Session 73X
Forum on Advancements in Healthcare Management Research

Presented by:
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Lihua Dishman, DBA
Paulchris Okpala
Tom Olivo
Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

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- Paulchris Okpala, DHSc
- Tom Olivo
Faculty

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• Lihua Dishman, DBA, A.T. Still University of Health Sciences
• Paulchris Okpala, DHSc, California State University, San Bernardino
• Tom Olivo, Success Profiles, Inc., Healthcare Performance Solutions

Learning Objectives

• Examine the most recent research pertinent to the practice of healthcare management.
• Discuss recommended initiatives to implement in your organization.
Agenda

• Critical Evaluation of the Influence of Leader Personality and Culture on Staff Nurse Retention
  Paulchris Okpala, DHSc

• Successful Leadership Hiring and Appointment Practices: Closing the Gap Between Healthcare Organizations
  Tom Olivo

Agenda (cont’d)

• Patient Experience and Financial Performance of United States Hospitals: A Longitudinal Analysis of 1,377 For-Profit, Non-profit and Government Hospitals
  Lihua Dishman, DBA
Logistics

• Each presenter will speak for about 20 minutes.
• There will be 5 minutes for clarifying questions at the end of each presentation.
• There will be an additional 10 to 15 minutes for discussion after all of the papers have been presented.

Your role in this session

You are our panel
Faculty Biography & Contact Info

Leslie Athey is the American College of Healthcare Executives’ director, Research and is located in Chicago, IL. She has more than 25 years’ experience with conducting research about health and health services. As director, Research, she leads ACHE’s research studies and worked with ACHE’s Research Committee to select papers to be presented at this Forum on Advances in Healthcare Management.

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Critical Evaluation of the Influence of Leader Personality and Culture on Staff Nurse Retention
Presenter

Paulchris Okpala, D.HSc, MHA, MPA, RCP, CRT

Learning Objectives

The key learning objectives for this presentation:

- To understand the leadership personality and culture in the health care system
- To understand the influence of various leadership personality on nurse retention
- To understand the influence of various leadership culture on nurse retention
- To appreciate the role of leadership culture in enhancing nurse retention
Background

- Enhanced nurse retention is key in managing financial and human resource performance in health care organizations (Jones, 2008; Hayes et al., 2012). Cost of nurse turnover is shown in Table 1 (Jones, 2005)

<table>
<thead>
<tr>
<th>Nurse Workforce Size</th>
<th>Turnover (%)</th>
<th>Average Salary</th>
<th>Cost to Replace</th>
<th>Annual Cost of Nurse Turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 Nurses</td>
<td>10%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$650,000</td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$950,000</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$1,900,000</td>
</tr>
<tr>
<td>300 Nurses</td>
<td>10%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$1,950,000</td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$2,925,000</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$3,900,000</td>
</tr>
<tr>
<td>500 Nurses</td>
<td>10%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$2,950,000</td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$4,975,000</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>$50K</td>
<td>X1.3</td>
<td>$6,950,000</td>
</tr>
</tbody>
</table>

- Strategies such as improved remuneration and enhanced working conditions (Twigg & McCullough, 2014)
Background

- Despite the approaches being used, nursing turnover is on the increase (Figure 1).

\[ \text{Figure 1. Nurse turnover rate (Poole, 2015)} \]

- There is a need to assess alternative ways of enhancing nurse retention so as to boost organization performance and delivery of care services.

Background

- Leader personality and culture are suggested to have influence on staff retention (Jones, 2008).
- Leader personality also affects the level of communication and interaction that the employees have with the management (Grant et al., 2011).
- Leadership culture determines the level of employee satisfaction and success of the organization (Van Dierendonck, 2011).
- However little research attention has been directed towards the assessment of the extent to which leader personality and culture affect nurse retention in healthcare organization.
Study Aim

- The study aimed at establishing how leader personality and culture influence nurse retention among the health care facilities.

The objectives of the study included the following:

I. To establish the documented types of leader personality and cultures in health care sector
II. To determine how the identified leader personality and culture influence nurse retention

Research Design

- The study adopted a quantitative analysis of existing data
- The various online data sources selected from specific online databases were those that contained primary data collected through well-designed randomized controlled designs
- Individual studies were selected based on Boolean search using selected keywords
- A total of 70 existing studies were considered based on the recommendation by Creswell (Creswell, 2013).
Data Collection

- The databases used included American Nurses Association, Agency for Healthcare Research and Quality, ProQuest and Emerald database.
- Studies were retrieved using keywords such as nurse retention, nursing turnover, leadership culture, leadership personality.
- The data was purposively collected from the obtained studies based on the study’s research questions.

Data Analysis

- Raw data were open coded and the obtained categories organized based on study’s research questions.
- The data was then tested for normality using `explore` function of SPSS Ver. 23.
- Descriptive statistics such as percentages and means was used to assess the nurse retention status.
- The data on the influence of leader personality and culture on the level of nurse retention was analyzed using ANOVA test.
- Analysis was done at 0.05 level of significance using Bonferroni test.
Findings

Leadership personalities and culture in healthcare organizations

- Leadership-as-coordination that was reported to be significantly highly frequent compared to leadership-as-dominance and leadership by example (59%, p=0.002).
- Pro-social leadership personalities are significantly more frequent (65%, p=0.032) compared to the pro-self personalities (31%) (Table 2).

Table 2: The percentage frequency of identified leadership personalities and cultures among healthcare organization leaders

<table>
<thead>
<tr>
<th>Leadership Culture</th>
<th>% Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership-as-dominance</td>
<td>28</td>
</tr>
<tr>
<td>Leadership-as-coordination</td>
<td>59</td>
</tr>
<tr>
<td>Leadership by example</td>
<td>17</td>
</tr>
<tr>
<td><strong>Leadership personalities</strong></td>
<td></td>
</tr>
<tr>
<td>Pro-social personalities</td>
<td>65</td>
</tr>
<tr>
<td>Pro-self personalities</td>
<td>31</td>
</tr>
</tbody>
</table>

Influence of Leadership Culture & Personality on Nurse Retention

- Influence of leadership personality on nurse retention was carried out using Two-way Anova.
- Leadership culture significantly influences on nurse retention levels and account for up to 18.3% of nurse retention levels (p= 0.037).
- Leadership personalities do not significantly influence nurse retention levels (Table 3).

Table 3: The influence of leadership culture and leadership personalities on nurse retention levels

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected model</td>
<td>5</td>
<td>8.345</td>
<td>0</td>
</tr>
<tr>
<td>Culture</td>
<td>2</td>
<td>8.003</td>
<td>0.037</td>
</tr>
<tr>
<td>Personality</td>
<td>1</td>
<td>0.302</td>
<td>0.518</td>
</tr>
<tr>
<td>Culture*Personality</td>
<td>2</td>
<td>11.438</td>
<td>0.616</td>
</tr>
</tbody>
</table>
Influence of Leadership Culture on Nurse Retention

- Pairwise comparison was used to evaluate influence of leadership culture on nurse retention.
- The culture of leadership leadership-as-coordination and leadership by example have positive influence on the nurse retention with p=0.022 and p=0.041 respectively (Table 4).

Table 4: The influence of various leadership cultures on the nurse retention level

<table>
<thead>
<tr>
<th>Nurse retention</th>
<th>Leadership-as-coordination</th>
<th>Mean difference</th>
<th>Std error</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership by example</td>
<td>Leadership-as-coordination</td>
<td>6.207</td>
<td>2.011</td>
<td>0.022</td>
</tr>
<tr>
<td>Leadership by example</td>
<td>Leadership by example</td>
<td>5.793</td>
<td>1.011</td>
<td>0.041</td>
</tr>
<tr>
<td>Leadership-as-dominance</td>
<td>Leadership-as-dominance</td>
<td>-1.355</td>
<td>2.031</td>
<td>1.002</td>
</tr>
</tbody>
</table>

Discussion

- Healthcare managers can increase the level of nurse retention through the adoption of positive leadership cultures such as leadership by example and leadership-as-coordination.
- Adoption of the culture of leader-as-coordination is associated with the inclusion of the nurses and other employees during decision-making and the sharing of resources (Hyttter, 2007).
- Culture of leadership by example involves the strategies where the leader acts as the first person to implement agreed resolution and the employees emulate the actions of the leader (Weberg, 2010; Laschinger., 2012).
Discussion

- Block (2003) indicated that leadership culture that encourage employee participation in decision promote employee satisfaction and loyalty to the organization.
- Employee conscious leadership culture is important in ensuring the employee satisfaction and retention (Peterson & Luthans, 2003; Mohammad & Hossein, 2006).
- This study, however, did not examine the organizational changes needed to facilitate the adoption of leadership culture and personalities that have been shown to enhance nurse retention. This question should be answered by future studies.

Conclusion

- Leadership-as-coordination and leadership by example have the potential to enhance nurse retention compared to leadership-as-dominance.
- Healthcare administrators should work towards putting in place strategies that promote the culture of leadership-as coordination by ensuring that the nurses are involved in decision-making and enhancing organization leadership.
- The study did not establish leadership personality to have significant influence on nurse retention. However, more research should be carried out to determine this outcome.
Presenter Biography & Contact Info

- Dr. Okpala is the Graduate Coordinator of the Master of Science in Health Service Administration program and Assistant Professor in the Department of Health Science and Human Ecology at California State University, San Bernardino (CSUSB). He obtained his Doctor of Health Sciences degree from A.T.Still University of Health Sciences, Mesa, Arizona. Master of Health care Administration with concentration in Leadership from Bellevue University, Nebraska, Master of Public Administration from Bellevue University, Nebraska, Bachelor of Science in Health care Management from Bellevue University, Nebraska; Associate of Science degree in Health care Management from Ashworth University, Norcross, Georgia; and Associate of Science degree in Respiratory Therapy from Concorde Career College, Garden Grove, California. Dr. Okpala has worked in both acute care and skilled nursing facilities as a licensed Respiratory Care Practitioner. His research studies primarily focused on harnessing the importance of theory, evidence-based research and advance technology in improving the quality of healthcare services and prevention of degenerative diseases among the vulnerable individuals in the society.

Contact Information

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Email: pokpala@csusb.edu
References


References


Successful Leadership Hiring & Appointment Practices

Closing the Gap Between Healthcare Organizations
Learning Objectives

1. Identify common challenges compromising successful talent acquisition and development.
2. Demonstrate 3 specific categories of leadership effectiveness that improve a leader’s odds of success.
3. Show leadership alignments and statistically mapped leadership attribute targets.
4. Discuss when and where to style flex.
5. Understand the frequency of leaders being in and out of alignment.
Agenda

• The Problem
• “Operation Prototype” Hypothesis
• Research Methodology
• Business Case
• Distribution of Behavioral Styles
• Prototype Profile of Effective Healthcare Leaders
• Findings and Implications for Healthcare
• Biography & References

The Problem

The Legacy Method of Appointing Managers & Leaders in Healthcare

• In healthcare, the dominant criteria used for selecting people for management and higher leadership positions has been based upon:
  – Tenure: The length of time employed
  – Experience: Exposure to a wide variety of scenarios
  – Technical Skill: A competency with technology, systems, procedures, etc.
The Problem

No statistically positive correlation exists between this set of criteria and consistent success in business.

*If there were, organizations could easily just appoint people who fit these three criteria and be wildly successful.*

Leadership Alignment & Talent Management

*When I told you I was normal, I may have exaggerated slightly.*

*When asked... How effective people feel they are as a leader/manager, approximately 90% feel they perform in the “Top Decile” of performance.*

*Obviously, The Math doesn’t add up.*
The Challenge with Leadership Effectiveness, Coaching and Self-Awareness Perception Gaps
“Operation Prototype” Hypothesis

• With all levels of leadership and management in business there are “common denominators” of success.
• These are the “Must Haves” to be perceived by others as a more effective leader or manager.
• There are also unique success factors that enable some people to be more effective at more advanced levels of leadership and management.
• Everyone is good at something but not everyone is suited to be a senior level executive.

Research Methodology

30,000+ Leaders
Performance Management
Eye Chart

7,500+ Leaders
Talent Management
Eye Chart

4,207 Leaders
Behavioral Assessments

Specifically analyzing “A Level” leaders succeeding in high degree of difficulty roles.
• 145 @ Executive level
• 356 @ Director level
• 667 @ Front-line Manager level
• 1,168 Total with all 3 Results

500 Leaders participated in the Qualitative interview case study.
Other Qualitative feedback from over 2,000 leaders and managers.
Business Case

Why Demonstrated Leadership Behaviors Are So Important:

• The single greatest contributing factor to achieving successful outcomes by virtually every measure is the Talent and Demonstrated Ability of the person in charge; otherwise known as “the Manager.”

• This Talent is responsible for approximately 70% of the variance between high and low performing functions/departments.

• If you don’t prioritize talent, all other initiatives and programs are well intentioned but likely a waste of time.

The Distribution of Behavioral Styles
The Distribution of Behavioral Styles

The Prototype RP – 6 “Success Profile” (Median scores n = 4,207)

The Prototype Profile of Effective Healthcare Leaders

Are you More...

Traits intensity as you move left and right from center

2017 CONGRESS ON HEALTHCARE LEADERSHIP
The Prototype Profile of an Effective Healthcare Leader

- 3 of 6 macro Behavioral Factors proved more important for people to be perceived as “A Level” Leaders or Managers.

```
                          RightPath 6 Style Factors
                                                                                      Leaders within 5pts of Sweet Spot
                                                                                      "A" Leaders
                                                                                      Succeeding or  
                                                                                      Excelling  
                                                                                      & etc.
                                                                                      Differences
                                                                                      Control
                                                                                      Interaction
                                                                                      Conflict and Pace
                                                                                      Order
                                                                                      Adventurousness
                                                                                      Innovation
                                                                                      35%        53%        18%
                                                                                      27%        27%        0%
                                                                                      31%        45%        14%
                                                                                      44%        44%        0%
                                                                                      24%        34%        10%
                                                                                      37%        39%        2%

Behaviors that “A" level Leaders tend to demonstrate
They are clearly more:
- Directing – Somewhat Assertive
- Challenging – Somewhat Impatient
- Adventurousness – Competitive

When Executives are compared to Director and Manager level “Prototype A Level” leaders...

They tend to be somewhat...
- More Directing (taking the lead on any initiative).
- More Reserved (with communication and executive presence).
- More Challenging (impatient and results focused).
- More Strategic (see the “big picture” without getting “into the weeds” with detail).
- More Competitive (achievement oriented and ambitious to strive toward goals).
- More Creative (imaginative and thinking differently to solve problems).
Findings

How many leaders and managers are naturally hardwired to be within the “sweet spot” zone of effectiveness?

It is just as rare for someone to be within the zone on all 6 factors as it is to be out of the zone on all 6 factors.

- All 6 factors = 77 or 2%
- 5/6 factors = 267 or 6%
- 4/6 factors = 784 or 19%
- 3/6 factors = 1,356 or 32%
- 2/6 factors = 1,105 or 26%
- 1/6 factors = 533 or 13%
- 0/6 factors = 85 or 2%

Findings

<table>
<thead>
<tr>
<th># of Behavioral Attributes &quot;In Success Range&quot; for Behavioral traits that Matter by an individual leader</th>
<th>% of the total Management population (n=4,207)</th>
<th>% of population &quot;A&quot; level leaders (n=1,168 and 383)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>12%</td>
<td>29%</td>
</tr>
<tr>
<td>2</td>
<td>26%</td>
<td>33%</td>
</tr>
<tr>
<td>1</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>0</td>
<td>24%</td>
<td>6%</td>
</tr>
</tbody>
</table>

- Someone naturally hardwired to demonstrate at least 1 of these 3 behavioral style traits is 5x more likely to be successful than someone who doesn't.
- Someone naturally hardwired with any 2 out of the 3 most important behavioral style traits is 10x more likely to be successful.
- The most critical trait to demonstrate: Dominance (degree of assertiveness to be directing). 62% of successful "A Level" leaders are hardwired with that behavior.
Leadership and Management Success Rates

What percent of the population demonstrates the natural hardwired talent in all three attribute categories to be consistently effective in leadership/management roles?

Approximately **12%**

How many are very likely to become effective with disciplined self regulation, a focus on development and formal coaching from their immediate supervisor?

An Additional **26%**

“Prototype RP-6 Success Profile” (a CEO & Physician)

Coaching Implications
“Operation Prototype” Conclusions

**Findings:** As of December, 2013, an analysis of the quantitative data and qualitative interview transcripts reveals that the common denominators of success are clustered into three specific categories of demonstrated effectiveness attributes. The 1/3, 1/3, 1/3 balance.

- **Category 1:** Character attributes (not being - having). Who you are from a values and integrity standpoint and what you stand for.
- **Category 2:** Behavioral style attributes (intensities). Your hardwired preferences and how you consistently show up with other stakeholders.
- **Category 3:** Knowledge/Skill/Experience attributes (competencies). What you know and demonstrate consistently well.

These three categories should not be considered separate and distinct. They are interrelated and to some degree - can be amplified by each.
Findings and Implications

- Align people in the right profession, role, or job where their natural and developed strengths are best suited for their career path.
- We estimate less than 25% of people match perfect alignment of natural ability and professional careers.
- Intensity to succeed at all costs and the mindset to “always be right” can result in a leader that lacks followers. The result is self destruction where everyone is wrong, blame directed on everyone else and there is no teamwork.
- The demands of high degree-of-difficulty departments requires objective and decisive decision making. Leaders must have courage to challenge the status quo and set high uncompromising standards of performance.
- **Remember, this is not an issue of people being considered good vs. bad. It is about people being effective vs. ineffective.**

Presenter Biography & Contact Info

Tom Olivo, CMC, is the founding partner in the consulting firm Healthcare Performance Solutions (HPS) and the President of Success Profiles, Inc.

Mr. Olivo has 25+ years of experience measuring and comparing commonalities of highly successful athletes, business leaders, and organizations. Tom has worked in multiple industries with thousands of senior executives and managers, emphasizing the importance of Business Analytics and Getting the Right People in the Right Roles.

Over the past 15 years, Tom has operated solely in Healthcare with profound focus on making a difference to every outcome possible. This has been achieved utilizing proprietary measurement tools and includes evaluation of the effectiveness of 30,000+ leaders and the business practices of 500+ hospitals and systems.

Tom is considered by business leaders to be an expert in Talent Management and is one of the most requested speakers on the topic of quantifying the impact leadership has on performance outcomes.

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ToOlivo@HealthcarePS.com
406.582.8884
References


• RightPath Resources, The Distribution of Behavioral Styles.

Patient Experience and Financial Performance of United States Hospitals

A Longitudinal Analysis of 1,377 For-Profit, Non-Profit, and Governmental Hospitals
Faculty

• Lihua Dishman, DBA, MBA

Learning Objectives

• Analyze the relationship among patient experience, hospital types, and hospital financial performance.

• Examine the impact of patient experience on hospital financial performance.

• Examine the impact of hospital types on the relationship between patient experience and hospital financial performance.
**Agenda**

- Patient experience is among the top priorities of hospital leaders today in a shift to focus on patient-centered care.
- Hospital financial performance indicators include Operating Profit Margin, Total Profit Margin, Cash Flow Margin, Return on Assets, and Return on Equity.
- Hospital types include for-profit, non-profit, and governmental hospitals.
- Study findings suggest that improving patient experience and hospital financial performance relies on board engagement, leadership engagement, employee engagement, and patient engagement.
- This presentation will focus on the following key learning points:
  - The longitudinal, national study’s background, objectives, and research questions
  - The study’s three players: Patient Experience, Hospital Types, and Hospital Financial Performance
  - Overview of the study’s methodology
  - Descriptive and empirical findings from the study
  - Implications and recommendations for hospital administrators
  - Main limitations of the study
Background of the Study

**State of the U.S. Population Health**
- U.S. national health spending high as a % of GDP.
- U.S. healthcare system’s performance ranks low among developed countries (Davis, Schoen, & Stremikis, 2010).

**Triple-Aim Initiative**
(Berwick, Nolan, & Whittington, 2008; IHI, 2009)
- 1. improve the experience of care,
- 2. improve the health of populations, and
- 3. reduce per capita costs of health care.

**Patient Protection and Affordable Care Act (ACA)**
- A shift in reimbursements from volume to value
  \( \text{HVBP} = \text{Hospital Value-Based Purchasing} \)
- Patient experience survey \( \text{HCAHPS} = \text{Hospital Consumer Assessment of Healthcare Providers and Systems} \)

**Financial Challenges of U.S. Hospitals**
Two Study Objectives

To investigate the relationship among patient experience, hospital type, and financial performance of U.S. Medicare-certified inpatient acute care hospitals.

To assess the effects of patient experience on hospital financial performance, the moderating effects of hospital type on hospital financial performance, and the directions of these effects.

Three Players: Patient Experience, Financial Performance, and Hospital Type
To Answer Two Research Questions

Research Question 1
What is the relationship between patient experience of hospital care and financial performance of U.S. hospitals?

Research Question 2
What is the role of hospital type in moderating the relationship between patient experience of hospital care and financial performance of U.S. hospitals?

What Is Patient Experience?

Patient experience is “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” (Wolf, 2013, p. 3).

Patient Experience in Primetime Drama: *Heartbeat*

Top Three Organizational Priorities in the Next Three Years:

**Patient Experience Remains a Top Priority**


- **52% of U.S. hospitals answer**
  - Top Organizational Priority 1: Patient experience or patient satisfaction

- **61% of U.S. hospitals answer**
  - Top Organizational Priority 2: Quality and patient safety

- **37% of U.S. hospitals answer**
  - Top Organizational Priority 3: Cost management/reduction

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**How Is Patient Experience Measured?**

Two Prevailing Measurements

**Measurement 1**
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey:
- It is the “first national, standardized, publicly reported survey of patients’ perspectives of hospital care” (CMS, 2013b, p. 1) since 2008

**Measurement 2**
Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) Survey:
- It is a standardized tool for measuring patient perceptions of care by physicians in an office setting (Press Ganey, 2015)
HCAHPS’ 4 Dimensions of Patient Experience

**Clinical Services**
- Most hospitalized patients receive care from nurses, doctors, and clinical support staff across departments such as pathology, imaging, pharmacy, and rehabilitation (White & Griffith, 2016).
- Targeting “team-based care”—matching resources to patient and family needs—is essential to maximize value-based care” (Anderson et al., 2014, p. 11).

**Communication**
Effective communication is bidirectional between the party who conveys information and the party who receives it, and occurs when both parties can comprehend the conveyed information and clarify the intended message (Schyve, 2007).

**Care Environment**
- Patient satisfaction survey results informed U.S. hospitals: physical care environment (e.g., facility cleanliness and quietness) was more important to patients and families than prior general beliefs (Fottler et al., 2011).
- A hospital facility’s cleanliness can predict patients’ perceptions of a hospital’s quality of care (Gupta, 2008).
- Lowering noise levels around patient rooms and improving sleep resulted in less stress and faster recovery (Ulrich et al., 2004).

**Perception**
- When asked to evaluate their inpatient care, most patients will first speak of the nurses, not the doctors, who have provided care; and they are more likely to rate the entire hospital experience favorably if their perceptions of nurse care are good (White & Griffith, 2016).
- Dissatisfied patients are more likely to write comments to report negative perceptions of hospital experiences (Huppertz et al., 2014) and give the hospitals lower overall ratings.

Three Hospital Types Source: CMS (2011)

**For-Profit Hospitals**
- Are controlled by for-profit corporations with stockholders as owners, and not exempt from paying federal, state, or local taxes (Nowicki, 2015).
- Have a mission to maximize shareholders’ wealth (McCue & Thompson, 2010).

**Non-Profit Hospitals**
- Are faith-based or teaching and research focused, owned by charitable or other non-profit organizations, and tax-exempt.
- Have a mission to provide medical services to their community in exchange for governmental subsidies in preferential tax treatment, and must satisfy all stakeholders (Nowicki, 2015).
- Are subject to new mandates as a result of the ACA (Hearle, 2015).

**Government Hospitals**
- Are owned by the federal, state, county, city, or city-county governments, and tax-exempt (National Bureau of Economic Research, 2015).
- Have a mission to provide medical services to their community or constituents, and may be funded by local, state, and federal governments.
Five Hospital Financial Performance Indicators

**Operating Profit Margin (OPM)**
- A ratio of operating income to total operating revenue, indicating profits solely from a hospital’s operations (Nowicki, 2015).
- It “measures the amount of operating profit per dollar of operating revenues and focuses on the core activities of a business” (Gapenski, 2012, p. 694).

**Non-Operating Profit Margin (NOPM)**
- It equals Total Profit Margin minus Operating Profit Margin.
- Total Profit Margin (TPM) is a ratio of net income to total revenue that is the sum of operating revenue and non-operating income (Gapenski, 2012).
- TPM measures the amount of total profit per dollar of total revenue from a hospital’s patient services and non-operating activities such as investing (Nowicki, 2015).

**Cash Flow Margin (CFM)**
- A ratio of the sum of NI and depr. expense to total revenue (Zhao et al., 2008).
- It measures a hospital’s ability to generate sufficient cash flow from its operations in order to maintain financial viability (Alexander et al., 2006).

**Return on Assets (ROA)**
- A ratio of NI to total assets (Gapenski, 2012), indicating “the dollars of earnings per dollar of book asset investment” (p. 697).
- It measures a hospital’s efficiency in asset utilization to generate income and control expenses (Tennyson & Fottler, 2000).

**Return on Equity (ROE)**
- A ratio of NI to total equity (Gapenski, 2012), indicating “the dollars of earnings per dollar of book equity investment” (p. 697).
- Was a more relevant indicator of hospital financial position (Cleverley, 1995).
- A far less often used indicator (Pink et al., 2007).

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**Study Methodology Overview**

- **Quantitative** methods
- **Secondary analyses** of archival data
- Patient experience and financial data were self-reported by U.S. Medicare-certified inpatient acute care hospitals
- Panel data:
  - **Cross-sectional** data: 1,377 Medicare-certified inpatient acute care hospitals in the final study sample
  - **Longitudinal** data: 2009 to 2012
- Data sources: files maintained by the Centers for Medicare & Medicaid Services (CMS)
  - Patient experience: **Hospital Compare** (HC) data files
  - Financial performance: **Healthcare Cost Report Information System** (HCRIS) data files
- Data analyses: **descriptive and inferential** statistical analyses
The Study Answered Research Question 1

**Patient experience of hospital care has an impact on financial performance of U.S. hospitals.**

- **NOPM** had a statistically significant **negative relationship** with patient experience.
- **ROA** had a statistically significant **positive relationship** with patient experience, but inconsistently across the three hospital types or across the four-year study period.
- **CFM** was a consistent and statistically significant indicator of hospital financial performance, and had a statistically significant **positive relationship** with patient experience.
- **ROE** had a statistically significant **positive relationship** with patient experience, but inconsistently across the three hospital types.
- **OPM** was a consistent and statistically significant indicator of hospital financial performance, and had a statistically significant **positive relationship** with patient experience.
- **NOPM** had a statistically significant **negative relationship** with patient experience.

The Study Answered Research Question 2

**Hospital type is a moderator of the relationship between patient experience of hospital care and financial performance of U.S. hospitals.**

- **Governmental hospital type** had the greatest **moderating effect** on the relationship between patient experience and financial performance (measured by OPM and CFM).
- **Hospital type's moderating effects** were present year after year (except for hospital financial performance measured by OPM in 2011) and throughout the entire study period.
- **Hospital type was a statistically significant moderator** impacted the relationship between patient experience and hospital financial performance (measured by OPM and CFM).
- **As patient experience improved from the 1st quartile to the 3rd quartile,** governmental hospitals' OPM and CFM both rose sharply in all four years of the study period.
- **As patient experience rose from the 3rd quartile to the 4th quartile,** governmental hospitals' **OPM** decreased in 2009 and 2010 but increased slightly in 2011 and 2012, while **CFM** did not change in 2009 and 2010 but increased more noticeably in 2011 and 2012.

**2017 CONGRESS ON HEALTHCARE LEADERSHIP**
Five Important Descriptive Findings

1. Patient experience improved gradually from 2009 to 2012.

2. For-profit and governmental hospitals consistently outperformed non-profit hospitals in patient experience.

3. Smaller hospitals (bed size < 50, employee size < 100) consistently outperformed larger hospitals in patient experience.

4. Rural hospitals consistently outperformed urban hospitals in overall experience and in communication, clinical services, and care environment dimensions.

5. Operating Profit Margin (OPM) and Cash Flow Margin (CFM) were the two consistently significant indicators of hospital financial performance across for-profit, non-profit, and governmental hospitals.

Three Main Empirical Findings

1. Patient experience of care was associated with hospital financial performance as measured by the OPM and CFM.

2. Hospital type moderated the relationship between patient experience of care and hospital financial performance as measured by the OPM and CFM.

3. The governmental hospital type demonstrated the greatest moderating effect on the relationship between patient experience and hospital financial performance as measured by the OPM and CFM.
Five Implications for Practitioners

- Legislative actions and industry advocacy may be effective to help improve patient experience.
- Employee engagement and patient engagement may help hospitals improve communication with patients, deliver better clinical services, and provide a more healing care environment.
- It may be important to develop hospital employees’ competencies in quality leadership and patient-centered care in addition to their clinical and administrative competencies.
- FP, NP, and governmental hospitals may behave differently in strategies, operations, and financial management as related to patient care.
- Governmental hospitals may sacrifice operating revenues (e.g., treating fewer patients) or incur additional costs in order to continue improving patient experience after achieving a certain level.

Study Findings Informing Practitioners

- Healthcare legislators and policy makers at federal, state, and local levels
- All healthcare stakeholders at health system level, including health system designers, planners, and strategists
- All healthcare stakeholders at hospital level, including hospital board members, executive leaders, and financial managers
- All stakeholders involved in direct patient care
- Capital market investors, including equity and bond holders
**Recommendations for Practitioners: Board Engagement**

1. To **review** and **update** organizational mission, vision, and core values; and **align** them with organizational strategies inclusive of continuous quality improvement.

2. To **define** clearly the roles of the governing boards including key internal and external stakeholders.

3. To **establish** a standing patient experience oversight committee within governing boards.

4. To **position** HIT clearly as integral to improving PX and hospital FP; and include PX and FP metrics in hospital executives’ key performance indicators.

5. To **provide** governing board members with on-boarding and continuous training regarding metrics and best practices in delivering high quality of care and patient experience.

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**Recommendations for Practitioners: Leadership Engagement**

1. To **allocate** resources to develop leadership competencies of hospital executives, clinicians, administrative staff, and quality professionals.

2. To **develop** in each hospital a patient experience leader, **Chief Experience Officer**, who oversees the development and implementation of patient experience improvement initiatives and serves as a subject matter consultant and adviser to the hospital governing board, executive leadership team, and all employees.
Recommendations for Practitioners: Employee Engagement

1. To **cultivate** a trusting, respectful, positive, optimistic, supportive, and satisfying climate in hospital workplaces.

2. To **create** and **maintain** a healthy, safe, and productive physical environment with EBDs.

3. To **provide** nurses and nurse managers with PD opportunities to improve communication and cultural competencies, and **maintain** an appropriate nurse staffing level to meet nurses’ physical, emotional, and psychological needs.

4. To **implement** daily nurse leader rounds to provide nurse leaders with opportunities to interact with patients and their families directly, observe nurse-patient interactions, gather first-hand intelligence on needs-improvement, and lead by example.

5. To **develop** communication and cultural competencies of doctors to enable them to communicate thoughtfully with patients and their families, and other hospital staff.

Recommendations for Practitioners: Patient Engagement

1. To **establish and implement** an accountable and measurable process to understand patients’ specific characteristics and nonclinical needs in addition to clinical needs.

2. To **partner** with patients and their families, and involve them in making treatment decisions.

3. To **provide** transparency in treatment choices, treatment costs, potential risks, and expected outcomes.

4. To **establish and implement** a streamlined and measurable process to ensure smooth care transitions when discharging patients.

5. To **further establish and implement** an effective and measurable process to ensure that patients and families are following post-discharge instructions by checking in via telephone.
Four Main Limitations of the Study

- Data were from a random sample of adult inpatients who completed the CMS' HCAHPS survey after discharge from Medicare-certified inpatient acute care hospitals. Data accuracy is unverifiable.
- Aggregating patient data may have been done by the approved survey vendors, or the sample hospitals if approved by the CMS. Reliability and validity of the data aggregation were not confirmed. HCAHPS as a measurement of patient experience may be limited in scope, target population, and historical range.
- The hospital-level financial data were compiled in the CMS' HCRIS data files available to the public. The accuracy of these hospital self-reported financial data is unverifiable.
- FP had 5 indicators (OPM, NOPM, CFM, ROA, and ROE). Over 60% of the sample hospitals were non-profit (NP). Free cash flows may be added since it was a true FP indicator of closely held NP hospitals (Phillips, 2003) and positively associated with patient revenue and collection speed of bond-issuing NP hospitals (Singh & Wheeler, 2012).

Put It All Together

1. Board Engagement
2. Leadership Engagement
3. Employee Engagement
4. Patient Engagement

Patient Experience, Financial Performance, Strategic and Leadership Development
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Patient Experience:
Two Leading Organizations | Two Leading Journals
One Certified Professional Designation

The Beryl Institute
- Patient Experience Journal
- PX Monthly
- PX NEWSLINK
- Annual Patient Experience Conference in April
- Patient Experience Institute (PXi)
- PXi develops and manages study materials and actual tests for the Certified Patient Experience Professional (CPXP) designation

The Association for Patient Experience (AfPE)
- Journal of Patient Experience
- Patient Experience News & Trends eNewsletter
- Annual Patient Experience: Empathy + Innovation Summit in May in Cleveland, OH
- Annual AfPE Outstanding Caregiver and Practice of the Year Awards
- Sponsored by the Cleveland Clinic
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References


