Hospital Value-Based Purchasing VBP Quality Reporting Program

Support Contractor

HCAHPS® and Hospital Value-Based Purchasing

Presentation Transcript

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Matt McDonough: Hello and welcome to today's Webinar. My name is Matt McDonough and I'm going to be your virtual host for today's event. Before we start today's event, I would like to cover some housekeeping items with you so that you understand how today's event is going to work and how you can interact with our presenters throughout the course of today's event.

As you can see on this slide, audio for this event is available via Internet streaming. And if you're hearing my voice right now, then you know that. What that means is that no telephone line is required but computer speakers or headphones are necessary to listen to the streaming audio feed.

Now, if at any point during today's event, you have difficulty with streaming audio, there are limited dial in lines that are available. Please just send us a chat message if you need one of those dial in lines and

we'll get that information out to you. Also, today's event is being recorded.

Now, if you have some audio issues that we can troubleshoot, we'll cover some of the most common ones here. Occasionally you'll experience audio from your speaker is breaking up or the audio might suddenly stop, so how do you resolve that?

You simply click the pause button that's located in the upper left side of your screen as shown on this slide. Wait about five seconds and then click the play button. Your audio stream should resume and you should be able to hear the feed again.

Now, also, if you hear a bad echo on the call right now, that usually means, you're connected multiple times in multiple browsers or tabs. And you're hearing my voice streaming more than once. What you'll need to do is close one or more of those connections so that you only have one left. That will clear up the echo and you should hear my voice clearly once you do that.

Now, because we're in a Listen Only mode, that means that our audience lines aren't open. But, that doesn't mean that you can't interact with our subject matter experts today. We have a chat panel located on the left side of your screen, simply type your questions into that chat with presenter box at the bottom left side of your screen and then click the send button. Your question will be sent to all of our panelists and will be archived for future – being addressed in the future.

Now, we may not have time to get to all questions today but please note that we are keeping record of all questions that are submitted and we'll answer as many as we can time and resources permitting. That's going to do it for my brief introduction. So without further ado, I will hand over to our first speaker of the day.

Bethany Wheeler: Thank you Matt. Hello and welcome to our Hospital Value Based Purchasing Improvement Series on HCAHPS® webinar. My name is Bethany Wheeler and I will be your host for today's event.

Before we begin, I'd like to make a few announcements. First, this program is being recorded. A transcript of the presentation along with the Q&As will be posted to our inpatient website www.qualityreportingcenter.com and will be posted to qualitynet.org at a later date. If you registered for this event, a reminder e-mail as well as the slides were sent out to your e-mail one or two hours ago. If you did not receive the e-mail, you can download the slides at our inpatient Web site again, www.qualityreportingcenter.com.

For today's presentation, we will be continuing our improvement series for the Hospital Value Based Purchasing program highlighting the organizations that performed well with the HCAHPS® survey. They will tell their stories, successes and struggles on their way to achieving their current HCAHPS® performance. Before those two organizations speak to their improvement stories, we will cover an overview of the HCAHPS® survey methodology and calculations, including calculations within the Hospital Value Based Purchasing program.

As you can tell, we have a packed schedule. So, without hesitation, I will introduce our guest speakers. Dr. William Lehrman is the government task leader for the HCAHPS® survey at CMS. Since joining CMS in 2003, he has participated in the development, management, public reporting and oversight of HCAHPS®, and the analysis of publication of its results. He is also involved in the development, implementation and evaluation of the Hospital Value Based Purchasing program and the coordination of patient experience surveys for other types of healthcare providers. Prior to joining CMS, Dr. Lehrman taught and conducted research on organizations at universities in the U.S., Australia and Japan.

Our second set of guest speakers hail from Sentara Healthcare. Genemarie McGee is the chief nursing officer for Sentara Healthcare. She has been with Sentara for 25 years and has held several positions in the organization, including vice president and nurse executive for Sentara-Lee Hospital and director of the emergency department at Sentara Norfolk General, which is a level one trauma center and home to Nightingale Regional Air Ambulance. She earned her Bachelors of Science degree in Nursing from East Carolina University and her Masters of Science degree from the University of Maryland in Baltimore.

Melinda Montgomery is Director of Organizational Development for Sentara Healthcare. She has been with Sentara for almost 20 years and has overall responsibility for leading the organizational development team and helping leaders and teams be more effective in their role. She has oversight for the organization’s talent management and succession planning efforts. Melinda received her PhD in industrial organization psychology from Old Dominion University.

Our last guest speaker is Amy Phelps, the Director of Quality Services for Mena Regional Health System. She has been with Mena Regional for 18 years and has held several positions within the organization, including surgical services assistant nurse manager and team leader within the operating room. She works directly with physicians and

frontline staff daily to ensure that every patient receives exemplary care and service during her stay.

She earned her Bachelors of Science degree in Nursing from Arkansas Tech University and her Masters in Nursing with emphasis on nursing education from Walden University. She is currently working on a Masters in Nursing with a specialization in Adult-Gerontology Acute Care at the University of Arkansas for Medical Sciences in preparation to becoming an advanced practice registered nurse.

And now, without further hesitate – hesitation, Dr. Lehrman, take it away.

William Lehrman: Thank you very much Bethany and I like to stress my appreciation for everybody who's spending part of their busy day with us to learn about the HCAHPS® survey and the part it plays in Hospital Value Based Purchasing.

So, I'm going to spend about 10 minutes to talk a bit about the HCAHPS® survey and especially how it's used in hospital VBP. As you know hospital VBP links a portion of CMS payment to hospitals to the performance on a set of quality measures. You probably are aware of this, but the VBP program, our hospital VBP program applies to Inpatient Prospective Payment System hospitals or subsection D hospitals. Other types of hospitals do not participate in IPPS and in fact, there are some, I believe there are some, small categories of IPPS hospitals that are exempt from the VBP program.

The VBP program is established by the Patient Protection and Affordable Care Act of 2010, or the ACA. And, this set up or this gave CMS the authority to link a bit of its payment to hospitals to the performance on a set, an expanding set, of quality measures. It began in fiscal year 2013 that is patients discharged from October 1st 2012, and it has been – so it has been operating for several years and we foresee it operating into the future.

In the next slide, we see that the purpose of hospital VBP is to encourage hospitals to improve the safety and quality of care that their inpatients receive during acute care stays. We are hopeful that, CMS is hopeful that, hospitals are motivated to reengineer the processes, their internal processes, to improve patient's experience of care and also safety outcome and quality measures. But, I'm mostly focusing on experience of care. And, the general attempt of hospital VBP is to attach hospital payment to the quality of care they provide not just the quantity of services. So, that's been a theme at CMS for several years,

adjusting our programs to pay for quality of care not just quantity of care.

On the next slide, you can see how the funding or the payment attached to the VBP program has increased year by year, going from one percent to hospital payments in 2013 to two percent in the fiscal year 2017 program. And I believe it's going to stay at two percent. So, I didn't really know too much about the financial aspect of how the payment works; but, essentially there's a reduction in the DRG payments to hospitals that is earned back based upon the score in the VBP program. And, one of the elements to that score is patient experience of care.

And in fact, on the next slide, you can see the elements or domains, as we call them, that will be involved in the VBP program in fiscal year 2017. And, by the way, I'm pitching all my remarks to fiscal year 2017 because every year the program has changed a little bit. So, in fiscal 2017, which will begin in October 1st of 2016, there will be five domains: Clinical care, has two aspects, both the processes and outcomes; safety is not a major element; efficiency and cost reduction that's 25 percent; and what is now called, the patient and caregiver centered experience of care, care coordination or HCAHPS® domain that will cover 25 percent of the VBP payment in fiscal year 2017.

OK. A couple of important points here: the first important point is that the HCAHPS® data used in VBP is taken from the Hospital Inpatient Quality Reporting program, or IQR program. So, there's no special or extra data collection for hospital VBP. CMS uses the data that was collected and submitted for the hospital IQR program and uses that to create the VBP score in the patient experience of care domain. So, no additional data collection or submission is required to participate in the VBP. I also would like to point out that HCAHPS® was an original or chartered member of the VBP program back in 2012. Back in 2012, HCAHPS® accounted for 30 percent of the VBP score and clinical process measures accounted for 70 percent. As you can see from this slide, over time, clinical process measures have declined quite a bit to only about five percent in the fiscal year 2017 program. HCAHPS® has held it's own pretty well moving from 25 – moving from 30 percent originally, in the first three years I think, to 25 percent of the program in fiscal 17 and forward. And CMS has added a number of new domains to the VBP program, which shows their interest in attaching payment to quality of care in several different domains of inpatient experience.

The next slide shows you a little graphic of the domain weights and you can see here the specific measures that are included in each of these domains. And, [I'm] just pointing out that the patient and caregiver

centered experience of care domain is entirely composed of hospital performance on the HCAHPS® survey. I'm assuming everybody here is familiar with the HCAHPS® survey. It was launched in 2006, we began to publically report results on hospital compare in 2008. It became a charter member of the hospital VBP program in 2012. There are over 4,000 hospitals that participate and publicly report their HCAHPS® scores on the hospital compare Web site and of course, HCAHPS® is a short survey, post discharge, of acute care patients who had an overnight stay or longer in the maternity, surgical – or maternity – or medical service lines.

OK. The next slide shows the components of the patient experience domain score. Essentially, there are two components to the patient experience domain. There's a base score and a consistency point score. It was totaled 100 points. The base score can range from zero to 80 points and a consistency point score, which is a very special element as the HCAHPS® domain or the patient experience domain in VBP, counts from zero to 20 points. So, every hospital has the opportunity to achieve zero to 100 points. And, we'll break that down a little bit more in the following slides.

So, the HCAHPS® survey, those of you familiar with it, know that there are 11 domains, or measures rather, reported on the Hospital Compare website. Eight of those domains, and we call them dimensions here in the VBP language, eight of those dimensions are used in hospital VBP. So, the survey asks patients about general or broad topics: their communication with nurses and with doctors, how responsive hospital staff was to their needs while in hospital, how well their pain was managed in the hospital, how well hospital staff communicated with the patient about new medicines, whether the patient received written instructions at discharge, how clean and quiet the hospital environment was and the patients' overall rating of the hospital based upon that experience in the hospital.

Importantly, VBP only counts the percentage of patients who chose the most positive response option on the survey. We call that sometimes the top box response. And, typically, the top box response to an HCAHPS® question is, nurses always treated me with courtesy and respect; or, for discharge instruction, I was given written discharge instructions when I left the hospital. So, the top box is that, the most positive response category. As mentioned, these are the same measures that are reported in the hospital compare, except that two items are combined for VBP. There is one item in the survey about how clean the hospital was and one argument, sorry, one item about how quiet the hospital environment was. For the VBP program, we combine those two into one dimension because those are single items in the survey.

So, in *Hospital Compare*, they report it separately but in VBP, they were combined. Now, the difference is, we only use the overall rating of the hospital item. There is an analogous question, the similar question about whether you would recommend the hospital to friends and family is very highly correlated with the rating questions. So, we chose to use, just use the rating item in VBP.

I can now announce on the next slide that for the fiscal year 2018, which is the year after the year I'm talking about, we will be adding a new dimension to the HCAHPS® domain of the patient's experience domain. That is the care transition measure, which was added to the survey back in 2013. So, we added to the survey in 2013, we began to publicly report results in 2014, and because – well we'll talk about this later, but the VBP program is based upon two different years, a baseline year and a performance a year. So, for the care transition measure, that new dimension, the baseline will be 2014 and the performance period will be 2016. And, we will just simply add the new dimension into VBP giving an equal weight with the existing eight dimensions in VBP, so a bit more about that later.

So, back to time periods; as I mentioned, in VBP there are two time periods, a baseline period and then two years later, a performance period. So, essentially, we want to compare a hospital's performance during a baseline to the performance scoring, performance period, two years later. PPS hospitals that participate in VBP, or the HCAHPS® portion of VBP, must have at least 100 completed surveys in that performance period of year to be included. So, PPS hospitals have to achieve at least 100 completed surveys. We recommend, we strongly recommend that IPS hospitals, IPPS hospitals achieve at least 300 completed surveys in a calendar year and that is in order to build up the reliability of that data. But, as a minimum, PPS hospitals have to have 100 completed surveys in a performance period. If they don't have enough completed surveys to be included in VBP, then they will not receive a score for the HCAHPS® section of VBP program. And that may affect whether or not they participate at all in VBP, it depends on how many other domains they achieve scores in. That's a bit beyond the HCAHPS® portion though.

OK, moving to the next slide. There are two components to HCAHPS® scoring and VBP. We measure improvement of a hospital from the baseline period to the performance period two years later. And, we also measure achievement in the performance period. So, for improvement we look at the hospital itself, we compare the hospital's performance on HCAHPS® dimensions during the baseline period and compare that to the performance two years later. And, from that, we calculate improvement points, which range from zero to nine for each of the

eight dimensions. For achievement, we look at the difference between the hospital's dimension scores, each of those eight dimensions, in the performance period, and we compare that to the national median score in a performance period. So, we get two numbers for each of the eight dimensions: improvement points and achievement points. We keep or retain the larger number to calculate the VBP score, the baseline – the base score for VBP. So, for each dimension, we calculate both improvement points and achievement points and you see here we give – we have more value to achievement. It ranges from zero to 10, we take the larger the two and we sum it up across those eight HCAHPS® dimensions.

And, you all should be familiar with your VBP reports, baseline report and a performance period report, and it will show you: your achievement points, improvement points, and also for both the baseline period and the performance period, the floor, meeting and benchmark scores for each of the eight dimensions. So, the base score runs from zero to 80. As I mentioned, we calculate both improvement points and achievement points, we retain the larger of the two and we sum those across the eight measures to achieve the HCAHPS® base score.

The second part of the HCAHPS® VBP score is called "consistency points" and this is something which is unique to HCAHPS® in the VBP program. Consistency points range from zero to 20 points. And they are our means, CMS' means, of targeting the hospital's lowest performing HCAHPS® dimension during the performance period. So, we have 80 percent of the score from those eight dimension scores and we also had 20 points, we call them consistency points, so you could maybe call them bonus points, something like that, but they are accrued by the lowest scoring dimension. And, I'll try to make that more clear on the next slide.

So, consistency points are derived from the lowest performing dimension, which means that if all HCAHPS® dimensions are above or at the National Medium, then the hospital achieved the maximum 20 points in consistency. That means all of those dimensions are at or above the national medium, which is really good. So, they get 20, they get the maximum 20 consistency points. If the hospital has one dimension that is below the national medium for that dimension, then the hospital will earn between zero and 19 points, consistency points, based upon the calculation, the score for that dimension. So, we have a formula, it's kind of complex and I'll have a reference, a citation later where you can find how we calculate consistency points. But, essentially, the idea of consistency points is to have hospitals focused on the dimension on which they performed most poorly compared to other hospitals. If a hospital has more than one dimension that is below

the national medium for those dimensions, then we do another calculation to determine which one is actually the lowest and we chose the one that is actually lowest and calculate the consistency points based upon that lowest dimension.

OK. So, unique to HCAHPS®, consistency points are a way for us to point out which dimension [of] patient experience [...] a hospital [...] is weakest on and attach extra points to that weakest dimension. So, hopefully, driving hospitals to improve that aspect of the patient experience of care in which they are weakest. So, consistency points are a mechanism for CMS to direct hospitals, to motivate hospitals to look especially carefully at where they are weakest; especially if they are weakest, if they're below the national median on a dimension. So, in the recap, the HCAHPS® domain score is the sum of the base score and the consistency point score. The patient experience of domain score ranges from zero to hundred in total and it comprises 25 percent of the hospital VBP performance score for fiscal year 2017.

In the next slide, I show you a couple of key distinctions between the hospital IQR or public reporting program and the VBP program. Hospital IQR is based on current performance whereas the hospital VBP includes improvement, current performance and consistency. IQR public reports 11 HCAHPS® measures, hospital VBP has eight HCAHPS® measures. There are more hospitals, participating in IQR because IQR is meant for VBP hospitals only and to participate in hospital VBP, an IPPS hospital must have at least 100 completed surveys in the performance period. I should mention that in order to achieve improvement, or in order for us to calculate improvement points, a hospital must also have 100 completed surveys in the base line period. If it doesn't have 100 completed surveys in the baseline, then we would not calculate improvement points, so the hospital – we wouldn't make a comparison between improvement and performance. In that instance the hospital would only earn points based on performance.

OK. In summary, hospital VBP links a portion of payment from CMS to patient experience of care. [...] HCAHPS® has been part of VBP since the beginning. There is no additional data collection necessary for VBP. And only hospitals, only PPS hospitals with 100 completed surveys in a performance period will receive a patient domain – patient experience of care domain score in VBP.

And on the next slide, I present some resources you can check for more information, more details about the VBP program and I'll pass this over to Melinda and Genemarie. Thank you.

Melinda Montgomery: OK. Thank you Bill. This is Melinda Montgomery and on behalf of Genemarie McGee, we're honored to be speaking today and have the opportunity to talk to you about the actions we've taken to get nine of our 12 hospitals to the four summary star level. While we're very proud of this achievement, we do still have work to do, which we'll also speak about. But first, let me tell you a little about Sentara and who we are.

Next slide.

Sentara is an integrated healthcare system headquartered in Norfolk, Virginia, west facilities in both Virginia and North Carolina. We have 12 acute care hospitals, one of which is a level one trauma center and four of which are magnet designated. We have: over 1000 long term care and assisted living beds; home health and hospice services; medical transport to include Nightingale, our air ambulance; five medical groups with approximately 900 employed providers; optima health, which is our 450,000 member health plan; the Sentara college of health sciences, which offers a BSN degree, associate degrees, and several continuing education courses and 28,000 or so employees.

Next slide, please.

So, as I said, we are delighted to have nine of our 12 hospitals receive a four star summary rating. And, as you can see from this slide, back in 2008, only 60 percent of our patients rated us a nine or a 10. In 2014, 75 percent did so. And so far, this year, 77 percent give us a nine or a ten. It's real easy to become so focused on the future that we can forget how far we come and how much we've accomplished. So we're very pleased to have this external validation of a progress.

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So, how did we get here? We certainly didn't get here overnight it's taken us several years to improve our scores. Between 2009 and 2011, we were heavily focused on our goal setting process, our data, actions to move the scores, and recognition. So, back in 2009, we began setting long term patient satisfaction goals. For example, we wanted to be best in our regions by end of 2012 and we wanted to be among the top five integrated delivery networks by the end of 2015. Both of these goals, we have achieved.

Early on, we set our annual patient set goal at a roll out level. So, we wanted Sentara hospitals as a whole, overall to achieve a certain score on the rate hospital question. We did that for a couple of years and we learned actually that it allowed our lower scoring hospitals to hide behind the coattails of our higher scoring hospitals. So, in 2011, we

began setting the goal at a hospital level and have them working towards having each hospital individually at or above the 75th percentile by end of this year. I will say that we still have work to do here. We have five hospitals that are above the 78 percentile with one sitting at the 83rd percentile. That said, we also have four hospitals that are below the 50th percentile.

We do sample at a unit level so that our managers know, not only what's needed at the hospital level, but also what's needed as a unit level to improve the patient's experience. We want our leaders to own their data. At the corporate level, we only produced one one-page report monthly that shows how each of our divisions is doing. Our leaders, including our president, are expected to routinely review their data and know where their successes and challenges are. And, I can tell you that they do. They know their numbers, they know their comments, and they know them on a daily basis. Monthly, the data is reported at divisional and corporate level meetings and quarterly, it's reported at the board level. We report data for all divisions not just our hospitals. So, we also report data for our medical groups, our long term care divisions and our home health division. So, there is much visibility and ownership of patient experience across the organization not just in our hospitals. In 2010, we held what we called summits. These summits were attended by all the inpatient managers where we had each manager present his or her data, their best practices, their challenges, and their action plan. We wanted to ensure that our managers knew how to read their data reports. We wanted them to see that they were not alone in this journey to improve their patient experience. We wanted them to see that their peers were facing similar challenges. And, we wanted to help them act upon the patient's feedback by sharing best practices.

After these inpatient summits, we have what we call hospital wide summits attended by all leaders within the hospital to ensure that everyone understood that patient satisfaction was a team sport are not solely owned by the inpatient leaders. At these summits we reviewed the facility data and introduced the new nursing bundles, which I'm sure you all know about: the bed side shift report, white board, discharge phone calls, and hourly rounding. These hospital wide summits were key to helping everyone understand that it only takes one interaction in the hallway or at registration, in the cafeteria, in X-Ray, in PT to get us an eight instead of a nine or 10.

And then, lastly, in 2009 to 2011, we introduced what we call the patient's choice award and that's given to those units in hospitals that achieve at or above the 75th percentile for the right hospital question. We want to be able to publicly recognize stellar performance. In 2012, our focus turned to training, training, discharge phone calls,

involvement of our patients and families, and our strategic plan. We introduced a leadership training bundle, which is essentially teaching our leaders skills, such as how to hold staff accountable, how to effectively manage change, how to round with intent, and how to develop action plans. We also have, again, centralized our discharge phone calls; previously, those had been left to staff on individual units to make as they had time. And, as you can imagine, that was not as effective as it needed to be. We turn to our home health division to have nurses there to make phone calls for two of our hospitals. And then earlier this year, we outsourced these calls for 10 of our hospitals to a vendor using an automated call process. Escalations to a live body are still handled by our nurses in our home health division. In order to further engage our [...] physicians in this journey, we began sharing the patient satisfaction data at a hospitalist group level on a monthly basis. So, all hospitalist groups are shown on one report which helps them to see how they are doing compared to their peers. We also have begun sharing patient letters and stories at a monthly patient experience workgroup. And, this is a workgroup meeting which is attended by all vice presidents and above in our organization.

This system level work group is tasked with helping our leadership to see our company the way our patient's families and external benchmark organization see us, rather than the way we see ourselves. We want to humanize the numbers and make sure our executive understand the stories behind the numbers. Some of these stories will touch your heart some won't. But, they all help us to see our care and service from the patient family perspective. We implemented patient family advisory councils in each of our hospitals. And these patient and family members have been very active in reviewing educational materials, mystery shopping, reviewing building design plans and the like. And lastly, we became a line item on the organization strategic plan. Engaging the patient and family is part of our three key strategic imperatives.

Looking at today and into the near future, our attention is now placed on our ED's. Many of our inpatients come through the ED, so we need to ensure the experience in the ED is a good one. And, we do have work to do here; throughput, wait times, communication, compassion are all areas we need to improve upon. We're performing deep dives at hospitals where our scores have fallen. And these deep dives really consist of gathering and interpreting hard metrics, such as productivity, turn overs, tenure policy, safety metrics, along with reviewing our patient satisfaction scores and their comments and then looking at softer data, such as interviews with leaders, staff, patients, and doing some observations on these units. From these deep dives, we're really trying to determine why the scores fell and what we need to do to

correct it, both at the hospital level and in an organizational level. We're trying to help our managers to be more consistent in our patient rounding by providing them with a tablet based rounding tool. So, using the table allows the manager to send real-time requests to ancillary departments and it allows us to track trends in patient feedback.

Earlier this year, we held a[n] organization wide retreat composed of bed side care givers, report staff (such as IT), care coordination, registration, leaders, executives were involved and the purpose was to develop a three year plan related to service. From the retreat, we develop two key concepts. One of the concepts is not new but it did nee a refresh, and that concept is consistency. And, as we see it, it shouldn't matter who you are, why you're here, who you see, time of day, day of week, or location as to the level of care and service that you receive. So, exceptional service, exceptional care, that's what we want to always deliver. The second concept has to do with making the healthcare journey easier on our patients and families. So, we want our patients and families to truly feel like they have hit the easy button when they come into our care. But, too often, they do not. Too often, we actually add to the patient's burden rather than easing it.

So to summarize our journey over the past seven or eight years, we focused on things such as making sure everyone understands the data, making sure that we have actionable meaningful goals, communication, training, and greater patient and family engagement.

Now, let me turn it over to Genemarie McGee to discuss our keys to success and our challenges.

Genemarie McGee: Next slide please.

So, you can see on the slide that we have been really working on. Our leaders own the data. What that means is all leaders are expected to check their data routinely and they do so practically on a daily basis because it’s reported at their daily leadership huddles along with other patient care items of interest for the day. We focused on [things like] central lines, folks who have urinary catheters; it really does keep the focus on the patient. They are in their data actually so much that they tell us when there is something odd about the data, such as the sample size being a little too low or the data didn't update overnight. Like Melinda mentioned before at a corporate level, we only published one monthly report, which shows how each division is doing with respect to their patient satisfaction goals.

The consistent application of the nursing bundles has also been key. Bed side shift report, white boards, hourly rounding, and discharge

phone calls consistently executed, had made a positive difference. Accountability: our progress is shared monthly at divisional and corporate leadership meetings and quarterly at our board level. So, we are held accountable to improving the patient's experience at the highest level. Also, a key thing is that, for the past four years, every leader in the organization has had 15 percent of their bonus compensation tied to achievement of their patient satisfaction goals. Staff also have a portion of their annual bonus tied to the patient satisfaction goal achievement. In 2013, patient engagement, improving the patient's experience has become part of our defined strategic plan. So, it's actually in there in writing. And, Melinda and I both feel that that was key to really getting everyone focused on this.

Next slide please.

So, although we have had some success, we also still face challenges. As you heard Melinda say earlier, consistency is one of the things that we believe is key. We are moving towards a consistent patient experience. We still hear too many stories of rude, indifferent staff or processes that are very difficult for the patient to navigate because it makes it easier for us as Sentara employees. As we say, it should not matter who you are, why you're here, time of day, day of week or location, as to the level of care or service that you receive. Wherever, whenever, why-ever you're here, we want you to always receive consistent top notch care and service.

Staffing variances, as many hospitals and healthcare systems experience, we have had staffing challenges, which makes it more difficult for our staff to focus on the service aspect of their jobs. We are also a very goal driven company. We have lots of priorities and we have many goals, which can dilute our focus on service at certain times.

And then, finally, providing exceptional patient experience from a service perspective is not what we would call totally engrained in our culture yet. We can become so focused on achieving a number that we really forget the reason for the number, which is to ensure that we are delivering an exceptional patient experience from a quality, safety, and service perspective. We need to be focusing on processes, we believe, as well as behaviors.

And that concludes our presentation. Next, will be Amy Phelps and we'll hand that over.

Amy Phelps: All right. Thank you Genemarie. I was excited that I was asked to speak because I really wanted to help other hospitals that are smaller achieve success with their HCAHPS® scores.

Next slide please.

All right. Mena Regional Health System is a small – we are a rural IPPS hospital. We have 65 beds, we're non-profit, city owned, and we do not receive any type of tax support from our community. So, it's very imperative that we do well with Value Base Purchasing. We have several units that are listed there. We serve about an 85 mile radius and about 50,000 people. And, the nearest tertiary hospital is an hour and a half away. So, our oscillation has been good at sometimes but it is very imperative when you're trying to get care for patients, such as a cardiac patient or a stroke patient.

Next slide, please.

All right, so, what I posted here is basically our scores. And, it was back in 2012 when Value Based Purchasing came along that we decided we needed to work on these scores. Our biggest issue at the time was getting the hundred surveys. They talked about the hundred surveys and, when we first started, we couldn't get a hundred surveys and I'll tell you a little later how we boosted our survey getting those back. People just, you know, they didn't have a complaint or anything, they just didn't take the time to fill those out. So, as you can see there is our comparative data from fourth quarter 2012 and then the percentage changes with the latest that were just posted on *Hospital Compare*. We focused, we picked two areas to focus on with our nursing, our nurse manager, and our nursing staff. And, the nurses picked communication on medications, which rose 14 percent, and pain management, which rose 14 percent.

As you can see, those were the two measures the nurses were targeting but look at responsiveness of staff, it rose 20 percent and that really affected all of our values. I hate that willingness to recommend isn't included in Value Base Purchasing because that one is 28 percent, which we really lack. We felt like a lot of people didn't recommend our hospital because there is so much care that has to be moved to other hospitals, we have to transport you to other hospitals. We felt that might be why people weren't recommending us.

The next slide, please.

Steps to success: like I said, we talked with the nursing staff and the frontline staff and we picked the two elements to work on. And then, it kind of grew from there. Then we took a hospital wide program that we call iCARE, which is based on integrity, compassion, accountability, respect, and excellence. We worked with everyone hospital wide, we only have, what, 300 employees. And made sure that everybody

understood this, understood that, you know, the people you were taking care of could be your loved ones and basically treat others how you would want to be treated. With the iCARE program, there's employee recognition, patients and families and co-workers can comment on the care provided to them by an individual person, and there is some recognition for employees. We did so well last year with Value Based Purchasing, our quality measures that are on IQR, and outpatient reporting that the hospital said we were doing so well, they gave a performance bonus to employees last year based on our quality scores and performance. And so, a happy employee equals happy patient. And so, I'm a big believer in that. We celebrate small successes. When we passed meaningful use to when we got our scores to where we wanted them to be, we've had hospital wide parties for both day and night shifts and celebrated that. And when I see a nurse doing a really swell job on her, his or her, HCAHPS® score or I see comments from patients on patient, you know, written surveys here in the hospital for their consistently doing their quality scores really well, then I send them a candy bar and a thank you note individually recognizing them for their success.

Next please.

Little things that make a big difference, we're a small town and so we feel like we need to give our patients a small town touch. They don't like being pulled by computer, they don't want to talk to recordings and thing and so we do handwritten thank you note from many of our units, where all the employees sign thank you for choosing Mena Regional Surgery to have your surgery procedure. And, reminders to patients, you know, like I said, we had the big problem with just getting the surveys back. So, we remind the patient, you know, once you get home, you'll be getting a survey in the mail and please fill that out and let us know how we did or what we could to be – to do a better job for you. So, just letting the patient know, you know, that their survey results are important to us and for them to take the time to fill that out.

Next slide, please.

Challenges ahead: I'm targeting cleanliness and quietness next. And, if you've ever spent the night in a hospital, you'll understand that quietness is very hard to achieve. Being a small hospital, I sometimes take calls for surgery and I sleep up here and even with good walls and stuff they is beeping, there are people talking, there is loud TVs for patients and things. And so, we're working on quietness. I'm working with housekeeping right now to raise their score; they were very upset, they thought their scores should be better. Our hospital is very clean. And so, we're talking about some scripting when they go into patient

rooms; and they too have decided to do get well cards from the house keeping department.

Physician communication: our scores are good, but I would like to continue to grow that. I'm actually working with them. I think another thing that has helped is our CEO actually makes rounds every day and talks to patients. And so, when the CEO comes into your room that tells you, you know, you are important to us. And so, as Sentara said, maintaining and having that consistency with your scores, I think is the biggest challenge.

So, I've included my e-mail address and my phone number, if any small hospitals need any help or if I could help you in any way, I'd be glad to. And, thank you for letting me present. And, Deb is going to tell you about continuing education.

Deb: Well, thank you Amy. Today's Webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider and, as such, all nurses report their own credits to their board using our national provider number that you see on this slide, 16578.

We have an online CE certificate process and you can receive certificates two ways. If you registered for the Webinar through ReadyTalk, a survey will automatically pop up when these slide close out. The survey will allow you to get your certificate. Now, if you were in a room with other people, you won't have that survey pop up for you. So, we will also be sending out a survey link in an e-mail to all participants within the next 48 hours. So, if you're listening in a room with somebody else. Just pass that link to the other people in the room. This is what the survey looks like, actually the last part, the bottom part, of the survey. Again, it's going to pop up at the end of your slides. And, you see at the bottom of the survey, a little gray box that indicates done. When you're done with the survey, you click that gray button and this is the screen that opens up. If you have been receiving CE certificates from us in the past, you will be clicking on the existing user link. If you have not received any CEs from us before or, if this is your first one, you're going to have to register as a new user. This is a separate link from the ReadyTalk link that you used to get into the Webinar.

OK. This is what the new user page looks like. Again, this page will take you into our Health Services Advisory Group page, it's not ReadyTalk. You put your first name, your last name, we are suggesting that everyone use a personal e-mail for this account, the reason being is that, most healthcare facilities has firewalls that block our automatic

responses. So again, please use a personal e-mail, such as Yahoo or Gmail in the e-mail, where you see the e-mail box. This is what the existing user box looks like, the user name is whatever your entire e-mail address is, the entire e-mail that you registered into Health Services Advisory; not ReadyTalk, Health Services Advisory. And then, you put the password there.

OK. Now, I'd like to return the program back to our team leader, Bethany Wheeler.

Bethany?

Bethany Wheeler: Thank you Deb. So we received a few question during the presentation and I would like to turn it back over to each of our guest speakers to answer those questions.

We received one question for William Lehrman. Why does the top box measure get used instead HCAHPS® linear scores for each domain and dimension. It drops a lot of people who give answers like sometimes.

William Lehrman: Hi, thank you. The linear mean score that you're talking about was developed for the HCAHPS® star ratings, which just debuted this year in April on *Hospital Compare*. When the VBP program was being developed and designed, there's actually a report to congress back in 2007 where CMS proposed the program. It was decided that we wanted to focus on the most positive experience and reward based upon the most positive experience the patient had. So, that's why the score is based upon the percentage of patients who chose the top box or the most positive response, such as nurses always treated me with courtesy and respect. So, it was, it's part of the design of the program. I didn't know whether we're going to consider using linear mean scores as something like that that rolls across all measures. You could suggest that to us either directly or when we, every year, the IPPS Rule is put into the Federal Register as an open comment period where suggestions, such as that one, could be submitted to CMS.

Bethany Wheeler: Great. Thank you William. Our next set of questions are for Sentara, for Melinda and Genemarie. The first question: from your perspective, what discipline has the greatest impact on patient experience of care scores?

Genemarie McGee: So, this is Genemarie McGee and I think both Melinda and I agree that nurses probably have the greatest impact because they are with the patient typically 24 hours a day. However we have also found you cannot underestimate sort of the loudness or powerfulness of the

physician's interaction also. So, I think that's how we would answer that question. Melinda, would you add anything?

Melinda Montgomery: No, I think you're right on with that. It's the nurses and the physicians.

Bethany Wheeler: Great, thank you. Another question that came in: how do you attribute data to individual hospitalists? In the hospitalist report, where they could compare their performance, was their identity blinded?

Melinda Montgomery: Actually – this is Melinda, and we did not attribute it to individual hospitalists. We attributed it to hospitalist groups and so we do not blind the groups and so each of our hospitals groups, you can see their performance on the scores, the questions.

William Lehrman: Hi and this is Bill from CMS. I just want to add one point about that. The HCAHPS® survey was designed to compare hospitals to each other. We know a lot of hospitals use it in a more granular way to compare wards or floors or groups, even individuals. But, it was not designed for that purpose. You'd have to have a lot of data for those smaller subunits to make appropriate reliable comparisons. So, that's something we are emphasizing more so than in the past.

Bethany Wheeler: Great. Thank you for that addition, Bill. Another question for Sentara: How would you make these physicians accountable and help them achieve their goal?

Genemarie McGee: So this is Genemarie, I think number one, sharing their data and although we don't have it on individual physicians, we do share it with the hospitalist group. If we get letters that are either complimentary or letters that point out issues, particularly if it involves physicians, nurses, you know, our house keeping staff, we involve all those folks in that conversation and that response that we may have backed to a patient. We also involve our vice presidents of medical affairs and they meet with our physicians. And, at all their meetings, we share scores with how each hospital is doing and they also know that our staff's compensation, parts of it, are tied to that. And, that we have found is a real leverage with our physicians because they worked with our staff and they want our staff to do well.

Bethany Wheeler: Great, thank you for that response. Moving on to Mena and Amy: can you please define the iCARE acronym again?

Amy Phelps: The iCARE acronym is i for integrity, C for compassion, A is accountability, R is respect, and E is excellence. And so, these are the characteristics that we expect every employee to exhibit in all their actions every day. Thank you.

Bethany Wheeler: Thank you. Another questioner asked, if you could repeat your e-mail address again.

Amy Phelps: My e-mail is amy p, as in Paul, at minaregional.com and I did include it on a slide. So, I'll be glad to work with any rural hospitals that need help.

Bethany Wheeler: Great. And, we received one more question for you: How did Mena increase the number of surveys returned? We are in a new facility that just opened and opted for telephone surveys, but are not on target to achieve 100 surveys.

Amy Phelps: OK. We started by making sure that to start, we use an outsource, we outsource our survey. [...] We made sure that our questions were short. There was a bunch of extra questions; different units wanted to know what was in there [was] with the HCAHPS®. And so, we shortened that. The other thing is we did an article in the newspaper to stress to patients staying in the community how important it was to fill out the survey and to let us know how they were doing. And then, there is a reminder on the bottom of the discharge instructions that says you'll be receiving a survey in the mail and your opinion is always important to us. And so, there's just little reminders that they'll be getting a survey and how important it is for us to hear from them. And so, it really has increased it, I mean, we're still working on that because we always worry, you know, our system, it has a large hospital. And so, we may only have 600 admissions for the year and so it is a job. Thank you.

Bethany Wheeler: Thank you Amy and thank you to the rest of our guest speakers today. We're at the top of the hour, so that's all we have time for today. If you submitted questions that weren't answered during today's call, we are going to try our hardest to get those answered and out on the qualityreportingcenter.com website as soon as we can.

So, please check back in a week or two to see if those questions and answers have been posted. Thank you everyone and have a great rest of your day.

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