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The association between an established Chief Experience Officer role and hospital patient experience scores

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Abstract

The healthcare industry is currently reacting to multiple stakeholders demanding improvements to the patient experience. Some healthcare organizations are implementing new management structures, i.e., the role of Chief Experience Officer (CXO). This study statistically reviewed descriptors associated with hospitals that have and have not created and filled the role of CXO and, more importantly, measured the association between the CXO role and results of patients' perceptions of their experience of care as measured by publicly reported Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) results. This study was conducted utilizing data gathered on hospitals in three states, California, Florida, and New York. The results of the study yield insight into the organization characteristics of hospitals and the market factors associated with those hospitals that have filled the CXO role. Hospitals with a formal CXO role are larger, more likely to be for profit, and operate in metro areas of these states with higher per capita income. In addition, hospitals that have a formal CXO role are also more likely to have higher HCAHPS scores as determined by the patient recommendation question as well as the hospital overall rating question included in the HCAHPS survey.

Keywords

CXO, HCAHPS, patient experience

Background

The Patient-Centered Culture

Browne and colleagues described the patient experience as a measure of patient-centeredness,⁹ one of the six quality aims outlined in the IOM Report.⁷ IOM defined patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions".⁷ (p.143) Many organizations have adopted patient-centeredness as a chief aim as part of their quality efforts which has caused a cultural shift. For example, Virginia Mason adopted a significant cultural change by empowering any caregiver to stop care at any point in which there was risk of potential patient harm.¹⁰ (Kenney, 2011). Stubblefield described the top-down commitment required from the Chief Executive Officer (CEO) and the Board of Baptist Health System (Pensacola) to successfully adopt the cultural changes needed as part of its journey to achieve their goals of service excellence and patient-centeredness.¹¹ To lead these patient-centeredness cultural change efforts, some organizations have created a CXO role as part of their senior management team.

The Role of the Chief Experience Officer (CXO)

From an historical perspective, the Cleveland Clinic was the first organization to create a defined CXO position, seven years before the introduction of the Centers for Medicare & Medicaid Services (CMS) hospital value-based purchasing (VBP) program resulting from the Affordable Care Act of 2010. In 2003, the Clinic's leadership recognized that a cultural change was needed in which not just quality of care was the priority but also the patient experience. As such, a new role was created, the Chief Experience Officer, reporting directly to the CEO whose responsibility is to integrate the patient experience as a guiding value throughout the Clinic's operations.

The role of CXO has received attention since the introduction of VBP with executive recruiters describing a significant and recent (2015-2016) increase in recruiting for the role (R. Polemus, Senior Partner at Witt-Kieffer, personal communication, March 3, 2016). However, there has been limited empirical evidence research as to the prevalence of the position and whether this role has had an impact on changing an organization's culture to higher

levels of patient-centeredness as measured by improved patient experiences.

Conceptual Framework

The application of Resource Dependence Theory (RDT) is well suited for explaining the motivation for a hospital to seek transforming changes in the patient experience area. RDT provides the rationalization as to why an organization adopts the interests of stakeholders even if it requires disruptive changes to its operations. RDT views organizations as dependent on their external environment to obtain the necessary resources (i.e., inputs) and provide the output valued by stakeholders thereby resulting in a positive exchange relationship for continued sustainability.¹² (Pfeffer & Salancik, 1978). In other words, organizations need to be effective in managing the demands of their external environment, especially the demands of constituencies, which the organization is depended upon, for “acquiring and maintaining resources and support”.¹² (p. 2) With the implementation of VBP by CMS and other payers implementing similar contractual reimbursement terms that measure patient experience of care, hospitals seek strategic interventions that will advance the experience of care and yield an improvement compared to previous performance. Drawing from the motivations described in RDT, hospitals are likely to continue to search for improvement strategies in the patient experience area, i.e., adding the CXO role. As such, the introduction of the CXO role as an organizational structural change due to external environmental factors aligns well with RDT.

The Study

This study had several purposes. The first of these was to identify the prevalence of the CXO as an established role in sample hospitals. The second was to determine if there were differences in the organizational characteristics and market factors of those hospitals with an established CXO role and those hospitals without. The third purpose of the study was to determine if there is an association between hospitals with an established CXO role and reported higher HCAHPS scores as compared to hospitals without a formal CXO role. Based on the aims of the study, we tested the following four hypotheses:

Hypothesis 1

Several studies have investigated the organizational characteristics of hospitals that are high performing on the various domains of the HCAHPS survey. These include Chatterjee et al. who reviewed the safety net status of hospitals and found lower patient experience scores under the HCAHPS survey for those facilities.¹³ Richter and Muhlstein studied profitability and its relationship to patient experience and found that a negative patient experience was highly correlated with lower profitability.¹⁴

However, to date, the researchers did not uncover any empirical studies examining organizational characteristics of hospitals and the establishment of the formal CXO role. As described in RDT, differences in organizational characteristics may influence the ability of an organization to successfully respond to key constituencies in its external environment. For this study, the organizational characteristics chosen included number of beds, nurse staffing ratio, teaching status, and ownership status. These major characteristics were chosen to explore what types of facilities have established the formal CXO role and have previously been studied relative to HCAHPS scores. For this study, Hypothesis 1 states:

There are differences in organizational characteristics of hospitals that have a formally established CXO position as compared to those hospitals that have not established a formal CXO role.

Hypothesis 2

Lehrman et al. reviewed market factors and U.S. hospital characteristics associated with higher HCAHPS scores.¹⁵ The researchers found that hospitals in more urban locations with higher per capita income tended to score better on HCAHPS results. Little literature has reviewed market factors associated with the establishment of a CXO role. According to RDT, an organization needs to be able to secure and maintain the consistent acquisition of necessary resources from its external environment for survival. As such, the market factors chosen for this study included per capita income, population makeup (minority %), location (rural/urban) and level of competition as determined by the Herfindahl-Hirschman Index (HHI). These factors have also been studied by previous researchers related to HCAHPS scores. For the purpose of this study, Hypothesis 2 states:

There are differences in market factors of hospitals that currently have a formally established CXO position as compared to those hospitals that have not established a formal CXO role.

Hypothesis 3

RDT states that an organization’s ability to acquire resources helps explain variations in performance success. In a recent study, Wolf found that a high percentage (76%) of sampled hospitals believed they were either established or well established in their patient experience efforts, and an even higher percentage (82%) stated that improving patient experience was their first priority.¹⁶ Even so, there is no empirical research that has studied the association between the establishment of the CXO role and reported HCAHPS results. This study will be one of the first to report such information. For the purpose of this study, the third hypothesis states:

Hospitals that have a formally established CXO position will report higher overall hospital rating scores (a response of 9 or 10) as determined by HCAHPS Question 21 as compared to those hospitals that have not established a formal CXO role.

Hypothesis 4

In general, RDT helps to understand the impact the external environment has on organizational behaviors and performance, and the literature identifies various interventions that facilities have adopted in order to increase the likelihood that the patient will answer “probably yes” or “definitely yes” to the question of whether they will recommend the hospital to a family or friend. Dempsey et al. reviewed nursing communication and engagement levels and the relationship these have to hospital recommendation.¹⁷ The researchers identified a correlation between lower nursing engagement and lower HCAHPS performance. This study will be the first to review HCAHPS results in light of the establishment of a formal CXO role. For the purpose of this study, the fourth hypothesis states:

Hospitals that have a formally established CXO position will report higher patient experience scores indicating “likelihood to recommend” as determined by HCAHPS Question 22 as compared to those hospitals that have not established a formal CXO role.

Methods

Data

The sample hospitals in this study were acute care hospitals that operated in three states, California, Florida, and New York, in 2015. The states sampled were chosen to represent a varied geographic and service sample. VA Health Systems (N = 21) were excluded from the sample. The results of this data collection yielded two hospital cohorts, one that had an established and distinct CXO role (n = 160) and another cohort in which there was no established CXO role or if those duties were associated with another role (n = 502). Patient experience items used in the analysis were from the Agency for Healthcare Research and Quality Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for 2016. Organizational characteristics data was extracted from the American Hospital Association (AHA) database for January 2017. The market factors for each facility were extracted from the 2016 Area Health Resource File (AHRF).

Patient Experience Variables

In order to assess patient experience, we used two HCAHPS items: overall hospital rating and the willingness to recommend the hospital. The overall hospital rating HCAHPS item asked, “Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best

hospital possible, what number would you use to rate this hospital during your stay?” The variable reports the percentage of respondents that answered 9 or 10 to the question. The willingness to recommend the hospital HCAHPS item asked the patient if they would recommend the hospital to their friends and family. The variable reports the percentage of respondents that answered probably yes or definitely yes.

Chief Experience Officer (CXO) Variable

A binary indicator was created reflecting whether there was an established formal CXO role at the facility (=1) or not (=0) using information gathered by visiting the web pages of individual hospitals that were associated with the state hospital associations in the three states, California, Florida, and New York. The data was collected via three sequential steps. First, the hospitals were identified from the rosters of each state’s hospital association and cross-referenced with the AHA database. Second, a web search was performed to see if the individual hospital was independent or part of a multi-hospital system. Third, if the hospital’s website did not indicate that the facility had a CXO or if those duties were associated with another role, the facility research stopped. If the website was unclear, a phone call was made for clarification. If the hospital was part of a system, the web review also involved the system web site and a call to the system to determine if they had established the system-level role.

Organizational Variables

In order to control for the effect of organizational characteristics on the HCAHPS score, organizational-level variables reflecting the total number of beds, ownership type, teaching status, and nurse staffing were included in the analysis. Bed size of the hospital consisted of four categories: less than 100 beds (referent), 100-299 beds, 300-499 beds, and greater than 499 beds. The teaching status variable reflected whether the hospital was a teaching hospital. Ownership type consisted of three categories: for-profit, not for-profit, and governmental (referent). Nurse staffing was measured as the number of nurse hours per adjusted patient day. A number of studies have investigated the organizational characteristics of hospitals that are high performing on the various domains of the HCAHPS survey.

Market Variables

The market factors controlled for in this study included population density, percent minority in market population, per capita income, and market competition. Population density was included as a dichotomous variable: urban vs. not urban (referent). Percent minority in the market population was measured as the percentage of county residents who are non-White. Per capita income was a continuous variable indicating the average per capita income of the county. Finally, the level of competition in the market as determined by the Herfindahl-Hirschman

Index (HHI). Previously, Lehrman et al. examined market factors and hospital characteristics associated with higher HCAHPS scores and found that hospitals in more urban locations with higher per capita income tended to score better on HCAHPS results.¹⁵

Data Analysis

The data were analyzed using Stata Version 15 and employed logistic regression and ordinary least squares (OLS) regressions (N=662). We first modeled the relationship between hospitals with a CXO position and organizational and market characteristics using a logistic regression analysis. We then employed OLS regression to evaluate the relationship between the hospital’s patient experience ratings and the CXO position, controlling for organizational characteristics and market factors.

Results

Table 1 presents the descriptive statistics comparing non-CXO hospitals to CXO hospitals. Tests of significance were conducted as appropriate (*t* tests for continuous variables and chi-square for categorical variables). Around one third of the hospitals had a formal CXO position

(32%). The average percent of patients reporting high overall hospital rating scores (9 or 10) was significantly higher for hospitals with a CXO position ($p<0.05$) compared to hospitals without a formal CXO position. Likewise, the average percent of patients reporting answering “probably yes or definitely yes” to whether they would recommend the hospital was significantly higher for hospitals with a CXO position relative to hospitals without a CXO position ($p<0.001$). For hospitals with and without a CXO position, around half the sample were hospitals with 100-299 beds, and half the sample were teaching hospitals. Almost 60% of the hospitals without a CXO position were not-for-profit hospitals and 20.3% were for-profit hospitals, whereas 65% of the hospitals with a CXO position were not-for-profits hospitals and 29.4% were for-profit hospitals ($p<0.001$). The vast majority of hospitals in the sample were located in urban areas ($p<0.05$). Around two-fifths of the population in the surrounding areas hospitals with and without a CXO were non-white. The average per capita income in the surrounding areas was significantly higher for hospitals with a CXO position ($p<0.01$) and the mean HHI was 0.60 regardless of whether the hospital had a CXO position.

Table 1. Bivariate Associations between Sample Characteristics and CXO Position

| Variables | Non-CXO n=502 n / % | CXO n = 160 n / % | χ^2 / t |
|---|-------------------------|-------------------------|-----------------------|
| Patient Experience | | | |
| Overall Hospital Rating (Mean/SD) | 66.30 / 9.41 | 68.49 / 7.89 | $t=-2.570^*$ |
| Willingness to Recommend Hospital (Mean/SD) | 92.07 / 6.27 | 93.84 / 2.76 | $t=-3.475^{***}$ |
| Organizational Variables | | | |
| Hospital Bed Size | | | |
| <100 beds | 111 / 22.11 | 25 / 15.63 | $\chi^2=3.640$ |
| 100-299 beds | 247 / 49.20 | 81 / 50.63 | |
| 300-499 beds | 96 / 19.12 | 35 / 21.88 | |
| >499 beds | 48 / 9.56 | 19 / 11.88 | |
| Teaching Hospital | | | |
| Yes | 241 / 48.01 | 90 / 56.25 | $\chi^2=3.297$ |
| No | 261 / 51.99 | 70 / 43.75 | |
| Ownership Status | | | |
| governmental | 105 / 20.92 | 9 / 5.63 | $\chi^2=21.678^{***}$ |
| for-profit | 102 / 20.32 | 47 / 29.38 | |
| not-for-profit | 295 / 58.76 | 104 / 65.00 | |
| Nurse Staffing | 7.86 / 9.58 | 8.01 / 3.52 | $t=-0.203$ |
| Market Variables | | | |
| Location | | | |
| Rural | 66 / 13.15 | 11 / 6.88 | $\chi^2=4.644^*$ |
| Urban | 436 / 86.85 | 149 / 93.13 | |
| % Minority (Mean/SD) | 44.58 / 23.71 | 42.91 / 1.52 | $t=1.013$ |
| Per Capita Income (Mean/SD) | \$47,529.18 / 17,449.84 | \$52,520.08 / 24,301.08 | $t=-2.845^{**}$ |
| HHI (Mean/SD) | 0.60 / 0.35 | 0.60 / 0.34 | $t=-0.002$ |

Note: *** $p<.001$, ** $p<.01$, * $p<.05$. N = 662

Table 2 presents the organizational and market correlates of the CXO position. Relative to governmental hospitals, for-profit hospitals had 6.8 times higher odds of having a CXO officer and not-for-profit hospitals had over 4 times higher odds of having a CXO officer ($p < 0.001$). Likewise, hospitals located in areas with higher per capita income were associated with higher odds of having a formal CXO officer ($p < 0.05$).

We examined the relationship between the CXO position and two patient experience HCAHPS measures: overall hospital rating and willingness to recommend the hospital (Table 3).

Overall hospital rating: Hospitals with a CXO officer have significantly higher percentages of patients reporting high overall hospital rating scores (or 9 or 10) compared to hospitals without a CXO officer ($p < 0.05$). Hospitals with greater numbers of beds were associated with lower overall hospital rating scores. Relative to hospitals with less than 100 beds, hospitals with 100-299 beds were associated with 4.2% fewer patients reporting high overall hospital rating scores ($p < 0.001$), hospitals with 300-499 beds were associated with 3.5% fewer patients reporting high overall hospital rating scores ($p < 0.001$), hospitals with greater than 499 beds were associated with 4.7% fewer patients reporting high overall hospital rating scores ($p < 0.001$). Relative to governmental hospitals, for-profit hospitals

were associated with 2.6% fewer patients reporting high overall hospital rating scores ($p < 0.05$) while not-for-profit hospitals were associated with 3.2% more patients reporting high overall hospital rating scores ($p < 0.01$). Increases in nurse staffing was associated with higher percentages of patients reporting high overall hospital rating scores ($p < 0.001$). Urban hospitals were associated with 4.1% more patients reporting high overall hospital rating scores ($p < 0.01$) and hospitals located in areas with higher percentages of non-white population were associated with 0.04% fewer patients reporting high overall hospital rating scores ($p < 0.05$).

Willingness to recommend hospital: Hospitals with a CXO officer also have significantly higher percentages of patients reported answering “probably yes or definitely yes” to whether they would recommend the hospital compared to hospitals without a CXO officer ($p < 0.01$). Relative to hospitals with less than 100 beds, hospitals with 100-299 beds were associated with 1.5% fewer patients reporting “probably yes or definitely yes” to whether they would recommend the hospital ($p < 0.05$), on average. Additionally, relative to governmental hospitals, not-for-profit hospitals were associated with 4.7% more patients reporting “probably yes or definitely yes” to

Table 2. Logistic Regression Examining Correlates of CXO Position

| Independent Variables | CXO Position OR |
|--------------------------------------|--------------------|
| Organizational Variables | |
| Hospital Bed Size | |
| <100 beds | (referent) |
| 100-299 beds | 1.180 |
| 300-499 beds | 1.415 |
| >499 beds | 1.660 |
| Teaching Hospital | |
| No | (referent) |
| Yes | 1.484 |
| Ownership Status | |
| governmental | (referent) |
| for-profit | 6.824*** |
| not-for-profit | 4.110*** |
| Nurse Staffing | 1.004 |
| Market Variables | |
| Location | |
| Rural | (referent) |
| Urban | 1.770 |
| % Minority | 0.993 |
| Per Capita Income (in 1,000s) | 1.012* |
| HHI | 1.708 |

Note: *** $p < .001$, ** $p < .01$, * $p < .05$. N = 662

Table 3. Relationship of CXO on Patient Experience HCAHPS Ratings, OLS Regression

| Independent Variables | Effect of CXO on Patient Experience | |
|--------------------------------------|-------------------------------------|-----------------------------------|
| | Overall Hospital Rating | Willingness to Recommend Hospital |
| | Coefficient | Coefficient |
| CXO Position | 2.057* | 1.372** |
| Organizational Variables | | |
| Hospital Bed Size | | |
| <100 beds | (referent) | (referent) |
| 100-299 beds | -4.212*** | -1.485* |
| 300-499 beds | -3.496** | -0.743 |
| >499 beds | -4.670** | -0.822 |
| Teaching Hospital | | |
| No | (referent) | (referent) |
| Yes | 0.555 | -0.242 |
| Ownership Status | | |
| governmental | (referent) | (referent) |
| for-profit | -2.597* | 1.361 |
| not-for-profit | 3.205** | 4.701*** |
| Nurse Staffing | 0.205*** | 0.039 |
| Market Variables | | |
| Location | | |
| Rural | (referent) | (referent) |
| Urban | 4.145** | 0.390 |
| % Minority | -0.042* | -0.011 |
| Per Capita Income (in 1,000s) | 0.003 | 0.003 |
| HHI | -1.392 | 1.338 |

Note: *** p<.001, ** p<.01, *p<.05. N = 662

whether they would recommend the hospital (p<0.001), on average.

In summary, our findings reveal that there is support for all four of our hypotheses. First, there are differences in organizational characteristics of the hospitals in the sample that had filled the CXO role. Those differences, which were statistically significant, were associated with the CXO hospitals' ownership status. Second, there were differences between market factors associated with hospitals that had invested in the CXO role compared to those that had not. Those differences, which were statistically significant, were associated with the CXO hospitals' location (rural versus urban) and per capita income. Third, the cohort of hospitals that had filled the CXO role scored higher top box answer (9 or 10) in comparison to the cohort without a CXO. The resulting difference was highly significant. In reviewing other factors influencing the outcome of higher top box score, a number were significant. Number of hospital beds was associated with a lower score, and not-for profit ownership status was associated with a higher score. Finally, the cohort of hospitals that had filled the formal CXO role scored higher in likelihood to recommend as compared to the cohort without a CXO. In

reviewing the factors influencing the outcome of higher likelihood to recommend, two factors were significant - the number of hospital beds and not-for-profit ownership status.

Discussion

This study used RDT to explain why a hospital seeking to ensure the flow of needed resources from the environment would be motivated to adopt and operationalize a structural change by creating a formal CXO role within the organization. When analyzing the results of this study, three forces become apparent for understanding managers' decision-making for establishing this role and the potential for more effective performance. These include adoption process, operational alignment, and stakeholder interests. These three forces along with RDT reasserts the willingness of the organization to disrupt its normal operation. These operational and strategic changes - becoming more patient-centered and aligning better with key constituencies' demands - reflects the organization's response to important factors and stakeholders in the external environment.

Adoption Process

The adoption of stakeholder interests, especially those associated with increasing patient-centered practices has been accelerated by the formation and operation of coalitions and associations promoting stakeholders' interest in these changes. Organizations like IOM are exerting a powerful influence on regulators, payers, and hospitals to adopt changes and have assisted in implementing penalties and incentives to promote these concepts.

Operational Alignment

The creation of reimbursement related penalties and rewards around the patient experience has caused hospitals to adopt operational changes designed to increase the likelihood of patient satisfaction and patient engagement with their care. In addition to instituting changes in operations, many facilities have integrated patients and families into their planning and organizing efforts. This includes the process of expansion and design of the facility's environment and investing in new managerial structures (such as a CXO) to ensure patients' needs are integrated into strategy and operations.

Stakeholder Interests

Regarding patient experience, there is strong support for a clearer and more rigorous definition of the interests of the patient related to safety, outcomes, and the experience of patient care within a hospital. As previously noted, RDT describes how penalties and reimbursement incentives would form the basis of adoption by hospitals of more rigorous demands proposed by external forces, namely the government and patient interest groups (i.e., stakeholders).

From the managerial implication and practical application viewpoints, it is clear that the body of knowledge is expanding regarding potential interventions, strategies, and management structures that can improve patient experience and the resulting reimbursement associated with value-based contracting. Hospitals that have not invested in the CXO role should evaluate their current progress given their existing leadership structures. As a minimum, this structure should assign specific accountability for the patient experience with a key leader that can advance this effort and implement evidenced based practices to drive these improvement efforts.

This study does indicate an association between having someone formally in the CXO role and higher reported scores for the recommendation and overall rating questions as reported in HCAHPS results. Health services organizations should support the development of more leaders in patient experience training and development, encouraging the growth of credentialed professionals in these roles regardless of whether or not they are led by a CXO. While it may be true that the return on investment for establishing a CXO is hard to quantify today, that

situation may change as the value associated with outcome measures begins to have greater influence on payment rates.

The limitation of this study provides opportunities for future research. While our study revealed an association between the CXO role and higher HCAHPS scores, more longitudinal data will be necessary to determine if this association (by early adopters) continues to result in statistically meaningful and higher HCAHPS scores, in addition to analyzing the motivations of these early adopters would provide insight. More research into the characteristics of individuals filling the CXO role may yield further insight into patient experience results. Future studies should analyze the strategies CXOs have implemented to improve specific areas surrounding scores such as nursing or physician communication and whether these demonstrate an increase in patient experience scores. Hospitals and health systems should welcome future analysis of the potential return on the investment associated with higher reimbursements under VBP and the cost of implementing strategies designed to improve patient experience, including creating a formal CXO role and the potential infrastructure associated with that effort. Finally, although we included hospitals from three states representing the geographical and service diversity of hospitals, future research may examine more hospitals for better generalizability.

Conclusion

This study begins to narrow the gaps in current research by providing useful information to guide healthcare leaders in understanding the relevance of a new C-suite role, the Chief Experience Officer. Based on RDT, this study offers a framework to understand the rationale for the investments and changes made by hospitals relative to improving patient experience. It provides greater insight into the types of hospitals that have utilized the CXO role as a strategy to improve patient experience and identified an association between those hospitals with a CXO position as well as several key characteristics and higher HCAHPS scores. The importance of improving patient experience is evidenced by the significant investments most organizations are making in infrastructure, management staff, programs, and cultural interventions to be more patient-centered.

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