The Chief Experience Officer Effect

If it's everybody's job, it's nobody's job

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There is an age-old question in healthcare leadership. If improving the patient experience is everybody's job, isn't it really nobody's job? When accountability belongs to everyone, it ends up resting with no one in particular.

That question drove my doctoral research at the University of Alabama at Birmingham. My colleagues and I later published what we found in *Patient Experience Journal* in 2021, and it still shapes how I think about leadership.

Where the role came from

The Cleveland Clinic created the first Chief Experience Officer in 2003, reporting directly to the CEO. The idea was simple: quality of care was not enough. Someone had to make the patient's experience a guiding value across the whole organization. A decade later, when Medicare began tying hospital payment to patient experience scores, executive recruiters saw demand for the role climb sharply.

But no one had measured whether it made a difference. So we did.

What we found

We studied 662 acute care hospitals in California, Florida and New York. One hundred sixty of them had a formal Chief Experience Officer. Those hospitals had significantly higher shares of patients giving them a 9 or 10 overall rating, and significantly more patients saying they would recommend the hospital.

I want to be careful here, because honesty is the point of research. Our study showed an association, not proof that the title causes the scores. Hospitals with a CXO were different in other ways too. Compared with government hospitals, for-profit hospitals had 6.8 times the odds of having one, and hospitals in higher-income markets were more likely to have one.

Two other findings stayed with me. Hospitals with more nurse staffing scored higher. And larger hospitals scored lower: compared with hospitals under 100 beds, every larger size group had fewer patients giving top ratings. The bigger the organization, the harder it seems to be to see care through the patient's eyes.

What the effect really is

After years with this data, I keep coming back to that age-old question. The effect does not live in the title. It lives in accountability: one named leader who owns the patient's experience, so it no longer rests with no one in particular. Everyone still has a part to play. But someone has to answer for the result.

I have come to believe that the further you get from the visit, the less you can see the flaws in the system. A hospital's C-suite is a long way from the bedside. A Chief Experience Officer, done right, is the person whose job is to close that distance: to bring the patient's view into the room where budgets, staffing and strategy are decided.

That is why our paper's most practical recommendation was the most modest one. Every hospital, with or without a CXO, should give specific accountability for the patient experience to a senior leader who can act on it.

A title without authority is decoration. Authority without the patient's view is just management.

Why it matters more now

The stakes have grown since we published. Under Medicare's Hospital Value-Based Purchasing Program, the patient experience domain accounts for 25 percent of a hospital's total performance score, and the program is funded by withholding 2 percent of hospitals' Medicare inpatient payments. In January 2025, CMS launched the most significant update to the HCAHPS survey in nearly 20 years: 32 questions, with new measures for care coordination, restfulness of the hospital environment, and information about symptoms. The first full year of those results reached Care Compare in October 2026.

In other words, the patient's experience is now part of the return on care, and part of the hospital's revenue.

Every organization needs an owner, not every one needs a CXO

A physician practice, a surgery center or a small rural hospital cannot always fund another executive, and may not need one. In our data, smaller hospitals often saw the patient more clearly already, and I suspect the same holds for small practices. But every healthcare organization, whether a hospital, a practice or a surgery center, needs someone who owns the experience. In a practice, that may be the administrator or a lead physician. In a surgery center, the director. The title matters less than the name. And whoever it is should own the answer to two questions. Does it serve the patient? Can it keep doing so?

What to do Monday morning

Ask three questions of your own organization. Who owns the patient experience, by name? If the answer is “everyone,” you have your answer: no one does. Does that person report to the CEO, or are they buried three levels down? And when the next budget or staffing decision is made, will anyone in the room speak for the patient?

If the answers are uncomfortable, I would welcome the conversation. My goal is to help you become your own best consultant, with the patient's view at the table.

When it seems crazy out there, and it sometimes is, remember that the patient is still a reliable true north. Someone in your organization should be paid to keep pointing at it.

Sources

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