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Patient Experience Coordinator

An Innovative Role to Improve Patients' Hospital Experience

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OBJECTIVE: The aim of this study was to test the impact of an innovative nonclinical support role to improve patient experiences while supporting nurse work on inpatient units.
BACKGROUND: On the basis of the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey, patients' experience declined nationally during the COVID-19 pandemic. A nonclinical support role, titled an Experience Coordinator, was created as a test of change to collaborate with care teams and respond to patients' and families' nonclinical needs.
METHODS: This is a quality improvement (QI) project for a supportive role development and implementation. The health system's HCAHPS data were compared before and after the role was tested on 3 inpatient units.
RESULTS: The HCAHPS data indicated that 5 of the 10 domains' top box ratings increased during the QI project month compared with the previous month.
CONCLUSION: The study findings may support the implementation of new innovative nonclinical positions to alleviate nurses' workload and promote patients' hospital experience.

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The COVID-19 pandemic stressed an already distressed healthcare workforce and negatively affected relatively stable patient experiences across the nation. The significant impact of the COVID-19 pandemic on the national healthcare workforce shortage has been profound. On September 2, 2021, the American Nurses Association, in a letter to the US Health and Human Services secretary, called for immediate action to address the unsustainable nurse staffing shortage.[1] The letter advocated that crisis-level nurse staffing jeopardizes nurses' ability to care for patients. Healthcare organizations should seek out ways to alleviate staff shortages and ensure quality patient care. To respond to the current workforce shortage and the call for action, a new role was created to be a part of the care team, the Experience Coordinator. The Experience Coordinator, created as a test of change in this study organization, is an innovative role different from others that are more familiar including patient advocates or representatives.

These aforementioned patient-related roles have similarities but function differently and have different responsibilities and values to nursing. Patient advocates, as the name indicates, are responsible for "speaking up" for patients. The word "advocate" stems from the Latin roots of "ad" and "voca," which means to speak for another person. In the health system, all healthcare personnel should be considered patient advocates and bear responsibility for advocating or "speaking up" for patients.[2] Patient representatives are individuals responsible for guiding patients and families through the healthcare system and/or treatment course.[2,3] The new role was not designed like the more traditional

patient representative or patient advocate roles, which often mediate between patients, families, and the clinical team. The traditional roles such as these tend to balance their job listening and responding to patient concerns about the clinical care or care team, which may create an unwelcoming relationship with the clinical team. Even the titles of these roles imply that they advocate or represent the patient interest solely versus directly assisting the care team to improve patient experiences; thus, the traditional patient advocate or representative roles may not be seen as supportive or helpful to nursing. In this article, a new role, Experience Coordinator, is tested, which is different from the ones traditionally used in the health system.

The Experience Coordinator role (SDC #1, http://links.lww.com/JONA/A988) was designed and titled to coordinate the patient experience, a shared responsibility of everyone on a clinical care team. It is an active and dynamic role designed to respond to patient needs of a nonclinical nature that do not require a nurse or nurse assistant. This innovative role provides another stakeholder with the responsibility to impact the experience of patients in the inpatient setting so that this responsibility does not rest with the clinical team alone.

Background

On the basis of information collected from the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey, as reported by Press Ganey Associates LLC,[4] patient experience at the study site declined significantly during the pandemic. In a review of the national patient experience data, the question asking about patients' likelihood of recommending their healthcare experience to family and friends, which had remained stable since 2018, showed an overall reduction of 4.5% in patients' likelihood of recommending a hospital to their families and friends during the pandemic. There was also an overall reduction of 4% in patients' rating of the hospital from 0 to 10, with 0 being the worst hospital possible and 10 being the best hospital possible.

The pandemic also brought about new stressors for nurses and patients related to visitor restrictions and personal protective equipment, including mask usage for patients, visitors, and families. Because of the nurse staffing shortage and declining patient experiences, healthcare administrations need to find innovative approaches to support nurses with nonclinical patient requests and visitor support and management. Thus, leaders at a university-affiliated hospital, referred to as study site, created an inpatient nonclinical support role. This position was titled Experience Coordinator and was designed to collaborate with nursing, respond to patients' and families' nonclinical needs, proactively listen, personalize patients' visitation and family requests, and connect patients and families to resources, such as pastoral care, language access services, and concierge services. These roles were not designed as the more traditional patient representative or patient advocates, as described previously, but created to assist nursing in responding to patient needs that were of a nonclinical nature and did not require a nurse or nurse assistant. This new role was developed based on patients' hospital experience feedback, including the HCAHPS surveys and the needs of clinical nurses. The job description was co-created by the clinical nurses on the pilot units. The purpose of this project was to test the impact of this innovative nonclinical support role to improve patient experiences while supporting nurses on inpatient units.

Theoretical Framework

The theoretical framework guiding this project is Watson's human caring theory[5,6] and the convergent care theory.[7] According to Watson,[5,6] caring is a moral ideal of nursing practice that promotes human-human transpersonal relationships and conserves human dignity in the cure and treatment-centered healthcare systems. The degree of cure determines a healthcare organization's success. The convergent care theory[7] emphasizes that an organization's success and health-related outcomes depend on all stakeholders' efforts.[7] Healthcare is a complex system; the nursing profession needs collaboration with and support from other disciplines and roles to perform at their best to achieve optimal outcomes in safety, quality, and experience. The nursing shortage at the study site and across the nation was at critical levels, exasperated during the COVID-19 pandemic. It was proposed that creating a nonclinical support role may alleviate nurses' workload, meet patients' nonclinical needs, and improve patient experiences, which is the underpinning belief of this project to test a framework for the Experience Coordinator role and job description.

Methods

Design and Ethical Consideration

This is a quality improvement (QI) project aiming to evaluate the impact of a newly developed innovative nonclinical support role to improve patient experiences. This project was exempted by the institutional review board of ECU Health Medical Center in North Carolina.

Setting

This project took place at the ECU Health Medical Center in North Carolina. This medical center is a not-for-profit academic medical center with 1000 inpatient beds.

Sample

To identify units for this QI project, a weighted analysis was conducted to assess what inpatient units most strongly influenced the hospital's total patient experience and

overall HCAHPS rating of the hospital. A weight-based calculation was done based on the units' patient volume, the survey return rate (n size), and the HCAHPS top box percentage score (percentage rating of 9 or 10).

All hospital units' data were used in the weighted calculations based on the overall rate question of the HCAHPS survey. This question asks, "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 Likert scale for this question is 0 through 10, with 9 and 10 being the top box scores. This question was one of the questions that showed a decline nationally during the COVID-19 pandemic. Next, units were ranked from highest weight to lowest weight. Units with the above–national-average HCAHPS top box scores were exempt from this QI project, with the weighted analysis used to determine the units for the project. The timeframe used for the weighted analysis was the 2021 fiscal year (October 1, 2020, to September 30, 2021). All hospital units' data were used in the weighted calculations, which were based on the overall rate question of the HCAHPS survey.

The units chosen for the project were a mother-baby unit, a medicine unit, and a surgical unit. The mother-baby unit had an overall weight of 124, the medicine unit had an overall weight of 69, and the surgical unit had an overall weight of 58. In addition, these 3 units also provided a diverse representation of patient populations.

The Creation of the Experience Coordinator Role

The role was designed to be a support role responding to individual patients' and families' needs and collaborating with nurses on nonclinical solutions. During patient encounters, the role collected data on types of patient requests. These requests were reviewed by a team of hospital leaders made up of nursing, environmental services, food services, and nursing operations. The role was under the supervision of the Office of Experience.

The essential functions of the position were to: 1) develop, maintain, and cultivate relationships with patients, family, and guests to respond to requests about food quality, room cleanliness, and overall experiences; 2) assist with the visitor screening process and visitor management, and facilitate virtual connections through technology and other resources; 3) review the patient visit guide in a preferred language, explain contents, and encourage the use of the journaling section to capture questions for care providers; and 4) provide service recovery and restore relationships by identifying problems and proactively finding a resolution to nonclinical issues, as well as partner with unit nursing leadership to follow up on patient/family concerns and grievances.

Implementation of the Role

A person who was already employed in this hospital's Office of Experience as an executive fellow and program specialist was chosen to test the Experience Coordinator role during the QI project. This person was prepared for the role by attending the health system educational offerings for hospitality and service recovery and was oriented to environmental, food, nutrition, and language access services. This initial Experience Coordinator role was introduced to all unit managers on the test units. The Experience Coordinator role was scheduled to check in with the nursing leadership on the 3 inpatient units and proactively visit all available patients in their rooms at least 1 time daily, Monday through Friday, for a 4-week pilot period.

The Experience Coordinator was instructed to introduce themselves to patients and families and that they were available to help patients with nonclinical, nonnursing requests and needs. The person in this role wore professional attire and a name tag with Experience Coordinator as the role. The Experience Coordinator kept notes on the number of patients able to be rounded on each day as information that would be used later to design staffing needs for this role. At times, the Experience Coordinator rounded with the charge nurse and/or nurse manager on the unit.

The Experience Coordinator understood that the role was a support role, and there may be a variety of requests or needs the patients and families may have. The Experience Coordinator was instructed to collect the nature of patients' requests and the responses so that a list would be compiled of possible requests from patients and families at the end of the trial. If the patient offered no initial requests, the Experience Coordinator might ask the following questions after introducing themselves: 1) Is there anything I can assist you or your family with today? 2) Have you ordered your meals today, or have you eaten today? If not, I can help you order your meals. 3) Is your room cleaned to your satisfaction? 4) Are there any resources you need that I can help connect you to? These questions helped trigger nonclinical concerns that the Experience Coordinator could address or coordinate solutions for.

Measurement

The data for the project were collected using measurements discussed hereinafter.

Quantitative Data: HCAHPS

The patient experience data used to determine the impact of the Experience Coordinator role on the 3 units included the following HCAHPS domains: overall rate, recommend the hospital, communication with nurses,

responsiveness of hospital staff, communication with doctors, cleanliness of the hospital, quietness of the hospital, communication about medicines, discharge information, and care transitions. Other data were used from custom questions added to the HCAHPS surveys before the QI project and included Quality of Food question and Watson Caritas Human Caring (WCHC) questions. The WCHC questions are: 1) delivered my care with loving kindness; 2) met my basic human needs with dignity; 3) created helping and trusting relationships with me; 4) valued my personal beliefs and faith, allowing for hope; and 5) created a caring environment that helps me heal. The questions from the HCAHPS survey were chosen based on the job description of the Experience Coordinator role as to what this role can and cannot do. We selected questions that can be influenced by this role.

Qualitative Data: HCAHPS

The hospital had added 5 nurses' daily care action yes/no questions to the standard HCAHPS survey.[8] One of these questions is, "Did your care team go over your patient visit guide, including the SMART checklist (S–signs and symptoms, M–medications, A–appointments, R–results, and T–tell us now) to partner with you in your discharge planning?" This question was selected because reviewing the patient visit guide was a nonclinical intervention that could be performed by this role versus a nurse.

Data Collection

The data were collected from September 1 to September 30, 2021, from HCAHPS surveys returned via email or text from patients on the chosen units. These data are stored on the Press Ganey website, where patient experience data are uploaded from returned surveys. The data collected from patient responses from the 4-week QI project period were compared with the previous month's data, which was from August 1 to August 30, 2021, from those patients who returned their surveys.

Results

Summary of Individual Units' HCAHPS Scores Before and After the Role Implementation

Among the 3 units, the mother-baby unit had the fewest improvements, with 3 HCAHPS domains and the Quality of Food question improved (Table 1). The 3 domains that improved were responsiveness, cleanliness of hospital, and quietness of hospital. The top box rates of all these domains increased from the pre–test-of-change month (August) to the QI project month (September)—the responsiveness increased by 2.5%, the cleanliness of the hospital increased by close to 20%, and the quietness of hospital increased by approximately 10%. The quality of food domain's top box rate increased by over 7%, and the receiving patient visit guide item increased during the QI project period.

The surgical unit had 6 of 10 domains improve, and 1 WCHC response improved during the QI project period. The WCHC question that improved was value beliefs/faith allowing for hope. The 6 domains that improved were recommend the hospital, communication with nurses, responsiveness, communication with doctor, discharge information, and care transitions (Table 2).

The medical unit had the greatest improvement among the 3 units. Eight of the 10 HCAHPS domains improved during the QI project period from August to September (Table 3). The improved domains were rate hospital, recommend the hospital, communication with nurses, communication with doctors, cleanliness, communication about medicines, discharge information, and care transitions. Quality of food also increased. On the medicine unit, all WCHC questions saw an increase. The following items, delivered care with loving-kindness, met basic human needs with dignity, created helping trusting relations, created caring environment to help heal, and value beliefs/faith allowing for hope, all improved.

Three Units' Combined HCAHPS Scores Before and After the Role Implementation

When results were combined among all 3 units (Table 4) to achieve a larger N size, 5 of the 10 domains increased top box ratings during the QI project month compared with the previous month. Questions, including communication with nurses, responsiveness, cleanliness of hospital, discharge information, care transitions, and quality of food, also increased. As the individual units did not have a large sample size, *P* values were calculated for the combined unit data.

When the domains were broken out by questions, patients' experiences toward the following questions all improved significantly, including nurses who listened carefully to you, help toileting soon as patients wanted, cleanliness of hospital, hospital staff took patient preferences into account, and patient understood purpose of taking medicines, which all had a *P* value less than 0.01 ($P < 0.01$). Quality of food also had a *P* value of less than 0.01. Questions, such as nurses explain in a way that is understandable and patient had a good understanding of managing their health, had *P* values less than 0.05 ($P < 0.05$) (Table 5).

Discussion

The COVID-19 pandemic stressed the national nursing workforce and negatively affected patient experiences.[1] This project introduced a nonclinical support role to support patient nonclinical requests and facilitate nursing work on inpatient units. Hospital Consumer Assessment

Table 1. *Pre and Post QI Project Improvement Top Box for 1-West*

HCAHPS Items	Pre QI Project (August 1-31) % Top Box	Post QI Project (September 1-30) % Top Box
Response of hospital staff domain performance	74.5	77.0
Cleanliness of hospital environment	48.1	66.7
Quietness of hospital environment	59.6	69.4
Quality of food based on diet	26.2	33.3
Patient visit guide (% yes)	72.6	75.0

of Health Care Providers and Systems ratings and WCHC questions were used as a measure for inpatient experience, and improvements in both measures were noted during the 4-week QI project.

Overall, all 3 inpatient units showed significant improvements in some HCAHPS domains' top box rates, although there were no clear patterns in the consistency of improvements in the domains affected at the unit level. This may be an outcome of how the role was designed and the selection of the units. The role was designed as a support role to respond to individual patients' needs and requests, and each unit had very different populations, which may translate to different needs. The mother-baby unit had a shorter stay than the medicine and surgical units. In addition, the mother-baby unit patient population was overall younger than the other 2 units' patient populations and had visitor guidelines allowing patients' partners to visit. Another aspect is the work schedule of the Experience Coordinator role—scheduled Monday to Friday only. On a unit like maternity, patients have a short length of stay, which might have affected patients' opportunity to interact with this role. More exploration needs to be conducted to understand the patient experience results based on patient demographics and unit type.

Among the 3 units chosen, 3-West, the medicine unit, had the most significant patient experience improvements related to the Experience Coordinator role. Compared with the other 2 units, this unit has the longest hospital stays, with an older patient population and more restrictive visitor restrictions. It is unknown how visitor restrictions and not having family or other support persons with patients during the pandemic impacted patients' ability to meet their nonclinical needs. A study compared HCAHPS top box scores to hospitals that maintained patient visitation versus those that did not and indicated that, although beneficial for slowing the spread of the virus, visitor restrictions negatively affected patients' perceptions of staff responsiveness.[9] Patients' experience of the responsiveness of hospital staff significantly improved in 2 of the 3 units that piloted the Experience Coordinator role. The findings of this project show promise in introducing a nonclinical support role to inpatient care teams; however, with only a 4-week pilot, it would not be appropriate to report that the positive change was related to the role. In contrast, it is suggestive that the role might be a positive change but needs more study for a longer period and extend to 7 days a week.

Healthcare is a complex system, requiring healthcare professionals to work together, help one another, and collaborate to achieve optimal outcomes for patients, healthcare professionals, and organizations.[7,8,10] The Experience Coordinator role was formed and trialed as one of the pandemic-generated innovations based on patients' and nurses' needs during specific situations to support patients and nursing teams in a collaborative spirit.

As the Watson Human Caring Theory indicates, human relationships play an important role in building and improving transpersonal relationships between

Table 2. *Pre and Post QI Project Improvement Top Box for 3N-Neuro*

HCAHPS Items	Pre QI Project (August 1-31) % Top Box	Post QI Project (September 1-30) % Top Box
Recommend the hospital	66.7	73.3
Comm with nurses domain performance	67.8	77.8
Response of hospital staff domain performance	41.8	66.7
Comm with doctors domain performance	72.6	84.4
Discharge information domain performance	80.8	88.5
Care transitions domain performance	40.5	61.4
Value beliefs/faith allowing hope	56.3	61.5

Abbreviation: Comm, communication.

Table 3. Pre and Post QI Project Improvement Top Box for 3-East

HCAHPS Items	Pre QI Project (August 1-31) % Top Box	Post QI Project (September 1-30) % Top Box
Rate hospital 0-10	46.7	53.9
Recommend the hospital	53.3	76.9
Comm with nurses domain performance	62.2	84.6
Comm with doctors domain performance	53.3	74.4
Cleanliness of hospital environment	33.3	61.5
Comm about medicines domain performance	45.8	70.0
Discharge information domain performance	64.1	96.2
Care transitions domain performance	37.5	48.7
Quality of food based on diet	25.0	30.8
Delivered care with loving-kindness	42.9	76.9
Met basic human needs with dignity	50.0	76.9
Created helping trusting relations	42.9	69.2
Create caring environment to help heal	42.9	69.2
Value beliefs/faith allowing hope	53.9	69.2
Patient visit guide (% yes)	50.0	69.3

Abbreviation: Comm, communication.

healthcare professionals and patients.[5,6,11] The caring moments created by the Experience Coordinator role with patients, such as responding to patients' call bells promptly, listening to and acting on patient nonclinical requests, assisting with visitation, and reviewing the patient visit guide, are important relationship-builders that led to improved patients' experiences.[8]

Current literature shows the positive effects of nurse-led interventions on promoting patients' hospital experience.[12] This supportive role also addresses the top 10 priorities for health system leaders beyond the pandemic,[13] such as workforce optimization and optimization of patient care outcomes. For this health system, the QI project patient data and the positive comments from unit nurse leaders offered supportive evidence to implement the Experience Coordinator role on other inpatient units. More exploration is needed to learn the longer, broader effects of this role on patient experience and the influence on nurses' experience.

Limitations and Future Research Recommendations

The implementation of the Experience Coordinator, trialing the use of a nonclinical support role on inpatient units, was introduced as a pilot QI project. It aimed to test the possibility, functionality, and feasibility of the role. The interest was to see whether patients responded positively

Table 4. Pre and Post QI Project Improvements in HCAHPS Items

HCAHPS Items	Pre QI Project (August 1-31)			Post QI Project (September 1-30)		
Total	N	% Top Box	Percentile	N	% Top Box	Percentile
Rate hospital 0-10	85	58.8	6th	64	56.3	3rd
Recommend the hospital	85	64.7	27th	64	64.1	24th
Comm with nurses domain performance	85	77.6	28th	64	79.2	41st
Response of hospital staff domain performance	81	63.1	36th	63	66.8	55th
Comm with doctors domain performance	84	79.8	41st	64	76.0	16th
Cleanliness of hospital environment	84	48.8	1st	64	62.5	7th
Quietness of hospital environment	85	54.1	24th	64	51.6	17th
Comm about medicines domain performance	60	65.0	69th	40	62.5	51st
Discharge information domain performance	81	81.9	9th	61	87.7	52nd
Care transitions domain performance	85	53.4	56th	64	53.9	59th
Quality of food based on diet	68	25.0	4th	55	29.1	15th
Human caring overall	83	62.3		62	59.0	
Delivered care with loving-kindness	83	60.2		62	59.7	
Met basic human needs with dignity	82	67.07		62	61.3	
Created helping trusting relations	83	59.0		62	56.5	
Create caring environment to help heal	83	60.2		62	56.5	
Value beliefs/faith allowing hope	80	65.0		62	61.3	
Patient visit guide (% yes)	76	65.8		64	65.6	

Abbreviation: Comm, communication.

Table 5. Pre and Post QI Project Improvement HCAHPS Domain Questions and P Value

HCAHPS Domain Questions	Pre QI Project (August 1-31)			Post QI Project (September 1-30)			
Total	N	% Top Box	Percentile	N	% Top Box	Percentile	*P*
Nurses treating patients with courtesy and respect	87	83.9	24th	64	86.3	43rd	0.060
Nurses listening carefully to you	85	76.5	43rd	64	74.0	24th	0.006[a]
Nurses explain in a way that is understandable	85	72.9	25th	64	80.8	84th	0.037[b]
Call button help as soon as wanted	71	65.8	59th	63	57.4	21st	0.096
Help toileting soon as patients wanted	45	60.0	15th	38	75.6	83rd	0.001[a]
Cleanliness of hospital	86	48.8	1st	64	62.5	7th	0.001[a]
Staff talked about help when you left the hospital	82	75.6	4th	64	78.6	10th	0.635
Information regarding symptoms and problems	82	89.0	41st	64	92.9	84th	0.635
Hospital staff took patient preferences into account	87	43.7	40th	65	48.6	66th	0.001[a]
Patient had a good understanding of managing their health	85	58.8	82nd	64	53.6	59th	0.011[b]
Patient understood the purpose of taking medicines	71	60.6	55th	55	58.1	40th	0.008[a]
Quality of food	70	24.3	3rd	55	29.1	15th	0.001[a]

[a] $P < 0.01$.

[b] $P < 0.05$.

to the role as measured with HCAHPS data and to trial questions such as "What would the role do and how might it function?" There are several major limitations.

Nurses' experience was not collected during this study and is a limitation of this QI project. More study is needed to understand the significance of the Experience Coordinator role from healthcare team members' perspectives. For the QI project, the 3 units chosen were based on their weighted impact on the overall entity patient experience ratings. Each unit differed in patients' population and demographics, which might have affected the individual unit comparison results. Retrospectively, choosing 3 like units with similar patient populations might be better to have larger, more homogeneous patients for measurement. Another limitation of this study is the N size for patient responses at the unit level; continuing the QI project for greater than 4 weeks might provide further insights into the role's effects on patients' experience. The last limitation is related to data collection and analysis. With the pilot and the quick plan-do-study-act cycle, we only had a 4-week piloting time and have limited data collection and analysis capabilities, which will be addressed in future articles when this role is implemented hospital-wide.

Implications for Hospital Administrators

The nursing shortage will continue to motivate hospital leaders to seek out innovative and new ways to alleviate staff shortages and ensure quality patient care simultaneously. Challenges with nurse staffing and maintaining and elevating the quality of care can be a catalyst to trial new staffing models that may support desired outcomes. Nurse administrators will be called upon to lead and support these pilots and evaluate their success and possibility for implementation and, more importantly, their potential to affect outcomes in the future positively. This QI project suggests the Experience Coordinator role could be one strategy for supporting nursing work and patient experience.

Conclusion

The creation of the new supportive nonclinical role shows promise in improving patient experiences. The pandemic resulted in lower scores in patient experience across many care settings.[3] This pilot study provides promising information that should be further explored regarding the impact of the Experience Coordinator and the benefit of this role from the perspective of the nurse.

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