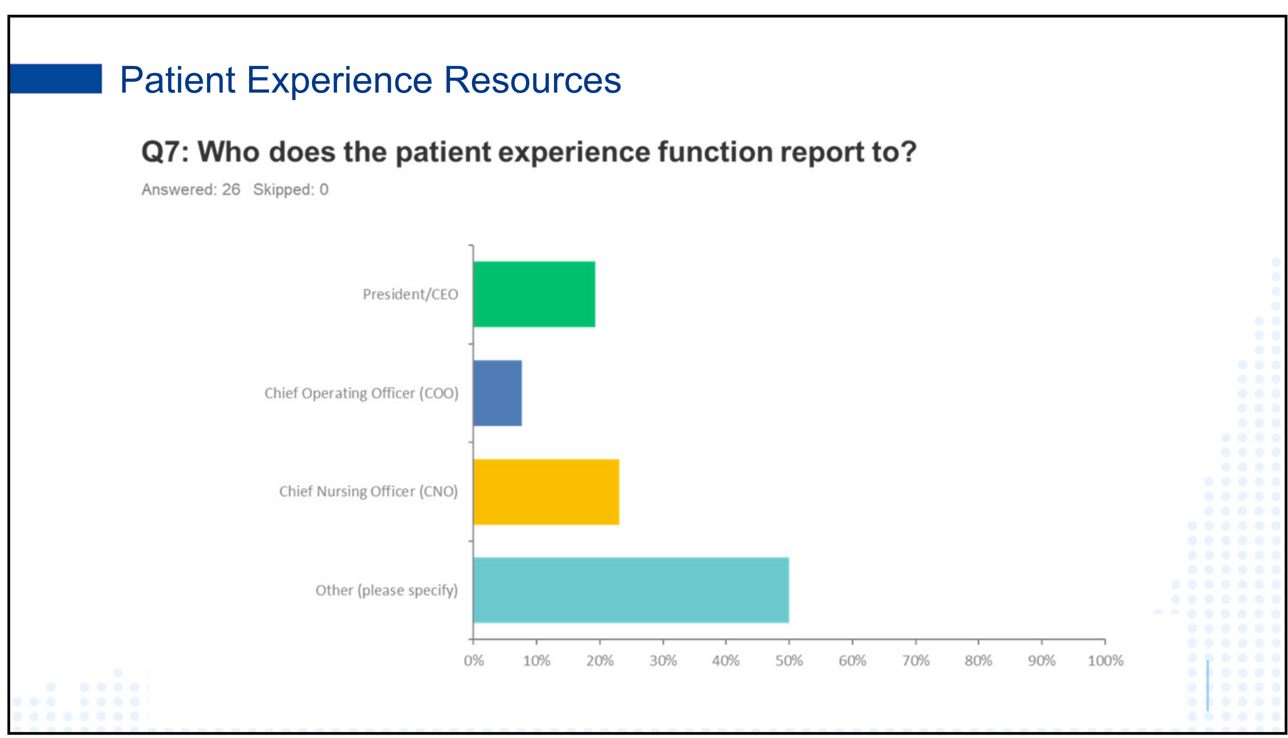

Prioritization of Patient Experience
Q17: Is patient experience explicitly mentioned in your hospital's mission statement, vision statement, or strategic plan?
Answered: 25 Skipped: 1
Yes
No
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

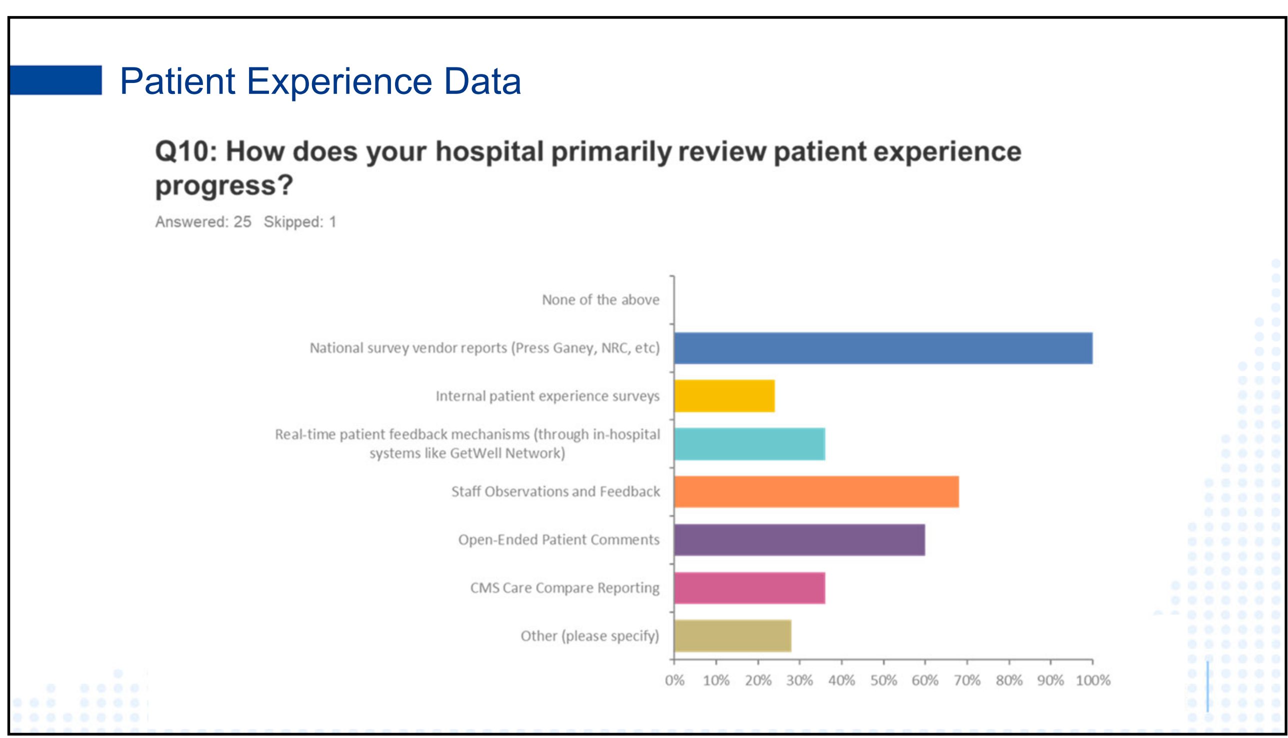

Prioritization of Patient Experience
Q18: Does your patient experience leader regularly present updates to the CEO and/or Board of Directors?
Answered: 25 Skipped: 1
Yes
No
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

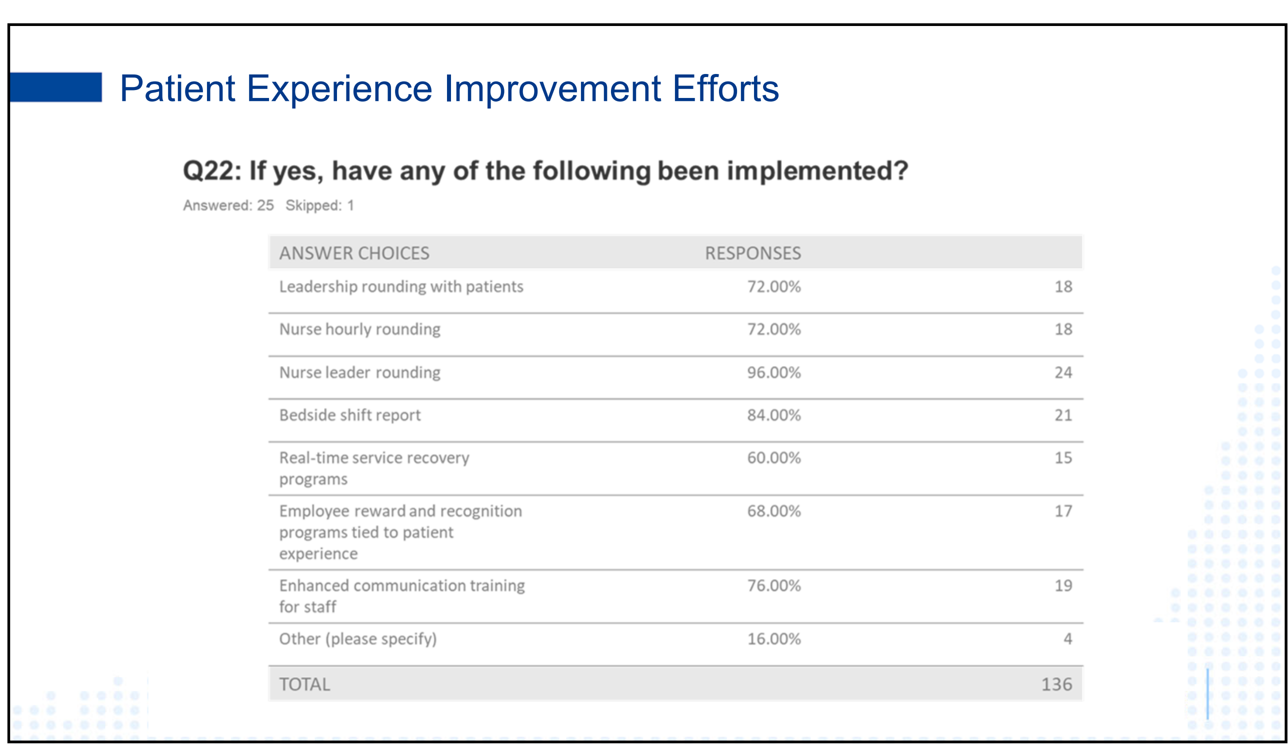

Prioritization of Patient Experience
Q19: How often is patient experience integrated in your hospital's strategic planning process?
Answered: 25 Skipped: 1
Always
Usually
Sometimes
Rarely
Never
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Patient Experience Resources
Q4: Does your hospital have a dedicated Patient Experience Executive Leader (CXO, VP of Patient Experience)?
Answered: 26 Skipped: 0
Yes
No
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Patient Experience Resources
Q6: If yes, how many full-time staff members work in the patient experience department?
Answered: 20 Skipped: 6
1-2 FTE
3-5 FTE
6-10 FTE
10+ FTE
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Patient Experience Resources
Q7: Who does the patient experience function report to?
Answered: 26 Skipped: 0
President/CEO
Chief Operating Officer (COO)
Chief Nursing Officer (CNO)
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%





Patient Experience Improvement Efforts

Q22: If yes, have any of the following been implemented?

Answered: 25 Skipped: 1

ANSWER CHOICES	RESPONSES	
Leadership rounding with patients	72.00%	18
Nurse hourly rounding	72.00%	18
Nurse leader rounding	96.00%	24
Bedside shift report	84.00%	21
Real-time service recovery programs	60.00%	15
Employee reward and recognition programs tied to patient experience	68.00%	17
Enhanced communication training for staff	76.00%	19
Other (please specify)	16.00%	4
TOTAL		136

Patient Experience Improvement Efforts

Q23: How does your hospital determine whether these best practices are effective?

Answered: 25 Skipped: 1

ANSWER CHOICES	RESPONSES	
Patient survey scores	100.00%	25
Staff feedback	60.00%	15
Regular observations	68.00%	17
Reduction in patient complaints	52.00%	13
Increased patient compliance with clinical instructions (i.e. Increased medicine compliance post-discharge)	20.00%	5
Increased patient referrals	8.00%	2
Other (please specify)	8.00%	2
TOTAL		79

Patient Experience Needs

Q26 What additional support or resources would help your hospital improve patient experience further?

needs auditing tool initiatives dedicated support leadership patient
training data coaches resources staff
patient experience PX additional Better
hospitals funding

Patient Experience Needs

Q24 What is the biggest challenge your hospital faces in improving patient experience?

high Support hospital improvements volume improving
competing priorities communication
patient experience Consistency staff initiatives
resources Enhancing challenge areas Patient focus patient experience
investment many

Conclusions

- Mismatch between prioritizing patient experience improvement and resourcing the improvement.
- Hospitals measure patient experience primarily through HCAHPS.
- Hospitals are largely trying the same best practices and improvement strategies.
- Limited impact of best practices could be improved through investment in consistency of teaching and coaching to those practices.