



**26**

years of transforming  
health care  
organizations into  
high performers  
and counting

# 2011 Pulse Report

## Perspectives on American Health Care



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# Executive Summary

In this report, Press Ganey presents its first integrated portrait of performance across the health care continuum. Using the largest private-sector databases on patient satisfaction and employee and physician partnership, one of the largest on clinical measures, and survey data from the federal government, the state of health care delivery in challenging times is analyzed.

There is some encouraging news: Hospitals are focusing on ways to improve their scores on clinical quality and the patient experience of care. Medical group practices and home health agencies are also working hard on these metrics, in anticipation of public reporting of data on the patient experience and the prospect of future payment based on performance. And employee and physician satisfaction and engagement continue to rise.

Health care in the United States is in a period of transformation as profound as any in its history. It is slowly moving from a system that encourages the most intensive and technologically advanced treatments for patients to one based on the value of delivered services. New laws and a new economic reality have forced a growing emphasis on high-quality, highly coordinated and cost-effective care. Providers increasingly are managing population health rather than simply treating people after they become ill.

Even if the Affordable Care Act – the nation's health reform law, passed in 2010 – is repealed or amended, health costs and their contribution to the federal budget deficit and private industry's financial struggles make this new world of health care all but inevitable. On its current trajectory, the federal Centers for Medicare and Medicaid Services (CMS) predicts that the U.S. will spend \$4.6 trillion on health care annually by 2020, representing about 20% of gross domestic product – an unsustainable course.

For all that spending, the care delivered to many patients is not yet of sufficient quality. The Commonwealth Fund Commission on a High Performance Health System's 2011 national quality scorecard found improvement on only half of the 22 indicators the fund uses to assess whether patients receive care that is effective, safe, coordinated and patient-centered. And new data from CMS show that nearly 7% of acute-care hospitals have higher-than-expected readmissions rates for heart failure, heart attack or pneumonia. Numerous other studies find similar conclusions in other areas of health care quality.

The same Commonwealth Fund study, however, found a bright spot: Where there are effective programs through which providers are required to report data on common metrics, quality-of-care indicators substantially improve, including control of chronic diseases and the provision of evidence-based hospital care.

## Reform Gets Serious

Providers are facing calls in Congress for significant reimbursement cuts and a fundamental restructuring of government health care programs. If those occur, they would pile on top of new demands for expensive electronic health records systems, the rise of consumerism and new forms of competition.

This past year saw health reform begin to crystallize in the form of an array of new regulations. One program that is now spelled out in detail is the Hospital Inpatient Value-based Purchasing (VBP) Program. On July 1, hospitals began a nine-month reporting period for clinical and patient experience measures that will be used by CMS to calculate a single overall VBP score for each organization. Starting on Oct. 1, 2012, those scores will be translated into changes in reimbursement, with 1% of Medicare payment at risk initially, scaling up to 2% by fiscal year 2017.

According to the Press Ganey Consulting Group, which works hand-in-hand with health care organizations on performance improvement, hospitals have begun to realize the potential impact of VBP and related measures, and are working hard to improve. That will be essential, as by 2013 hospitals will face potential penalties for excessive preventable readmissions and hospital-acquired conditions such as foreign objects left after surgery and infections acquired from catheters. Also, a new outcomes domain will be added to the VBP program, using three 30-day mortality measures – for acute myocardial infarction, heart failure and pneumonia.

The new Medicare Shared Savings Program – through which accountable care organizations (ACOs) will bring together hospitals, medical practices and post-acute providers to manage population health and improve care coordination – is another example of the impact of reform on quality. The number of quality metrics (33 in four domains of care) on which ACOs must report data to CMS are significantly more expansive than those under VBP. Also, ACOs will have their own

# Executive Summary (continued)

patient experience survey tool, a form of a survey already in use, called the Clinician and Groups Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey.

## Scores on the Rise

In general, this report finds that compliance rates with recommended care have increased for most of the top MS-DRGs, including acute myocardial infarction, heart failure, pneumonia and surgical care improvement measures. This shows a direct link between public reporting and a higher percentage of patients receiving the treatment most likely to result in the best outcome for a particular condition.

Scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey have been steadily rising over the past six years, in tandem with the steadily increasing requirements for reporting data. HCAHPS makes up 30% of the total hospital inpatient VBP score. In addition to eight well-known measures of patient satisfaction, there is a new element to the HCAHPS algorithm: consistency of scores across all domains, which will account for a fifth of the total HCAHPS score. To receive full points for consistency, hospitals must be performing above the 50th percentile on all HCAHPS measures.

When it comes to inpatient satisfaction generally, the priorities for improvement remain response to patients' concerns and complaints and addressing emotional stress associated with a hospital stay, especially wait times. The priority index for outpatient services remains almost identical to 2009 data, illustrating a continued need to meet the personal or emotional needs of outpatients. Patients have been rating experiences provided by outpatient facilities more and more favorably over time.

A new study by Press Ganey on performance of 3,062 hospitals that charts performance in the past 12 months on the elements of VBP finds a clear separation of hospitals that are high performers on total VBP scores and those on the lower end. (See discussion, page 7.) There are also differences among hospital size, geographic region and facility size. Notably, larger hospitals are more likely to be low-scoring, while hospitals with fewer than 100 beds are more likely to be high-scoring.

Other Press Ganey research (see page 10) has found that hospitals that perform better on HCAHPS tend to have better performance on clinical measures. These findings underscore a wide range of academic research tracing the correlations between high patient satisfaction and high quality of care. In addition, Press Ganey research shows that hospitals with poor clinical performance tend to perform far worse financially.

The Press Ganey Consulting Group finds that the operating room has become a focus for improving both HCAHPS and core measures scores. "If you want to improve VBP, you need to focus on improving surgery measures," said Christina Dempsey, RN, MBA, senior vice president of clinical and operational consulting services for Press Ganey. "Issues of patient flow, waiting times, ED logjams and patient satisfaction – all are interconnected and all have a relationship to the operating room (OR)."

## Other Care Settings

The coming of public reporting of patient satisfaction data in medical practices and home health has those sectors focused on finding ways of improving performance as well. Home health public reporting begins sometime next spring, while the government has yet to announce regulations implementing the CGCAHPS program.

The top priority item for medical practices is sensitivity to patient needs, indicating a need for medical practices to personalize their interactions with every patient.

The five-year trend in home care satisfaction shows upward movement over the past year; again, this is likely a result of the coming of public reporting of satisfaction data through the Home Health CAHPS program next year. After a drop from spring 2009 to fall 2010, home care patients' overall satisfaction has steadily improved and has maintained a high level in the last two quarters of 2010. Issues of highest priority to home care patients consist of front-office responses to requests to change nurses or aides and patient problems or complaints.

## Communicate, Communicate

As with all past Pulse Reports, the theme of communication is interwoven into this report. In medical practices, top-priority items all reference patient satisfaction with the care provider, with a common theme of patient communication and encouragement of patient engagement and participation in care. Nurse communication always is the key to higher HCAHPS scores, and communication about waiting times is perhaps the most important patient experience metric in the emergency room (ED).

Better communication also leads to better outcomes; Press Ganey consultants have seen that validating patient concerns and confirming comprehension are critical to ensuring compliance with treatment protocols.

Communication is central to health organizations' relationships with the people who work there. Nurses and other staff members want to be able to give more input on decisions and get more feedback about their performance. Physicians want more involvement in decisions and increased responsiveness from hospital leaders. Four of the five top issues in the Physician Priority Index are related to communication and collaboration.

Though many challenges remain for improving health care delivery in the United States, the data in this report suggest that the nation may at least be on the right track. They also reinforce the notion that mandates for public reporting of quality of care data continue to have a positive effect on quality improvement. What gets measured and analyzed is what gets fixed.

[Hospital section of Pulse Report >](#)

[Medical Practice section of Pulse Report >](#)

[Home Care section of Pulse Report >](#)



**5**

years of steadily  
increasing inpatient  
satisfaction scores  
and counting

## CLINICAL PERFORMANCE

# Value-based Purchasing and Hospital Performance

The Hospital Inpatient Value-based Purchasing program has an incentive pool funded by a withholding of a portion of baseline MS-DRG payments across all patients. When the program gets under way in fiscal year 2013, hospitals can earn back a percentage of that withhold based on performance on clinical quality and patient satisfaction measures. The measures are selected from those now used for public reporting and the Medicare annual payment update.

Each performance measure is scored on achievement and improvement; the higher of the two numbers is used to calculate the overall VBP score. Hospitals lose payment unless their performance is at benchmark levels. The VBP score is weighted at 70% clinical process of care measures and 30% HCAHPS measures.

Starting in fiscal year 2014, VBP will include new measures of clinical outcomes of care – three for mortality, two for patient safety and eight for hospital-acquired conditions. The 13 clinical measures under VBP are evidence-based standards of care that answer the question: Did the patient receive the care for which he/she was eligible?

Because current performance on many of the measures are at the high end of the equation, the performance threshold is set quite high, and failing to deliver the specified care to a very few patients can significantly impact VBP points and therefore DRG payment.

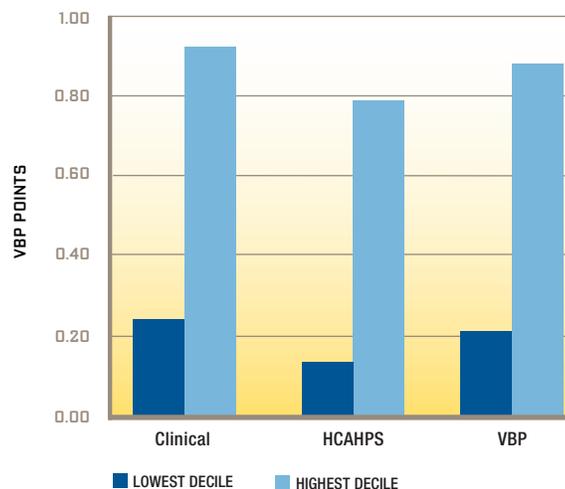
Press Ganey researchers analyzed public data from the U.S. Department of Health and Human Services' Hospital Compare database for the 12 months ended Sept. 30, 2010, from 3,062 hospitals, charting performance on clinical, HCAHPS and VBP scores. (Press Ganey has a Value-Based Purchasing Calculator that uses its own database of more timely HCAHPS and Medicare clinical data to arrive at an estimate of a hospital's overall VBP score.)

The study found a wide gap in performance among hospitals that are in the top 10% of performance on all three performance areas and those in the bottom decile. It also uncovered significant variations based on hospital size, geographic region and facility size. Those include:

- Larger hospitals are more likely to be low-scoring than high-scoring. Hospitals with fewer than 100 beds are more likely to be high-scoring than low.
- Most low performers are not-for-profits; more high performers are for-profit.
- Teaching hospitals are more often low-performing than high; non-teaching hospitals have equal representation in both groups.
- Hospitals in the Northeast and West tend to have lower VBP scores, while Southern hospitals are more likely to be high than low.

Because the VBP program does not adjust for such hospital characteristics, it is apparent that some hospitals will begin with a built-in disadvantage, and that they consequently will be required to work harder to maintain financial strength.

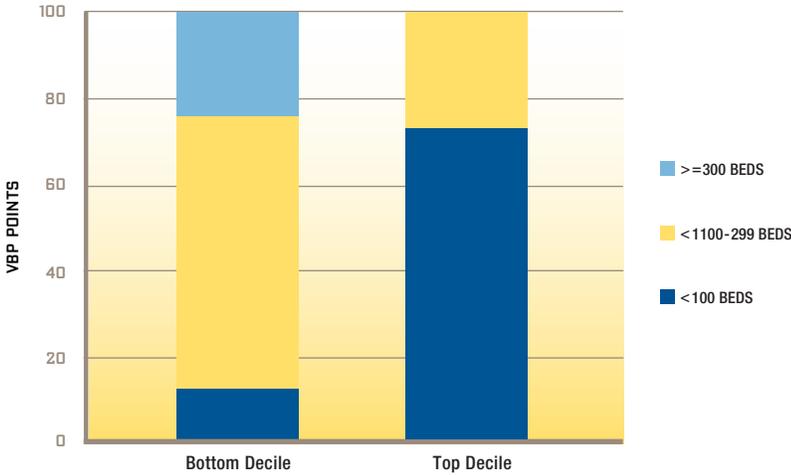
## CLEAR DIFFERENCES IN HOSPITAL PERFORMANCE HUGE GAP SEEN IN SCORES ON VALUE-BASED PURCHASING BETWEEN HIGHEST AND LOWEST ACHIEVERS



Source: Press Ganey study of data from 3,062 U.S. acute-care hospitals.

**CLINICAL PERFORMANCE**

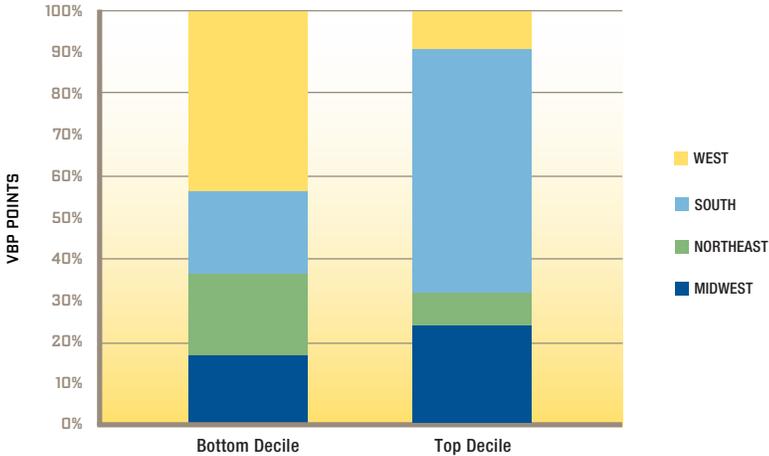
**SMALLER HOSPITALS TO FARE BETTER UNDER VBP**



Source: Press Ganey study of data from 3,062 U.S. acute-care hospitals.

**NORTHEAST AND WESTERN HOSPITALS SCORE LOWER THAN SOUTHERN FACILITIES**

DECILE CATEGORY AND LOCATION (% WITHIN DECILE CATEGORY)



Source: Press Ganey study of data from 3,062 U.S. acute-care hospitals.

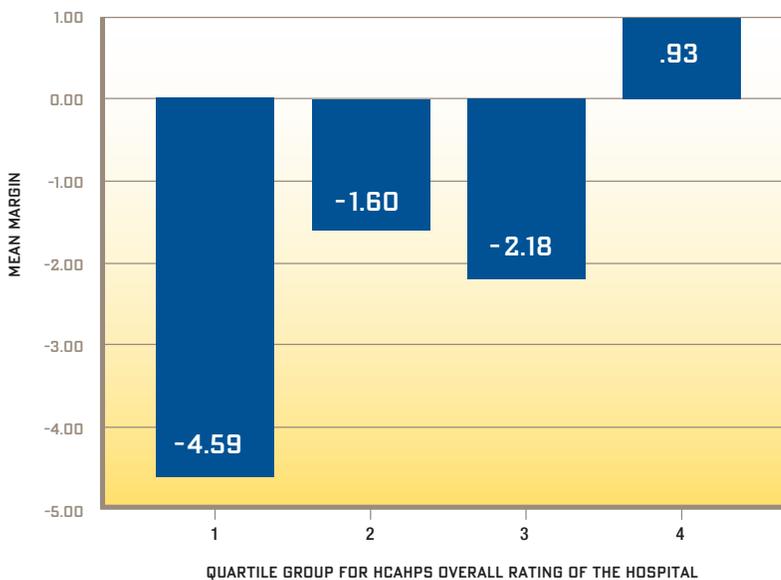
## CLINICAL PERFORMANCE

# Relationship of HCAHPS Scores to Profitability

Using public data on hospital profitability and HCAHPS scores, Press Ganey examined the relationship between patient ratings of the hospital and the hospital's profit margin. All U.S. hospitals were grouped into four equally sized categories based on how their patients rated them on the HCAHPS question, "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?"

The 25% of hospitals with the highest scores on this question were, on average, also the most profitable. The hospitals that had the lowest scores on this question were significantly less profitable. It is interesting to note that the only hospitals that showed a positive profit margin were those that were highly rated by their patients.

## HIGHER SCORES, BETTER BOTTOM LINE

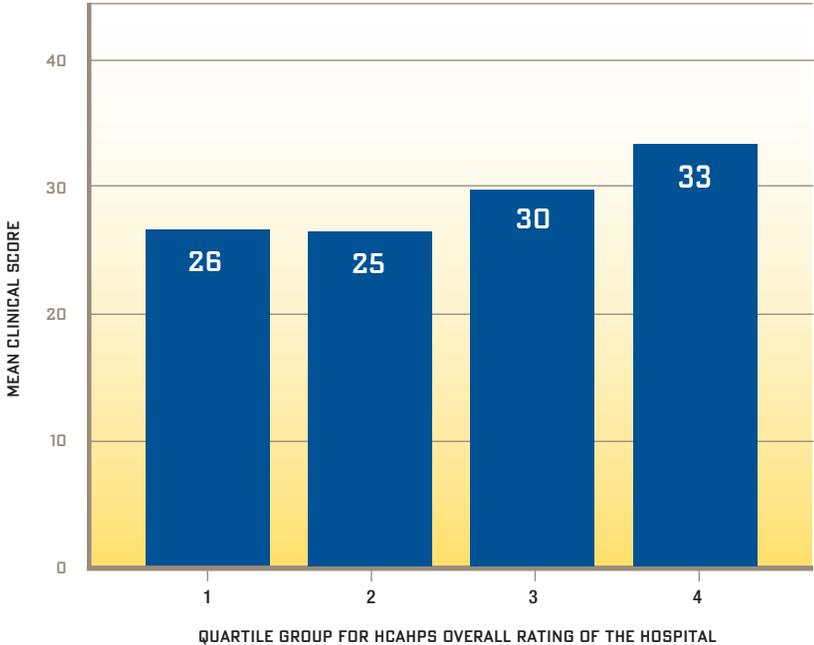


Source: Press Ganey study of data from 3,035 U.S. acute-care hospitals.

## CLINICAL PERFORMANCE

Using the same four groups of hospitals, Press Ganey compared their overall clinical scores. The clinical score is a summary measure of the multiple core measure questions included in the public data set. Although there is not a lot of difference in the clinical measures among the four groups of hospitals segmented on patient rating score, the top quarter of hospitals based on HCAHPS overall rating score also have the highest average clinical score.

### TOP CLINICAL PERFORMERS HAVE HIGHER HCAHPS SCORES



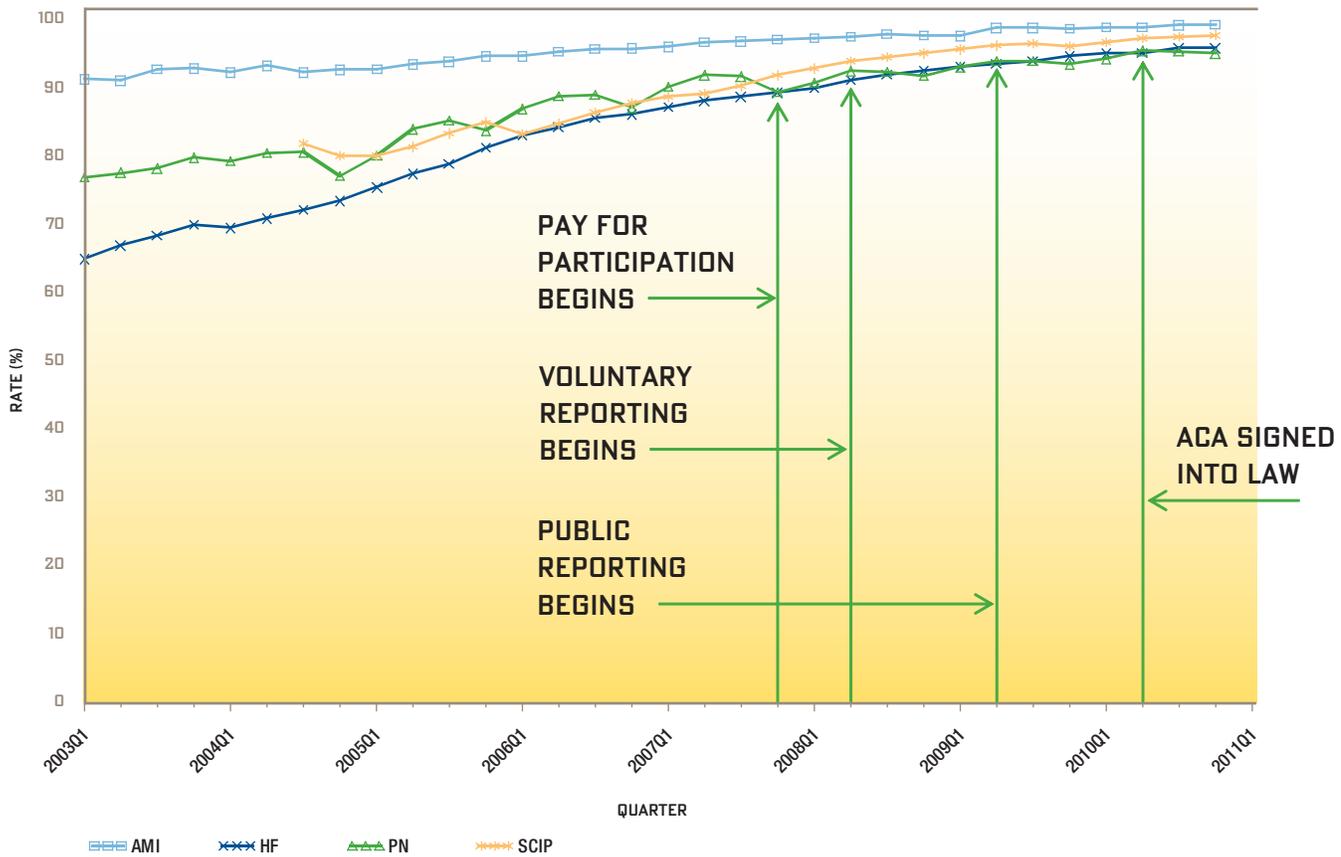
Taken together, these two charts suggest that excellence in patient experiences, clinical outcomes and financial profitability often occur together. This lends support to a view that quality often is structural or systemic; the Press Ganey Consulting Group has seen that when an organization focuses on quality, it tends to do so in all of its systems.

CLINICAL PERFORMANCE

# Core Measures Improvement Over Time

From the time public reporting began until it became required, compliance rates with evidence-based standards of care have increased for most of the top MS-DRGs, including acute myocardial infarction (AMI), heart failure, pneumonia and Surgical Care Improvement Project (SCIP) measures. This shows a direct link between public reporting and a higher percentage of patients receiving the recommended care for a particular condition. These measures are part of CMS' hospital inpatient VBP program.

## COMPOSITE SCORE



# Hitting High Marks Across Clinical Measures at Stormont-Vail

## Vitals

Stormont-Vail Regional Health Center in Topeka, Kan., is a 586-bed, acute-care referral center anchoring Stormont-Vail HealthCare, an integrated health care system serving a 12-county area in northeast Kansas that also includes a multispecialty physician group.

## Challenge

Meet the demands of core measures reporting and success in scoring under the Hospital Inpatient Value-based Purchasing Program, which ties a portion of Medicare reimbursement to scores on clinical care, efficiency and patient satisfaction. Among the clinical measures are those surrounding AMI and heart failure.

## Solutions

Using Press Ganey's Quality Performer<sup>SM</sup>, Stormont-Vail has established protocols throughout the organization for today's National Hospital Quality Measures and likely future standards. For example, pneumonia and flu vaccine assessment and delivery are included in its heart failure protocol, and reducing readmission rates, which will soon become the basis for Medicare bonuses and withholds, have been a focus of the heart failure program since early 2009.

The close integration of the system's multispecialty physician group and its growing cadre of employed hospitalists, emergency department, and cardiac and critical care subspecialists contribute to its ability to develop, implement and manage evidence-based protocols. The system's upper management and board also take an active role in overseeing quality, and consistently devote resources to improve performance.

## Performance and Outcomes

### AMI

Initiating percutaneous coronary interventions (PCI) within 90 minutes of arrival for patients suffering AMIs is among the most challenging of the National Hospital Quality Measures. Every second counts, right down to reserving parking spaces for the cardiac catheter team next to the front door to reducing time spent running in from the parking lot. Identifying opportunities for seemingly insignificant time savings such as this has been a big factor in Stormont-Vail achieving above-average performance on "door-to-balloon time" (arrival to angioplasty or other coronary intervention) for AMI. In the second half of 2009, the hospital scored at 100%.

Stormont-Vail has broken down its door-to-balloon process into five steps. They are door to electrocardiogram (EKG); EKG to calling the cardiac catheterization lab team; calling the team to team arrival in the cath lab; team arrival to patient arrival in the cath lab; and patient arrival in the lab to deployment of the first balloon device. Each of the five steps also has a target time; for example, the goal for door to EKG is 10 minutes and for patient arrival in the lab to first balloon deployment, 30 minutes. The time for each step is recorded for each AMI patient.

When the actual time exceeds the target, Stormont-Vail's heart care performance improvement team initiates a failure analysis – even if the 90-minute goal for door-to-balloon is met. In every case, the AMI/acute cardiology care team examines why the sub-goal was not met and what changes might be made to further streamline the process. Performance on each of the sub-goals and on total door-to-balloon time is presented in a dashboard format at monthly meetings of the interdisciplinary team, which includes representatives of the emergency department, cardiology department, cath lab, emergency medical services and the Health Connections team, which contacts the cath team in emergencies.

### Heart Failure

The ambiguity and subtlety of heart failure symptoms often are difficult to interpret or are masked by other conditions, such as pneumonia. As a result, heart failure may not be identified until late in a stay or even after a patient is discharged. To complicate matters further, it may surface at any time in any hospital unit – unlike AMI, which typically comes in through the ED or presents as an acute and usually easily recognizable complication.

## CASE STUDY

As an integrated delivery system with cardiologists actively pushing for evidence-based medicine, Stormont-Vail has for years recognized the value of standard order sets for improving care. And for several years the facility had one for heart failure. The problem was that it wasn't followed or enforced. As a result, many heart failure patients were leaving the hospital without receiving proper discharge instructions or medications.

Another problem was continuity of care. There was little coordination of discharges with physician offices, and many patients had to wait several weeks for follow up at the system's heart failure clinic.

Stormont-Vail took several steps to address the issues. One was establishing a multidisciplinary Heart Failure Strategy Group. It includes representation from cardiology, hospitalists and emergency physicians on the medical staff side, as well as case management, cardiac rehab, dieticians and representatives of the system's outpatient heart failure clinic, known as the Heart Improvement Center. Representatives of nursing units and the hospital performance improvement department also participate.

Because hospital care is driven by physician orders, a top priority of the Heart Failure Strategy Group was revising standing order sets so that all hospital departments were operating off the same script. One issue was that hospitalists, who provided much of the care for patients who are diagnosed with heart failure after being admitted for another condition, had their own order sets. Meeting with the cardiologists and emergency physicians, and with support from the chief medical quality officer, a new set of standard orders was established. Another step the system took was to create a position of a heart failure nurse. This nurse gathers and disseminates performance data, develops and oversees action plans to improve care, and educates and coaches nurses throughout the facility on heart failure protocols.

One result of the coordinated approach Stormont-Vail has taken is that heart failure readmission rates dropped from about 20% at the beginning of 2009 to about 17% at the end of the year. Smoking-cessation counseling was delivered in 100% of qualifying cases, left ventricle function assessment in 99% for the year.

Steady improvement has been made in the rate of angiotensin receptor blockers and angiotensin converting enzyme inhibitors prescribed at discharge.

# Inpatient Care

Two items that continue to be central to a patient's propensity to have a positive experience are tending to the general concerns and complaints of patients and addressing emotional stress associated with a hospital stay. Patients want to be more informed about aspects of their inpatient experience such as wait times. The items that appear in the priority index show that most facilities provide basic necessities of care, but subjective experience is very important to the patient.

According to the Press Ganey Consulting Group, it is most important to focus on how to change perception by seeing the patient as a human being and truly adhering to the golden rule of "treating people as you want to be treated." Sometimes patient satisfaction programs are seen as the "flavor of the month," and are initiated with little support or for a short period of time, which sends the wrong message to staff. The standards of behavior in health care organizations must establish clear expectations for how to treat others – being responsive, looking people in the eyes and speaking directly to them, building relationships, and including patients in decisions.

## INPATIENT PRIORITY INDEX

Survey Item	Mean	Correlation	Priority Rank
Response to concerns/complaints made during your stay	84.7	0.686	1
Degree to which hospital staff addressed your emotional needs	85.1	0.650	2
Staff effort to include you in decisions about your treatment	85.0	0.645	3
Promptness in responding to the call button	85.4	0.571	4
How well the nurses kept you informed	86.6	0.639	5

Survey items are correlated to "likelihood to recommend facility to friends and family." Data are based on responses of 2,854,198 patients from 2,067 hospitals received from Jan. 1, 2010, to Dec. 31, 2010.

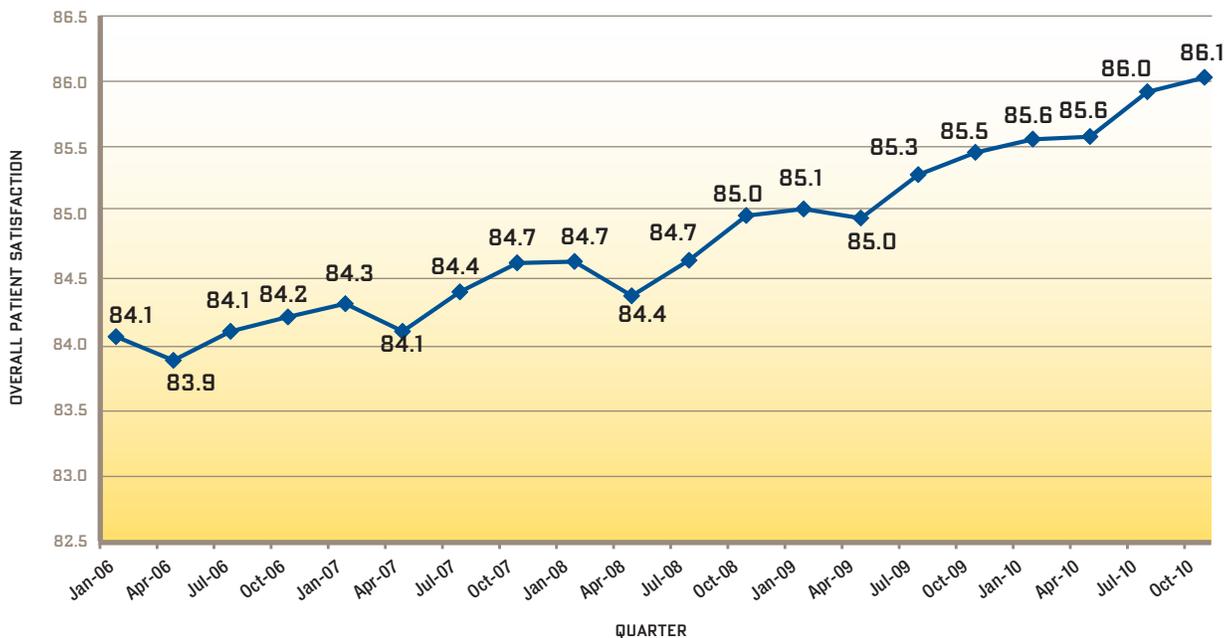
## SATISFACTION PERFORMANCE

# Inpatient Five-year Trend

Inpatient satisfaction has been steadily increasing for the last five years. Press Ganey expects this upward trend to continue with the pending impact of VBP.

Some organizations have created a heightened awareness of patient satisfaction by redesigning annual evaluations to look at quality and behavioral expectations. Many subsequently implement bonus and recognition programs for staff and physicians to reinforce the importance of quality and patient satisfaction.

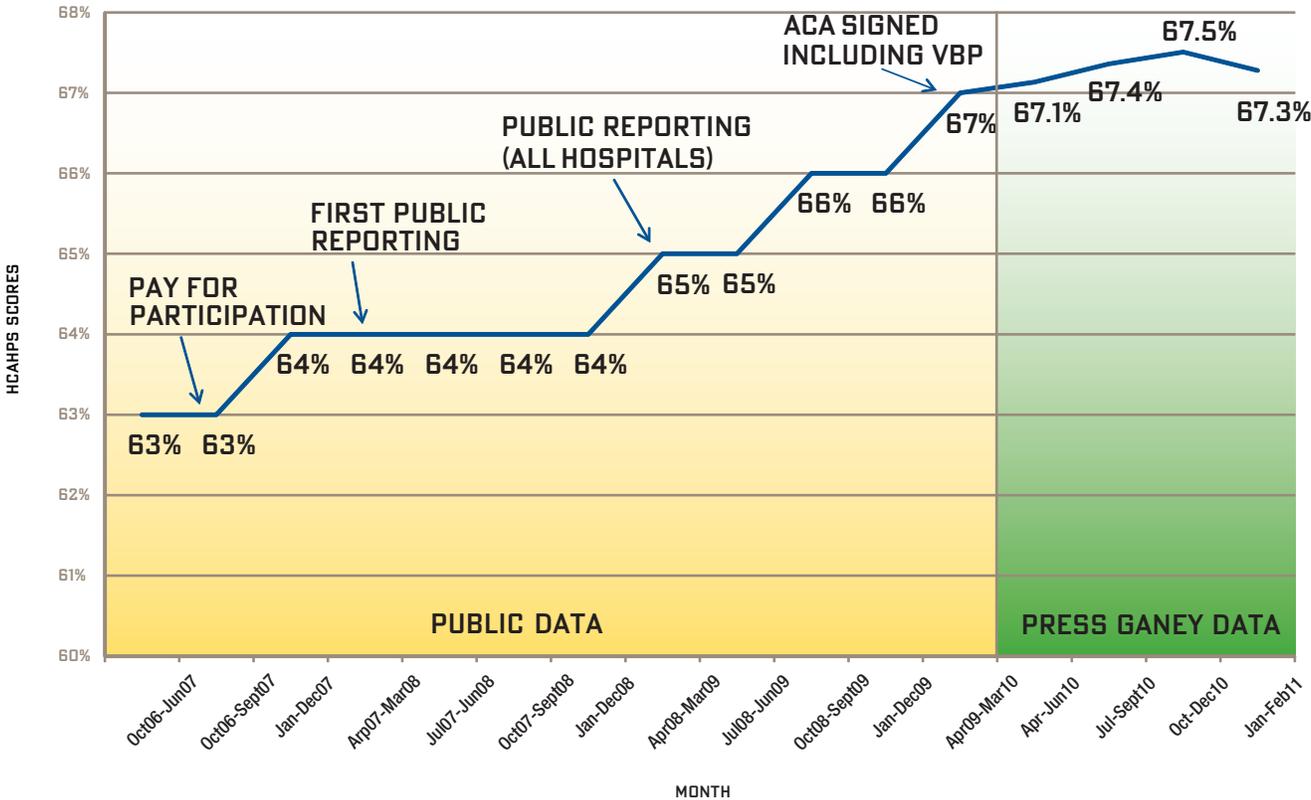
## FIVE-YEAR TREND IN INPATIENT SATISFACTION



# HCAHPS Trends Over Time

Pay for participation began in late 2006, and overall hospital rating scores based on the HCAHPS survey have continued to increase since that point. This upward trend continued when public reporting – first voluntary and later mandated – came into play and after the signing of the ACA, which included HCAHPS data in VBP. The rise in HCAHPS ratings over time shows that increased scrutiny and a stronger tie to reimbursement motivates organizations to improve performance as it relates to the patient experience.

## OVERALL HOSPITAL RATING



## SATISFACTION PERFORMANCE

# Inpatient Five-year Trend – HCAHPS

## “RATE THIS HOSPITAL” AVG TOP BOX %



From January 2007 through October 2011, inpatient top box (a rating of 9 or 10) scores for the question “rate this hospital 0-10” steadily increased.

Over the last four years, the trend has shown consistent seasonal effects in winter and early spring. The Press Ganey Consulting Group attributes this to higher occupancy rates, which leads to higher staffing ratios and workload. Under these conditions, the ability to provide consistently well-trained, well-oriented staff to provide care and services becomes even more important. High census can decrease the amount of time staff members have to spend with each patient, which affects responsiveness, effective communication, anxiety reduction and patient involvement in care decisions.

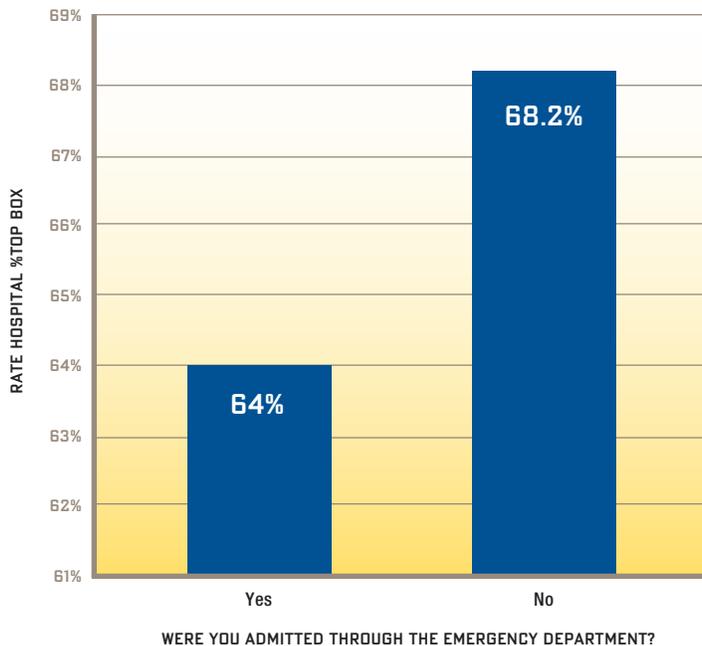
The large dip in spring 2008 reflects the point at which all facilities began surveying using the HCAHPS instrument.

# Patient Satisfaction by ED Admission

Patients that are admitted to the hospital through the ED tend to be less satisfied with their experience than patients who are not admitted through the ED. Longer wait times and transition issues associated with the admission process may contribute to lower scores.

According to the Press Ganey Consulting Group, the ED affects, and is affected by, other areas of the hospital. When patients have long waits in the ED prior to admission to an inpatient bed, they tend to be less satisfied with their overall experience. When there are significant peaks and valleys in the elective surgery schedule that drive variability in the inpatient census, this causes patients to be placed in off-service beds, which also reduces patient satisfaction and may drive increased length of stay, further reducing patient satisfaction. Improving the flow of patients throughout the organization and improving physician and nursing collaboration has proven to improve satisfaction as well as quality and cost.

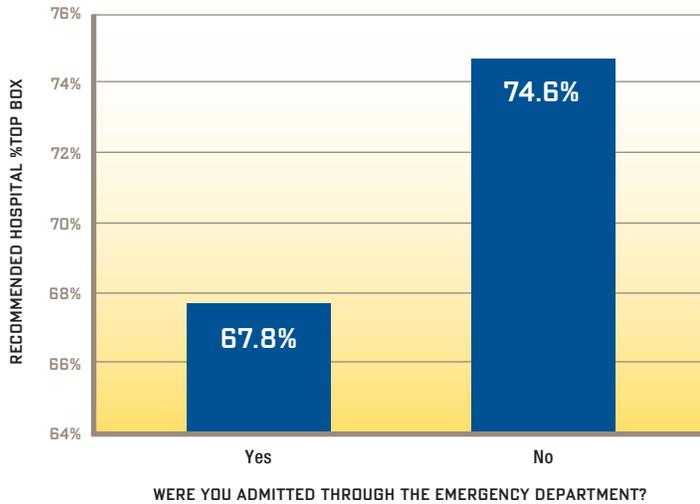
## LOWER OVERALL SCORES AMONG PATIENTS ADMITTED THROUGH THE ED ...



Based on responses of 2,854,198 patients from 2,067 hospitals received from Jan. 1, 2010, to Dec. 31, 2010.

## SATISFACTION PERFORMANCE

## ... AND FOR 'RECOMMEND' SCORES, TOO



Based on responses of 2,854,198 patients from 2,067 hospitals received from Jan. 1, 2010, to Dec. 31, 2010.

# A Playbook for Winning on HCAHPS

## Vitals

Our Lady of the Lake Regional Medical Center (OLOLRMC) is a 720-bed facility in Baton Rouge, La. One of the largest private medical centers in Louisiana, it treats more than 35,000 patients in the hospital and serves more than 350,000 persons through outpatient locations with the assistance of more than 1,000 physicians and 4,000 employees. A Magnet-designated facility, it was the hospital of the year for 2008 and 2010 (Louisiana State Nurses Association) and recipient of the Louisiana Performance Excellence award (Louisiana Quality Foundation) in 2008 and 2010.

## Challenge

The first posting of publicly reported data from HCAHPS in 2008 shocked hospital leaders. With the knowledge that before long those scores would have an impact on Medicare reimbursement, the hospital went to work.

## Solutions

The hospital uses Press Ganey HCAHPS Insights<sup>SM</sup> survey tool to guide decision making. After a hospital-wide review, OLOLRMC adopted a potent combination of process changes, shared decision-making and a new organizational structure around service excellence.

## Performance and Outcomes

"We were at the bottom of the barrel," says Deborah Ford, RN, MSN, vice president of patient care services of OLOLRMC's first publicly posted HCAHPS scores. "Here we were a Magnet-designated hospital, the hospital of the year for 2008 and 2010 (Louisiana State Nurses Association) and recipient of the Louisiana Performance Excellence award (Louisiana Quality Foundation) in 2008 and 2010. With all those awards, we wondered why we were having challenges."

The review of processes revealed that caregivers tended to define quality and patient satisfaction through the success rate for completing tasks in a complex health care environment. "I am a nurse myself," Ford says. "I knew I could put in a catheter with sterile technique, with no resulting infection. I could start my IV on the first try, and nobody feels anything. But that isn't what satisfaction is about. Patients expect care to be good. What they remember is that the nurse cared about them as a person. That is not a lesson I learned easily, nor do others."

Lynda Suhrer-Roussel, PhD, quality analyst at OLOLRMC, says: "HCAHPS looks at perception of, 'were these things always taken care of,' vs. the quality of the experience and the care on the standard inpatient survey. The tools are there for both surveys, but there is richer information on the integrated survey."

The hospital undergoes an annual strategic review to assign all objectives for the year. Each leader has a group that has certain deliverables and aligned action plans that are reviewed regularly. The hospital's chief operating officer holds a monthly patient satisfaction meeting attended by satisfaction team leaders.

The improvement effort focused initially on a few HCAHPS domains: communication with nurses, noise reduction, pain management, discharge instructions and medication education (later, venipuncture and responsiveness of hospital staff were added).

On each unit, there is shared responsibility for the patient satisfaction initiative. "Our model of shared decision-making sets the tone for nurses and other team members to become engaged in the patient satisfaction and premier service strategies," Ford says. Two leaders are assigned to each domain team to create a cross-functional approach that fosters diversity and creativity. For example, the "communication with nurses" domain team is led by a medicine division leader and an emergency room division leader.

It was decided early on that to build awareness of the project, ensure consistency of effort and provide easy reference, an HCAHPS manual was needed.

## CASE STUDY

Barbara J. Griffin, BSN, NE-BC, divisional director of nursing, who was in charge of the communication with nurses section, came up with the name and the theme of the manual. It is called the HCAHPS Playbook, in honor of a local high school football star who was treated at OLOLRMC following a serious auto accident.

The book contains a “play” for each domain. For example, the communications with nurses play focuses on hourly rounding, with nurses making hourly visits to each patient room. A nurse manager also rounds and audits how often nurses visit each room and what the call bell response has been. (A 10-minute or less response is the expectation.)

In each patient room is a “communications center,” a white board that must be rigorously maintained, with names of nurses and the visits they make, as well as the patient’s plan for that day.

As a result of the efforts, there has been a 7% increase in the nurse communication score for the percent of survey respondents who said nurses “always” communicate effectively.

There have been even larger improvements in other domains: A 19% bump for pain management, a 24% increase on noise and a 26% increase for medication instruction.

One of the most impressive results is that OLOLRMC’s “always” rating for the overall rating on HCAHPS question has improved 21% since 2007, while the recommend score rose 14%.

# Outpatient Care

The priority index for outpatient services remains almost identical to 2009's, illustrating continued opportunities to meet the personal or emotional needs of outpatients. In the outpatient setting, employees and physicians have a limited amount of time to make an emotional connection to patients and to help them feel valued by respecting their time and answering their questions.

The Press Ganey Consulting Group advises several ways to make improvements:

- Set standards of performance for physicians and staff regarding expected behaviors when treating patients, such as: effective communication, timeliness, expression of empathy, showing dignity and respect, etc.
- Outpatients expect their visit to be quick and efficient. When organizations fail to meet this expectation, outpatients complain and feel their time is not valued and that the provider is not sensitive to their needs.
- Employees and physicians should also be involved in service-recovery efforts and be educated regarding expectations and how to practice effective service recovery. Some outpatient areas set standards for wait times and ensure that patients who have waited beyond the expected wait time are proactively communicated with about the delay and have expectations reset for the duration of the visit. This kind of action demonstrates the patient's value to the organization and sensitivity to patient needs.
- Ensure that patient education tools such as discharge instructions are written in a way that patients can understand, and make sure staff really take time to review the instructions using the "teach back" method. With this method, the patients tell the staff member their understanding of what was said to ensure comprehension of discharge instructions and timelines for results. Discharge instructions should also be reviewed by a patient focus group to ensure adequate comprehension.

## OUTPATIENT SERVICES PRIORITY INDEX

Survey Item	Mean	Correlation	Priority Rank
Response to concerns/complaints made during your visit	92.0	0.70	1
Our sensitivity to your needs	92.2	0.69	2
Staff's concern for your questions and worries	93.2	0.64	3
Overall rating of care received during your visit	94.2	0.82	3
How well staff worked together to provide care	93.8	0.76	3

Survey items are correlated to "likelihood to recommend facility to friends and family." Data are based on 2,325,721 surveys received from Jan. 1, 2010, to Dec. 31, 2010.

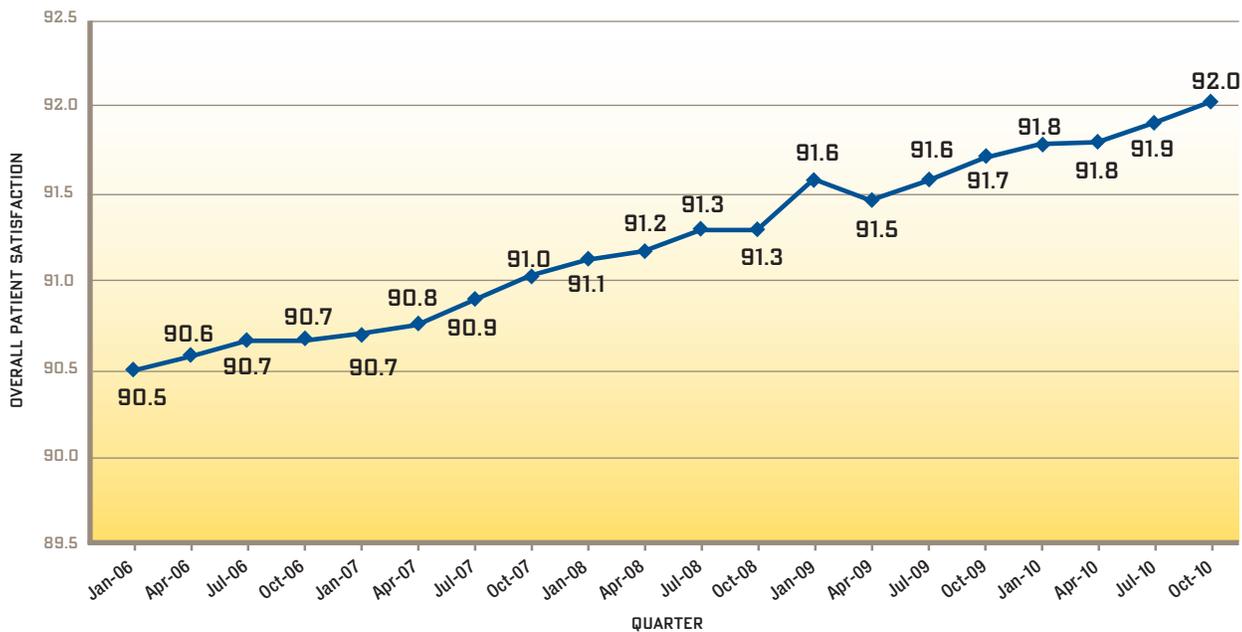
## SATISFACTION PERFORMANCE

# Outpatient Five-year Trend

Patients have been rating experiences provided by outpatient facilities more and more favorably over time.

Based on work with many clients in this area, Press Ganey consultants have seen that most health care organizations have learned that mixing inpatient and outpatient services together can lead to dissatisfaction due to delays and other inefficiencies. As more outpatient services are moved away from the main campus or designed to focus only on outpatients, the Press Ganey Consulting Group expects this favorable trend to continue to improve – or at least remain at its current level.

## FIVE-YEAR TREND IN OUTPATIENT SERVICES SATISFACTION

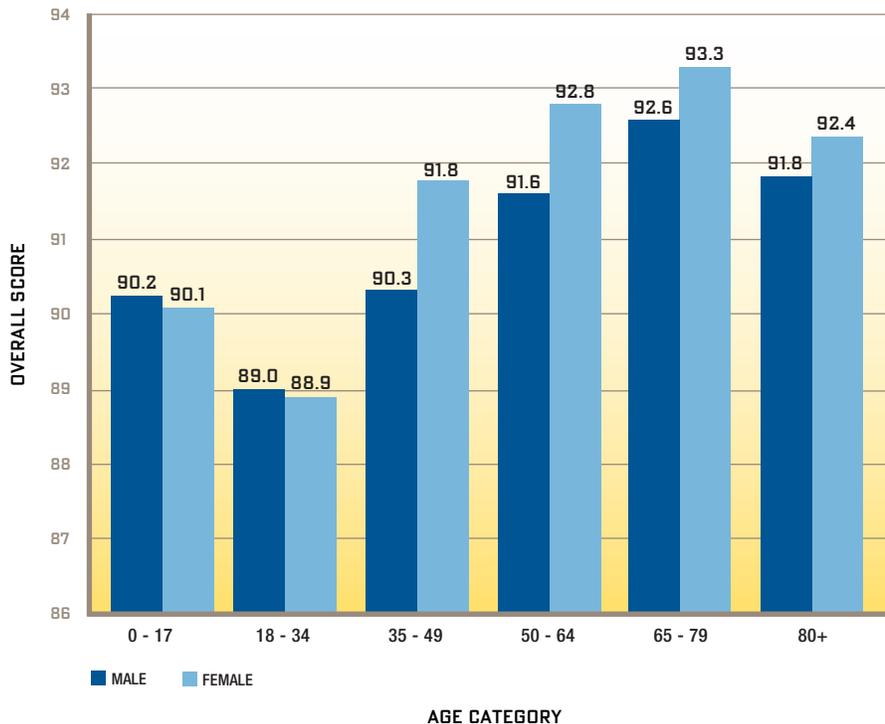


# Outpatient Satisfaction by Age and Gender

Patient satisfaction with outpatient facilities varies by patient age and gender. With two exceptions, the older the patient, the more favorable the rating of care. The exceptions are patients in the highest age category (80+) and patients in young adulthood (18-34). With the exception of the two youngest age categories, female patients report more satisfaction than males.

Younger patients in Gen X and Gen Y expect efficiency and quality. The Press Ganey consulting team continues to see this confirmed in working with clients. People in this age group may have young children and/or a job to get back to so waiting for a test, which might be unexpected, may be more of a nuisance for them than it is for older patients. One way to help is to look at the waiting area and determine if there are opportunities to make it more user-friendly for younger patients and multitasking parents by providing: charging stations for electronic devices, spaces to work on a laptop, Wi-Fi accessibility and medical/educational television or videos.

## PATIENT SATISFACTION BY AGE AND GENDER



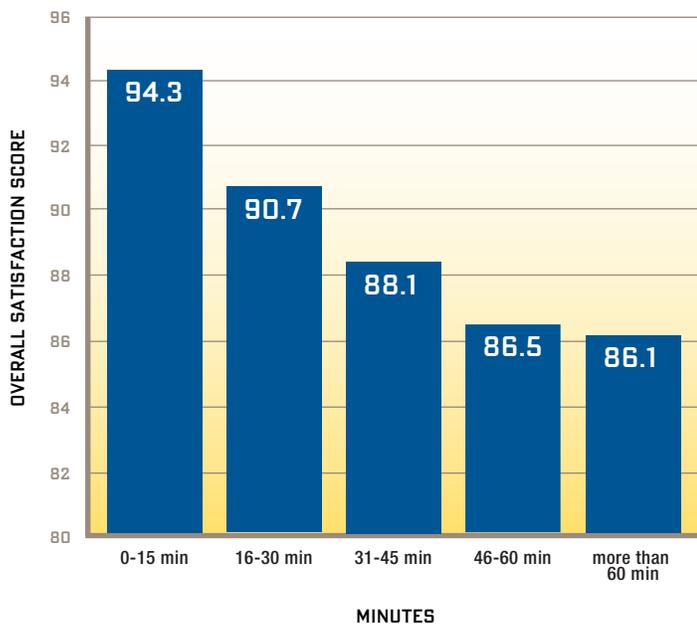
## SATISFACTION PERFORMANCE

# Helpfulness of Registration Desk

The relationship between patient-rated helpfulness of outpatient registration personnel and the amount of time the patient waits is inverse: The longer the wait, the less positive the rating.

Outpatients expect quick and efficient visits. Press Ganey consultants suggest that health care organizations take a close look at wait times to determine root causes and make plans to reduce them. This analysis requires a critical review, starting with the patient schedule or appointment availability. Sometimes organizations find the schedule has been modified to accommodate a provider or the employees in the department, resulting in scheduling limitations that either make patients wait at the time of the appointment, have a long wait for the appointment – or both.

## HELPFULNESS OF REGISTRATION DESK PERSONNEL BY TIME SPENT WAITING



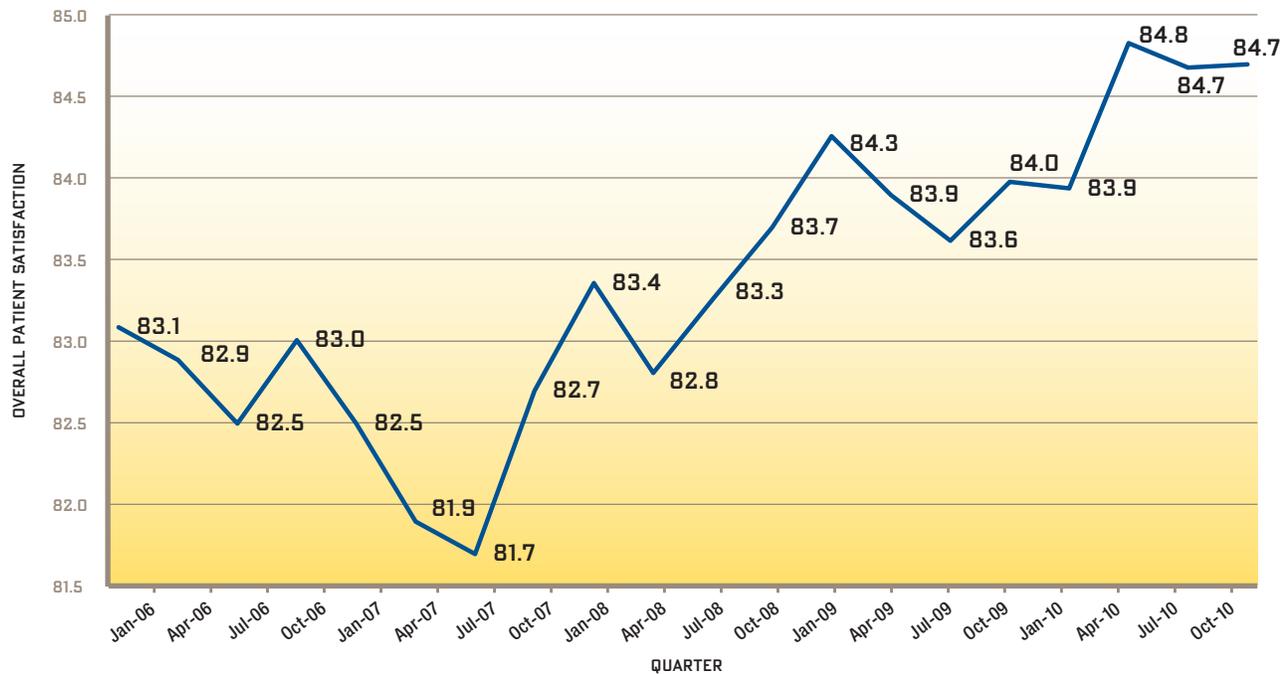
# Emergency Department Five-year Trend

Patient satisfaction with visits to the ED has increased overall for five years, starting in January 2006. From July 2007 to October 2008, it surged two full points. However, between October 2008 and January 2010, it remained relatively stable at around 84, based on a 100-point scale. Most recently, between January of 2010 and April of 2010, it increased by nearly a full point and then maintained that level for two more quarters.

The trend of improved patient satisfaction scores in EDs may be due to the increased public focus on wait times. Additionally, hospitals have been working to improve their HCAHPS scores. Since a significant percentage of hospital patients are admitted through the ED, patients' experiences with that portion of their hospitalization influence their overall hospital patient satisfaction rating.

Periodic dips in ED patient satisfaction are most likely related to seasonal surges in ED use, leading to long wait times and lower scores. Press Ganey research shows a consistent cyclical pattern year-to-year with satisfaction dipping in the spring months. Interestingly, the two most recent quarters do not appear to follow that same cycle.

## TREND IN EMERGENCY DEPARTMENT SATISFACTION



## SATISFACTION PERFORMANCE

## ED Priority Index

Year after year, priorities for improvement in the ED have remained relatively stable. This year's top five priorities were priorities in 2009 and 2008. This indicates that these are critical aspects of patient satisfaction in the ED, and that they have been quite challenging to address. Clearly, reducing delays would help improve patient satisfaction, but Press Ganey data have long shown that keeping patients informed about delays and setting expectations appropriately can have a strong mitigating effect. In general, the priorities all point to the need for an approach to emergency care that both considers and is responsive to the patient's perspective.

The continued recurrence of these same priorities year after year also emphasizes the need for more humanistic improvements in emergency care. Communication training for ED staff, including ancillary staff, is essential to the success of wait time management so that patients receive information and explanations that are professional and accurate, and delivered with empathy, concern and respect. It is important to standardize communication practices so that physicians and staff members address patients by name, introduce themselves and describe their own role in the care process. This personalizes the experience and helps patients feel cared about as people, decreasing their anxiety. The consideration a patient receives greatly influences his or her overall perception of care, making respectful communication an integral component of the experience.

### EMERGENCY DEPARTMENT PRIORITY INDEX

Survey Item	Mean	Correlation	Priority Rank
How well you were kept informed about delays	73.3	0.721	1
How well was your pain controlled	79.0	0.716	2
Degree to which staff cared about you as a person	83.2	0.791	3
Overall rating of care received during your visit	84.1	0.896	4
Doctor's concern to keep you informed about your treatment	83.9	0.699	5

Survey items are correlated to "likelihood to recommend facility to friends and family," and data represent the experiences of 1,602,975 patients treated at 1,908 emergency departments nationwide from Jan. 1, 2010, to Dec. 31, 2010.

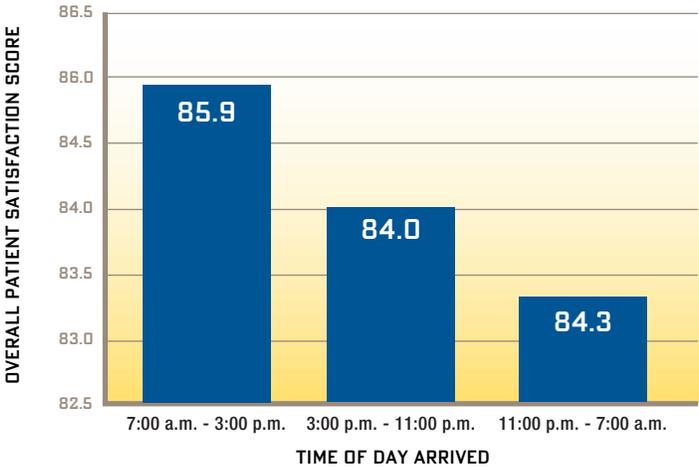
# ED Satisfaction by Arrival Time

Patients who arrive in the ED in the late afternoon and overnight hours report much lower satisfaction than those who arrive during the day. By mid-afternoon, wait times may be on the rise as patient volumes have increased during the day. If a shift change is occurring during a particularly busy time, it may add to any actual or perceived disorganization or delays for patients. Also, newer staff may have a difficult time adjusting to working late afternoon and overnight hours. Staffing patterns/issues, patient volume and acuity of patient conditions may significantly contribute to these differences in satisfaction.

The flow and efficiency of an emergency department is impacted by the efficiency and performance of other departments within the hospital. If patients are boarded in the department as a result of other influencing processes, such as inpatient discharges, OR scheduling and/or timeliness of response by consults, it creates a bottleneck for the ED. Ensuring that communication between departments is proactive – such as with daily bed huddles or electronic tracking boards that include the anticipated emergency department admissions – allows proactive decision-making before bottlenecks occur.

Communication among departments is essential so that ED staff members are able to keep patients and family members updated. Additional trends including the use of electronic communication with patients such as texting, pagers and electronic billboards have emerged as creative ways of keeping patients informed about wait times. Other techniques for improved efficiency include having the physician or advanced practice provider as part of the triage team, expedited testing, protocols at triage and the use of patient liaisons. EDs are also beginning to use tools such as queuing analyses to determine optimal staffing and physical capacity needs for the random patient arrivals throughout the day.

## SATISFACTION WITH THE EMERGENCY DEPARTMENT BY TIME OF DAY ARRIVED



Data represent the experiences of 1,602,975 patients treated at 1,908 emergency departments nationwide from Jan.1, 2010, to Dec. 31, 2010.

## SATISFACTION PERFORMANCE

# ED Performance: Top 10 Metro Areas

Patient experiences can vary based on many factors, including where patients receive care. The following tables identify metropolitan areas with the highest levels of ED patient satisfaction (major metro areas – population greater than 1 million and smaller metro areas – population less than 1 million). Regions with the highest mean scores are setting a standard for excellence. Remaining competitive requires a concentrated focus on meeting patient needs and expectations.

As hospital leaders become more aware of what is important for providing patients a positive ED experience, the use of patient satisfaction to identify the greatest opportunity for improvement has led to creative and effective management. A continued evaluation of patient flow throughout the hospital; ongoing improvement of communication skills by physicians and staff; and committed focus to providing quality, efficient care yield high performance and provides an exceptional patient experience.

## MAJOR METRO AREAS

Rank	Major Metro Area	Score
1	Miami-Ft. Lauderdale	87.0
2	Hartford, Conn.	86.8
3	Indianapolis	86.5
4	Columbus, Ohio	86.4
5	Milwaukee	86.2
6	New Orleans	85.6
-	Boston	85.6
-	Philadelphia	85.6
9	Detroit	85.3
10	Chicago	85.2

## SMALLER METRO AREAS

Rank	Smaller Metro Area	Score
1	Wichita, Kan.	88.2
2	Madison, Wis.	87.4
3	Grand Rapids, Mich.	86.8
4	Greenville, S.C.	86.4
5	Honolulu	86.2
6	Allentown-Bethlehem, Pa.	85.8
-	Dayton, Ohio	85.8
8	Toledo, Ohio	85.7
-	Stamford-Norwalk, Conn.	85.7
10	Baton Rouge, La.	85.6

# A Fast Track to Success in the ED

## Vitals

The Reading (Pa.) Hospital and Medical Center is a not-for-profit health care center providing comprehensive acute care, post-acute rehabilitation, behavioral and occupational health services to the people of Berks and adjoining counties. It has 673 acute-care beds. Its current emergency department, opened in 2005, has 80 beds designed to accommodate 280 patients per day. The Level II trauma center is Joint Commission stroke-certified and is an accredited chest pain center.

## Challenge

Rising ED patient census was overwhelming the new, state-of-the-art ED. By 2008 it had reached daily capacity, and now serves an average of 350 patients per day. As volume rose, patient satisfaction scores decreased to the single digits in terms of national percentile ranking. Wait times continued to be high, reflected in the number of patients who chose to leave without being seen. Patients did not always wind up in the most appropriate place for care. Internally, other departments were quick to criticize the ED and its staff.

## Solutions

Using results from Press Ganey's Emergency Department Insights<sup>SM</sup> patient satisfaction survey tool, Reading's ED leaders identified needed changes, including placing a physician and nurse in triage, taking patients immediately from the front door to an ED patient room, standardizing treatment protocols and improving communication with patients on the progress of their treatment. Moving patients to the safest, most appropriate level of care, whether in the ED or another place in the hospital, quickly and efficiently, was a priority, as was treating patients in the ED using best practice evidenced-based guidelines in emergency medicine.

## Performance and Outcomes

In 2008 ED Director Michelle Trupp, RN, and Charles Barbera, MD, chairman of the department of emergency medicine, formed a patient-centered team that would provide a higher-quality patient experience and a work environment of empowered physicians and nurses.

The team held meetings with vice presidents of marketing, quality, operations and other parts of the organization that touched on the patient's ED experience. Studies were conducted of ancillary services that could lead to lower ED scores, such as lab and radiology turnaround times. "We wanted everyone to understand that the improvement effort and its success would ultimately belong to everyone," Barbera says.

Another important step in creating a team approach was revisiting the ED treatment protocols that guided how physicians and nurses responded to clinical needs. "We wanted standardization of care delivery: everyone on the same page and responding with a protocol that each individual would use in treating a patient," Barbera says.

Perhaps the greatest impact in improving the patient's experience was achieved with the introduction of having patients taken straight from the entrance to an ED bed, what Reading calls "immediate bedding." This streamlines the triage and registration process and prevents the patient from being pulled like a yo-yo from waiting room to triage back to waiting room to registration back to waiting room and finally to an open bed. Instead, the patient is greeted, quick-triaged and then placed in a patient room where full triage assessment, registration, medical history and protocol placement take place.

Once in the acute care area, patients and families are assisted by ED representatives or guest services assistants, who help with non-medical needs, including food, warm blankets, communication and, most importantly, information, so that patients and families are kept informed throughout their experience. Additionally, there is a fast track and intermediate care area for patients presenting with a chief complaint that can be resolved within 90 minutes to two hours.

## CASE STUDY

Patients waiting for admission or requiring additional evaluation are transitioned from the acute area to an observation unit where they are monitored by a physician, physician assistant or nurse. The relocation provides a more comfortable environment for the patient and prevents boarding in the ED.

A major area of dissatisfaction was with pediatric patients. Press Ganey scores associated with pediatrics were in the 36th percentile in 2008. A separate pediatric treatment area was created with a dedicated pediatric area and staff. Time targets, scripting for staff and communication plans have resulted in a vastly improved experience for Reading's pediatric population, meeting the hospital's goal for a length of stay of two hours or less.

The results of these efforts have been impressive. Overall ED patient satisfaction scores increased from the low single digits as a national percentile to a sustained ranking in the 70th-plus percentile and the 99th for EDs with comparable patient volumes. For the observation area, the overall score rose from the 52nd percentile in 2008 to the 88th in 2010. In pediatrics, the overall score has reached the 88th percentile.

# Employees

Hospital leaders need to find additional opportunities for employees to have their say, ensure that employees feel they are getting adequate coaching and increase opportunities for performance recognition, according to the Employee Partnership Priority Index.

Three of the five items on the priority index relate to employee input – influencing policies/decisions, listening and asking for opinions – indicating that the opportunity to provide feedback to hospital leadership is a key factor in employee satisfaction and engagement. The other two items in the priority index focus on coaching and recognizing performance.

These findings also suggest employees want to interact with leaders in a meaningful way and to be respected for more than simply fulfilling a role. In a time when health care organizations have experienced a record number of layoffs, employees not only want to be recognized and validated as important players in the organization, they also want to know that their efforts to go above and beyond and their work will benefit them in some way (i.e., job security, increased opportunities, compensation, etc.).

Senior leaders should formalize efforts that regularly recognize and reward employees for excelling at their jobs and for identifying innovative performance improvement ideas. A key part of a formal effort is to institute a performance review/coaching system that is meaningful to employees.

## EMPLOYEE PARTNERSHIP PRIORITY INDEX

Survey Item	Mean	Correlation	Priority Rank
Excellent performance is recognized here	64.4	0.732	1
I have opportunities to influence policies and decisions that affect my work	58.2	0.703	2
Leaders really listen to employees	62.0	0.721	3
My direct manager provides coaching to help me achieve my goals	69.6	0.739	4
My work group is asked for opinions before decisions are made	55.0	0.696	5

Survey items are correlated to Partnership Score. Based on responses of 253,734 employees from 443 hospitals received from Jan. 1, 2010, to Dec. 31, 2010.

## PARTNERSHIP PERFORMANCE

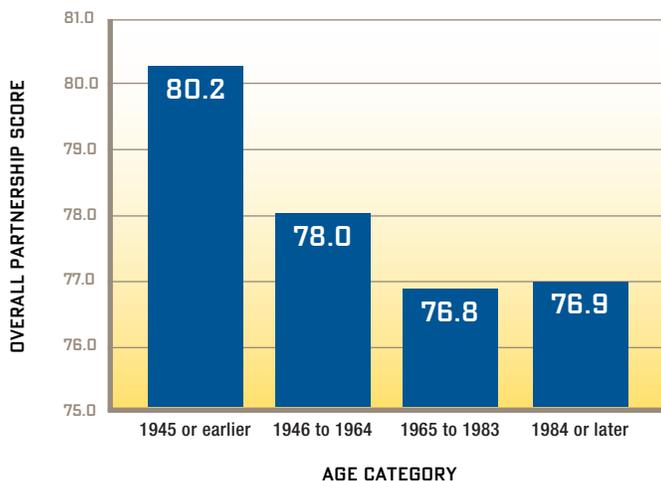
## Employee Partnership by Age

A clear generational difference in partnership is highlighted in the graph below. Older employees (those born in 1945 or earlier) tend to be the most engaged, while the youngest employees (those in the two youngest age categories) tend to be the least engaged.

Age has always played a fairly remarkable role in influencing an employee's perception of one's work role and responsibilities. Employees of different generations have been influenced by multiple forces that have shaped their perceptions of employer-employee relations, work-life balance, etc. Press Ganey has consistently found that the oldest employees tend to have the most positive view of the organization. Older workers may be in the workforce because they want to be and not necessarily because they have to be.

The projected demands of an aging population on health care organizations, coupled with an aging nursing workforce, is creating a dual challenge for many hospital leaders: how to retain the older nurse in the workforce and how to engage younger employees.

### OVERALL PARTNERSHIP BY AGE CATEGORY



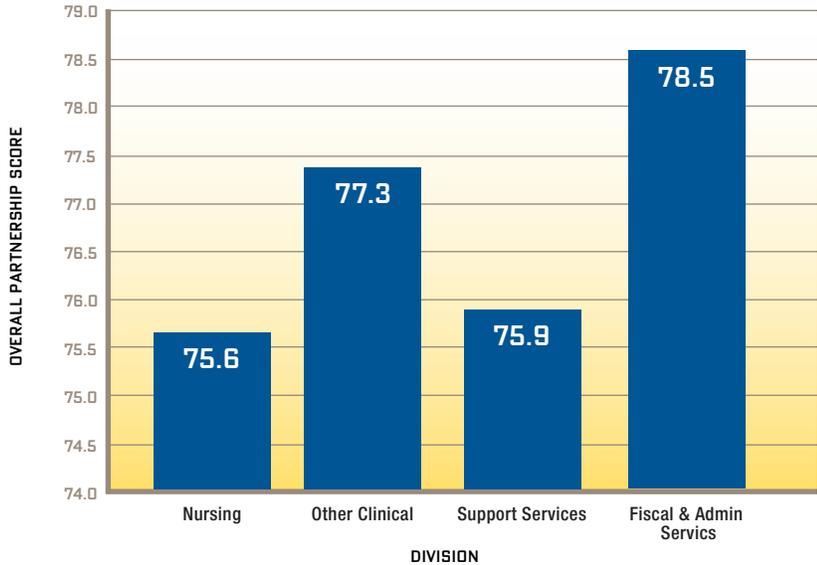
Survey items are correlated to Partnership Score. Based on responses of 253,734 employees from 443 hospitals received from Jan. 1, 2010, to Dec. 31, 2010.

# Employee Partnership by Division

As in past research, the national experience reveals that the closer the employee is to the patient, the lower his or her workplace satisfaction and engagement. Fiscal and administrative service workers are more engaged than all other types of workers.

The Press Ganey Consulting Group advises that this finding underscores the need for hospital leaders to avoid leading in isolation and to be purposefully connecting with a wide array of workers in the organization, especially those who are closest to the patient and the patient's family.

## OVERALL PARTNERSHIP BY DIVISION



Survey items are correlated to Partnership Score. Based on responses of 253,734 patients from 443 hospitals received from Jan. 1, 2010, to Dec. 31, 2010.

## PARTNERSHIP PERFORMANCE

## Physicians

**Priority Index**

Four of the five top issues in the Physician Partnership Priority Index are related to communication and collaboration. However, they also reflect physicians' interest in having a voice in decisions that relate directly to how care is delivered to their own patients. For example, an endocrinologist specializing in the care of diabetics may want to be involved in decisions about the delivery of diabetic care in the hospital.

Another primary concern for physicians is making patient care easier. The desire for highly efficient, smooth delivery of care is a critical driver for physicians. Whether it is OR turnover, a user-friendly electronic medical record or rapid lab and radiology turnaround times, hospital efficiency impacts physicians daily. Inefficiencies affect the delivery of patient care as well as physician productivity. For example, delayed test results can extend a patient's hospitalization and negatively impact a hospital's finances. Physician, patient and hospital interests are all aligned on this priority.

**PHYSICIAN PARTNERSHIP PRIORITY INDEX**

Survey Item	Mean	Correlation	Priority Rank
Administration seeks beneficial solutions	64.6	0.58	1
Treated as valued member	68.2	0.60	2
Responsiveness of hospital administration	65.3	0.57	3
Physicians involved in decisions	62.5	0.55	4
Patient care made easier	75.4	0.71	5

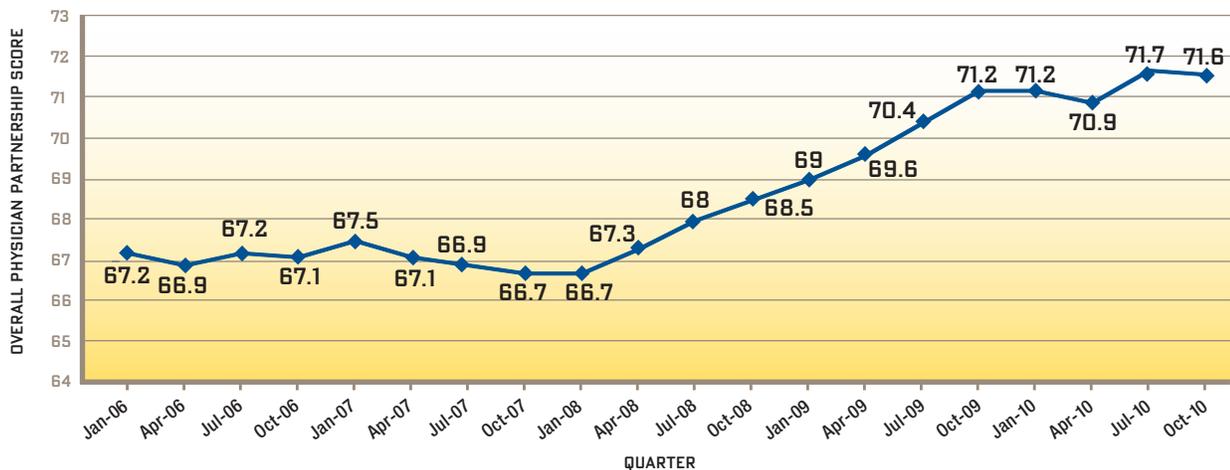
Survey items are correlated to "likelihood to recommend facility to friends and family." Based on 39,598 survey responses from 405 facilities received from Jan. 1, 2010, to Dec. 31, 2010.

# Physician Partnership Trends

There has been an ongoing upward trend in physician partnership over the past five years. More recently, there seems to have been a plateau from October 2009 through April 2010 and then again from July 2010 through October of 2010. Although there is still ample room for improvement, the general upward trend is a sign that efforts to improve relations with physicians have been successful.

As hospitals that regularly survey their physicians have gained better understanding of the operational concerns of their physicians, these organizations have been focusing on improvements, which are reflected in upward trends. The Press Ganey Consulting Group has seen that some have focused on improving the quality of nursing or increased collaboration between nurses and physicians. Other hospitals have developed improvement plans targeting satisfaction with radiology, clinical laboratories, the emergency department or ease of admitting patients. These kinds of initiatives have broad implications – as hospitals improve the quality and efficiency of their facilities in response to their physicians, patients benefit as well.

## FIVE-YEAR TREND IN PHYSICIAN PARTNERSHIP

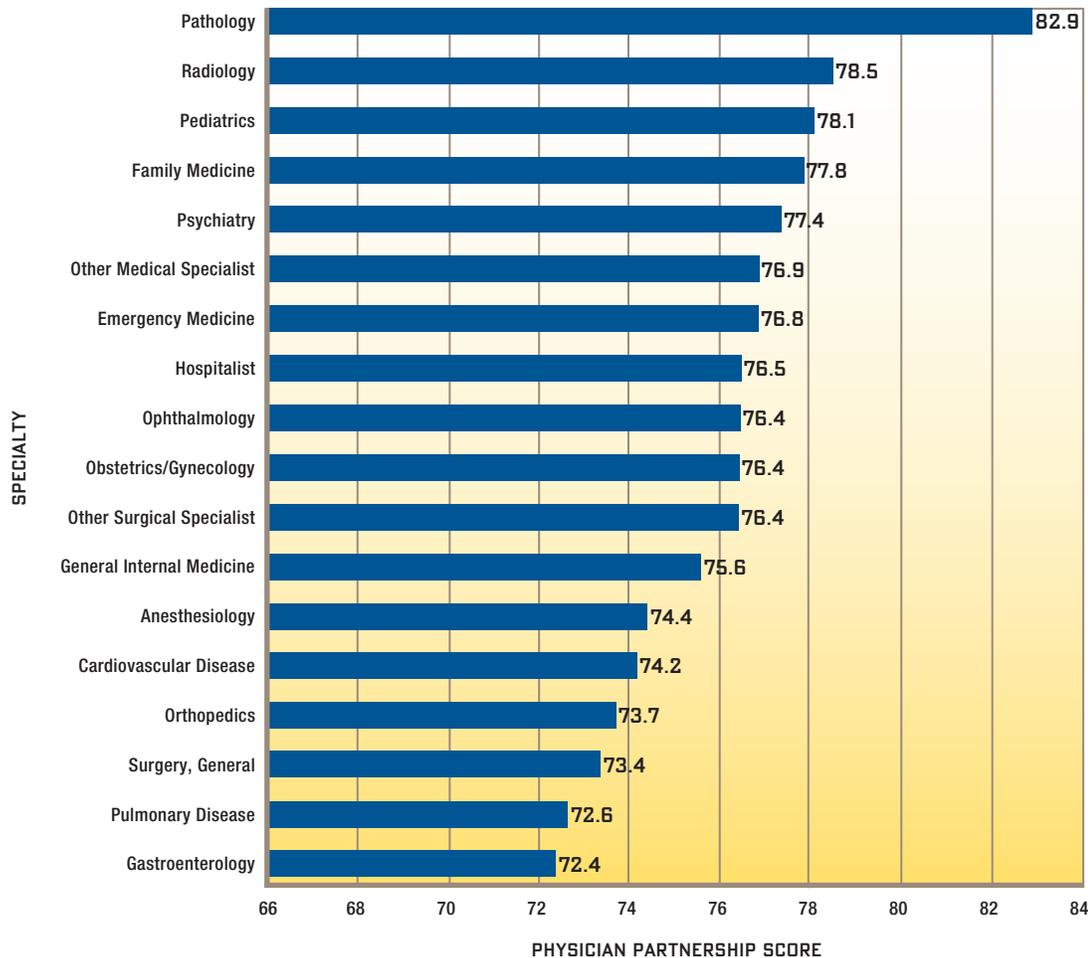


Based on 39,598 survey responses from 405 facilities received from Jan. 1, 2010, to Dec. 31, 2010.

## PARTNERSHIP PERFORMANCE

## Physician Partnership by Specialty

## PATHOLOGY, RADIOLOGY SURGE TO THE FORE



Based on 39,598 survey responses from 405 facilities received from Jan. 1, 2010, to Dec. 31, 2010.

Physicians specializing in pathology, radiology and pediatrics are the most satisfied; these same three specialties had the highest satisfaction last year. In comparison, physicians specializing in general surgery, pulmonary disease and gastroenterology were the least satisfied.

This represents a change from 2009, when cardiovascular disease and hospitalists were the specialties that ranked the lowest in satisfaction. The increase in hospitalist satisfaction is particularly noteworthy since hospital medicine is a new and quickly growing field.

Because they are hospital-based, hospitalists are now centrally involved in helping drive quality initiatives and process improvements in most hospitals. Their satisfaction and engagement are increasingly critical to hospitals being able to achieve goals related to patient safety, quality and patient satisfaction.



**3.1**  
million  
patient experiences  
and counting

# Medical Practice

The top priority item for medical practices is sensitivity to patient needs, indicating a need for medical practices to personalize their interactions with every patient. The remaining top-priority items all reference patient satisfaction with the care provider, with a common theme of patient communication and encouragement of patient engagement and participation in care.

Today, physicians and medical practices need to serve the “whole” patient. This often extends to understanding a patient’s culture, the relationship with a patient’s family or caregivers, and the unique communication needs individual patients may have. Press Ganey consultants have seen that validating patient concerns and confirming comprehension are critical to ensuring compliance with treatment protocols, and also increases the likelihood for better outcomes and greater patient satisfaction.

## MEDICAL PRACTICE PRIORITY INDEX

Survey Item	Mean	Correlation	Priority Rank
Our sensitivity to your needs	73.3	0.721	1
Likelihood of your recommending this care provider to others	79.0	0.716	2
Concern the care provider showed for your questions or worries	83.2	0.791	3
Care provider's efforts to include you in decisions about your treatment	84.1	0.896	4
Instructions the care provider gave you about follow-up care (if any)	83.9	0.699	5

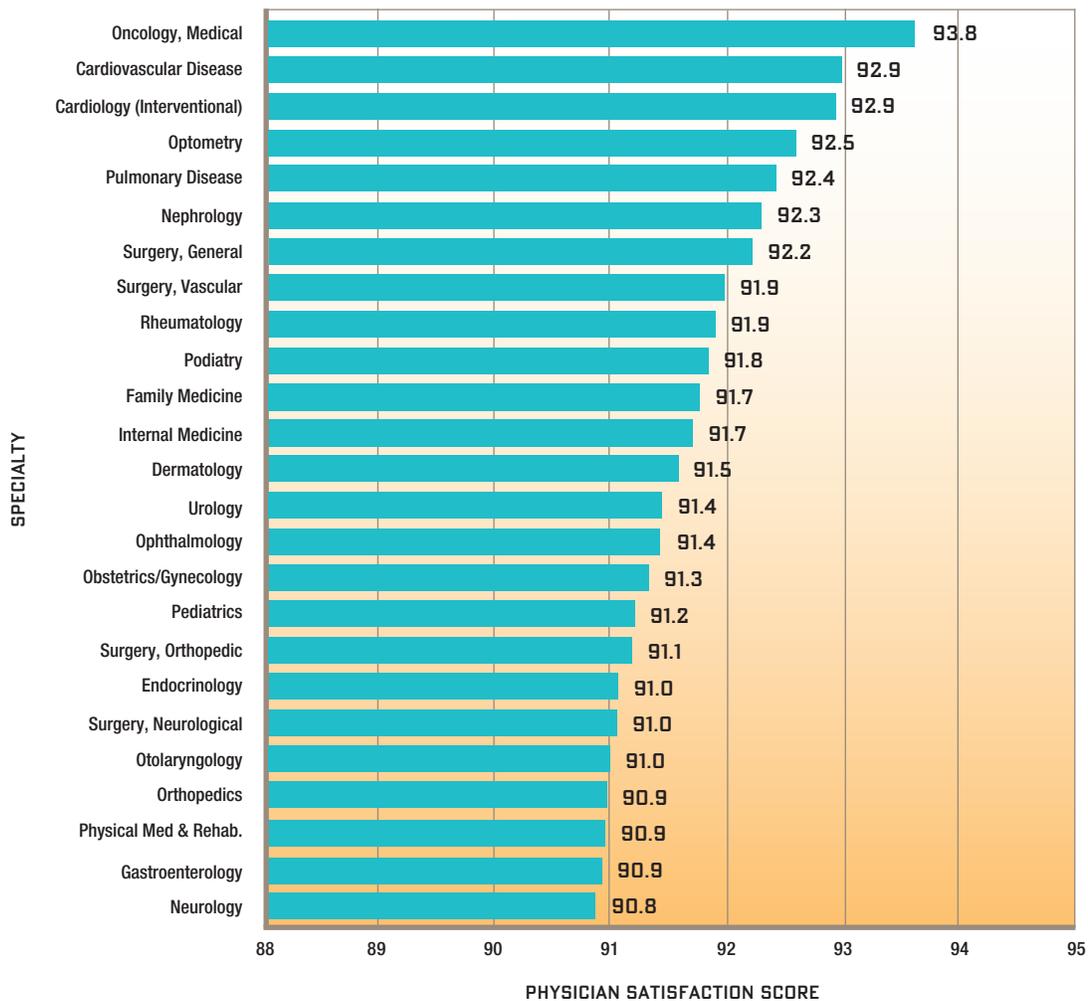
Survey items are correlated to “likelihood to recommend facility to friends and family.” Data are based on 3,165,906 survey responses from 721 facilities received from Jan. 1, 2010, to Dec. 31, 2010.

# Top 25 Medical Specialties

Oncology practices experience the highest level of overall patient satisfaction, followed by cardiovascular disease and cardiology.

Patients with cancer and heart disease tend to develop significant relationships with their doctors and the practices that serve them. All physicians tend to achieve high satisfaction ratings, but these specialties top the charts due to their sensitivity to patient needs, excellent communication and involvement of their patients in the care decision process.

## OVERALL SATISFACTION IN TOP 25 MEDICAL PRACTICE SPECIALTIES



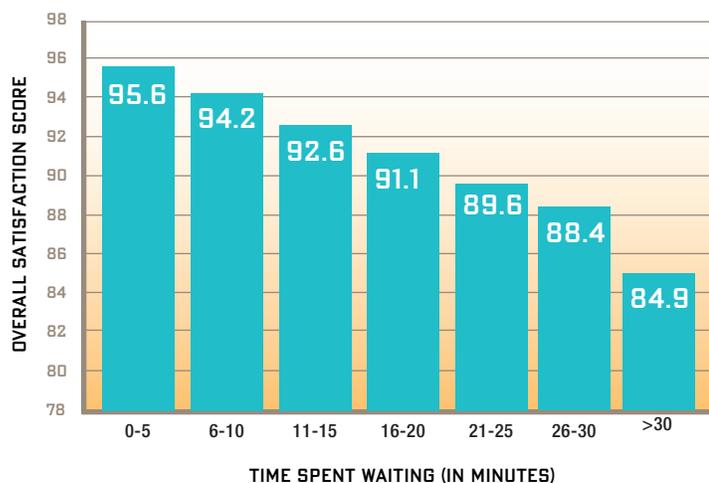
Data are based on 3,165,906 survey responses from 721 facilities received from Jan. 1, 2010, to Dec. 31, 2010.

# Medical Practice Satisfaction by Waiting Times

Consistent with the pattern observed in previous years, patients who spend less time waiting to see their providers are more satisfied with their office visit than patients who have longer wait times. It is important to remember that while most patients expect some amount of wait time upon arrival, they also expect that staff will acknowledge the value of their time by setting appropriate wait time expectations and explaining the reason for delay.

Communication about wait times has a direct impact on patient satisfaction. Press Ganey research shows that if patients are told how long they will wait, their frustration with waiting is often diminished. Many practices have begun to post wait times in their reception area and this has helped to establish patient expectations while also encouraging physicians and staff to improve. In some cases, just posting the wait times has caused the wait to diminish.

## LOWER WAITS, HIGHER SATISFACTION



Based on 3,165,906 survey responses from 721 facilities received from Jan. 1, 2010, to Dec. 31, 2010.

Note: The standard section and overall satisfaction scores for the 2010 data were calculated using only those 19 individual questions that are common to the standard question set on both the old and newly revised medical practice survey.

# Mystery Shopping and Shadowing Champions in a Medical Practice

## Vitals

Florida Physicians Medical Group (FPMG) is the Orlando, Fla., area's largest multi-specialty medical group practice. Its 225 board-certified physicians and surgeons in more than 30 medical specialties work in over 90 practice locations throughout central Florida.

## Challenge

Two years ago, FPMG had no formal process for measuring or improving patient satisfaction. Leaders began to discuss how to formalize the assessment of customer service. Having so many practice locations spread out over a large geographic region, each with its own legacy modes of behavior, meant the challenge wasn't insignificant. The first satisfaction survey found that overall satisfaction with FPMG placed it in the 54th percentile of the national database. Scores were particularly low for the overall visit, at the 40th percentile; and nurse/assistant, at 39th percentile. "Our leadership was not pleased with the 54th percentile," says Cynthia Parent, FPMG's director of operations. Under her leadership, the organization set a goal to have each practice at or above the 75th percentile nationally.

## Solutions

FPMG adopted the Press Ganey Patient Visit Insights<sup>SM</sup> solution. In weekly calls, a Press Ganey client improvement manager, and Katavi Jones, program manager for patient satisfaction, discussed phone etiquette and scripting. It also was recommended that FPMG use mystery shoppers to find out what was going on at their locations and adopt proven practices at their other sites. Another key tool is "shadowing champions."

## Performance and Outcomes

Like many organizations that have succeeded in dramatically raising patient satisfaction scores, FPMG has worked hard on customer service problems identified by its Press Ganey Priority Index, using a multi-pronged approach.

Employee education now begins at orientation, where Parent and Jones lead the customer service portion of the event. Using a presentation called The Journey to Preeminence, the two walk new employees through a range of expected behaviors. For example, a segment covers "compassion behaviors." These include what to say when entering a patient exam room (name and title, along with what the employee is doing there); how to listen actively; how to project a positive image and energy; and how to go above and beyond in engaging patients and families, including creating surprises and special moments.

"Customer service is vital to our success, and we stress the importance with all our staff throughout the organization such that it now represents 20% of their annual performance evaluation score," Parent says.

For practices that have an overall ranking below the 50th percentile, Jones and Parent have crafted an in-service program on customer service. "We have each practice go through its Press Ganey report and tell us three things they want to improve on during that quarter. We then do a site visit and an in-service for all staff members," Jones says.

Jones starts each site visit by having employees fill out a form that lists things they like and dislike, looking for what motivates them. The results, she says, let managers know a little bit more about their staff. "Then we talk with employees about helpful phone tips, such as smiling when on the phone. We talk with clinicians about how they greet the patient; how to break down any fears that the patient may have with coming into the practice. We also go over Hot Comments<sup>®</sup> and how to utilize them to improve specific items quickly," she says.

At Press Ganey's urging, Jones has become the main "mystery shopper," playing the role of a patient both on the phone and in person. "I can quickly find out if there is breakdown in registration," Jones says.

FPMG has also adopted the strategy of having employees who need extra training on areas such as answering telephones or speed of registration to spend time with employees at other practice sites that excel in those areas. "We try to

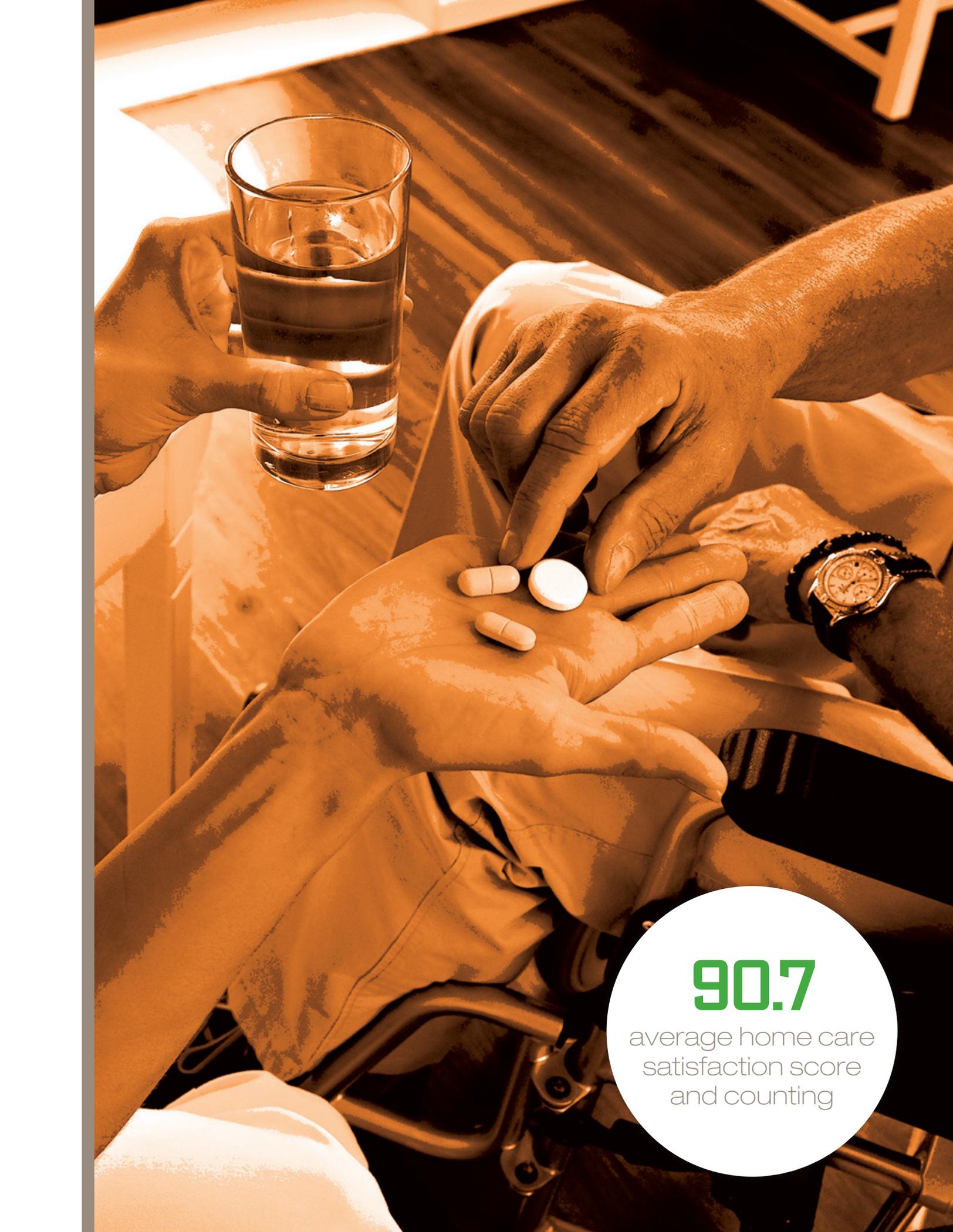
## CASE STUDY

identify our customer service stars in each area,” Jones says. “A practice manager may contact me with an issue where employees need help. I will contact another manager and say, ‘You are doing really well on registration; do you mind if a couple of sister employees come over and shadow your registration people to see how you do it?’ Observing someone in the same position who has succeeded in projecting a friendly attitude, it hits home a little more than me just going in and telling someone how to do something.”

FPMG’s employees and patient satisfaction team have focused diligently on the patient experience, and this has paid off. The overall satisfaction rating for FPMG rose to the 78th percentile nationally in late 2010.

Three other areas of significant focus also improved dramatically:

- Helpfulness on the telephone started at the 54th percentile on its first Press Ganey survey in 2009; by the third quarter of 2010, it had risen to the 83rd percentile nationally.
- Access to care started at the 56th percentile in 2009 and is now at the 79th percentile nationally.
- Likelihood to recommend practice rose from the 68th percentile to the 86th percentile.



**90.7**

average home care  
satisfaction score  
and counting

# Home Care

Issues of highest priority to home care patients are front-office responses to requests to change caregivers and patient problems or complaints. In addition, issues of improved patient well-being, addressing patients' emotional needs and the agency's handling of emergencies are priorities for this population.

The Press Ganey Consulting Group advises that diligently monitoring issues identified by patients as priorities provides the opportunity to focus improvement effort on what will have the greatest impact on the patient experience. It offers the following tips to help with this:

- Ensure that front-line staff is involved in patient satisfaction discussions.
- Create teams to review and develop suggested solutions to those issues that present most often.
- Provide ongoing customer service education and training for all employees and have service standards in place to serve as a guide for interactions and response to patients. Everyone's anxiety is reduced when responses are cordial, efficient and effective. Establish an expectation of consistency in response through training, team collaboration and ongoing evaluation of patient feedback.

## HOME CARE PRIORITY INDEX

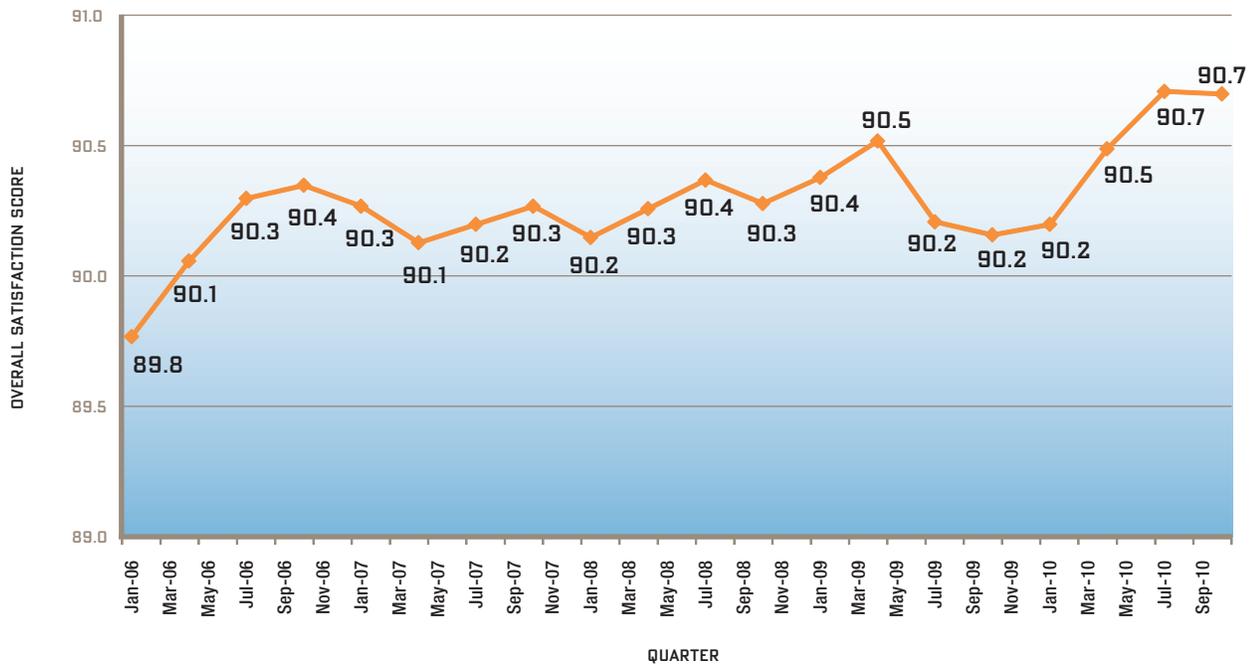
Survey Item	Mean	Correlation	Priority Rank
Request change nurse/aide handled	86.7	0.632	1
Office dealt with problem/complaint	87.1	0.621	2
Overall improvement in well-being	89.5	0.704	3
Staff addressed emotional needs	88.9	0.644	4
Office handled emergencies	88.1	0.627	5

Survey Items are correlated with patient ratings of 'likelihood to recommend' a home health agency to others. Data represent the experiences of 252,840 patients treated by 1,145 home health sites nationwide from Jan. 1, 2010, to Dec. 31, 2010.

# Home Care Five-year Trend

Home care satisfaction improved in 2010, following a drop-off from the spring of 2009 through early 2010. Patients have a consistently high regard for home care and the services that allow them to recuperate, recover and rehab at home. Patients acknowledge the benefits of receiving care from those agencies that have a culture focused on patient improvement and service excellence.

## FIVE-YEAR TREND IN HOME CARE SATISFACTION



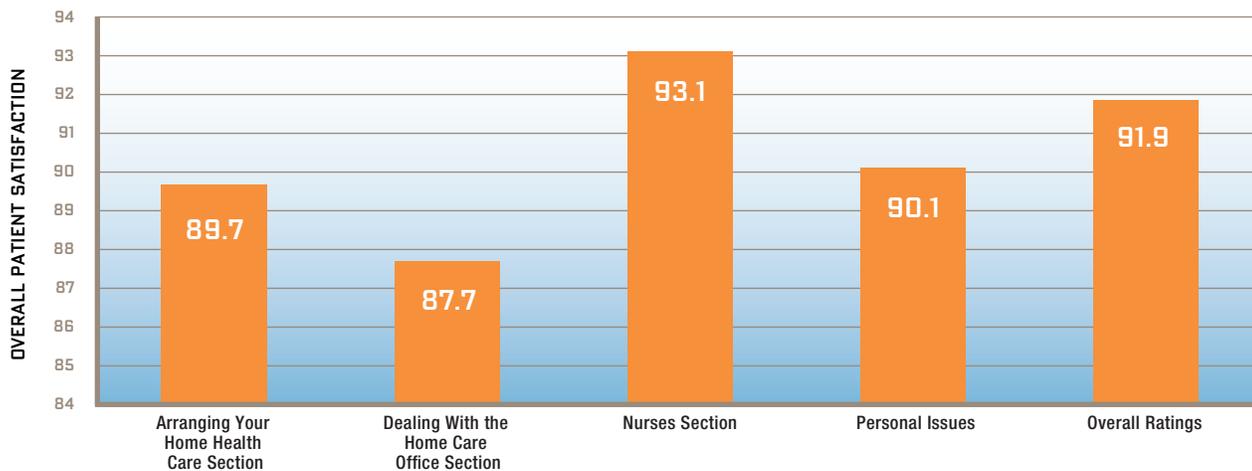
# Home Care Satisfaction with Operations

Nurses create the greatest amount of satisfaction among home care patients. Satisfaction with the agency's handling of patients' personal issues is somewhat lower, as is satisfaction with the agency's handling of arrangements for care. Dealings with the home care office were least satisfactory. Overall patient ratings – a combination of all survey sections – are high.

Patient compliance and improvement is greatly influenced by the confidence and comfort of the relationship with the nurse. Based on the experience of the Press Ganey Consulting Group in working with home care agencies, an important aspect of managing patient/family anxiety is ensuring that there is clear, concise communication on what clinical care is being provided, how and why it is being provided, as well as an opportunity for the patient to respond and ask questions. It is also important that the patient be kept informed in a timely manner if there is a delay in the nurse arriving at the appointed time, or if there is a change in who will be providing care that day.

Additionally, it is essential that patients and family be educated on communicating with the agency. It is important to provide pertinent phone numbers, contact information and a guide for when and how to use the information. Navigating a complicated phone menu can be frustrating and intimidating, leading to increased anxiety.

## SATISFACTION WITH HOME CARE OPERATIONS



Data represent the experiences of 252,840 patients treated by 1,145 home health sites nationwide from Jan. 1, 2010, to Dec. 31, 2010.

# A New Mission for Kaiser Home Care

## Vitals

With 19 home health agencies providing three quarters of a million annual patient visits across the continental West and Hawaii, Kaiser Permanente is one of the nation's larger providers of care in this sector.

## Challenge

Like many home care organizations, Kaiser was spurred into action by the onset of public disclosure of patient satisfaction scores and rankings. By the spring of 2012, the Centers for Medicare and Medicaid Services will begin public reporting of data from the Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Agencies have already begun collecting survey data. Kaiser believes that higher patient satisfaction leads to better clinical quality. Decreasing patients' anxiety increases their compliance with treatment and makes them open and honest, which means better clinical care as a result.

## Solutions

Kaiser uses Press Ganey's HCAHPS Insights<sup>SM</sup> survey tool to guide decision-making. It created a position of national service quality consultant for home care, and hired Shruti Kothari to fill it. She has driven along with dozens of front-line home health workers as they make patient visits in California, Hawaii and the Pacific Northwest. She has interviewed dozens more workers at nine Kaiser Permanente home care agencies. She has compiled reports on her findings and conducted two major presentations to all staff at regional events. And she leads monthly phone calls with representatives from each of the organization's four home care regions to ensure the promotion of best practices.

## Performance and Outcomes

Kothari's widespread efforts have yielded clear areas of potential improvement: communication, patient engagement, and courtesy and respect.

Under communication, she found that explaining key concepts clearly to patients and what the caregiver is in the home that day to do is critical to patients feeling they are part of the process.

One best practice she learned while on one of the many ride-alongs she did with home care staff was related to the use of a computer in the home. "Sometimes the nurse would be typing in complete silence for 10 minutes. That may not seem like a long time, but it's long enough that the patient can get really antsy and frustrated. I watched one clinician, however, who set up the computer, turned to the patient, and said, 'Now I am going to take a few minutes recording the things we did today, so the entire team is kept up-to-date about your care.' Later, he took a few seconds to read out loud what he was entering, such as 'Ms. Smith was able to walk up and down stairs today.' "

Disseminating those best practices is now a key to her job, Kothari says. A lot of service improvement results from similarly small details, she says.

At kickoff events in Northern and Southern California earlier this year, she presented her findings to hundreds of front-line staff and agency leaders. The five-hour sessions started with general presentations to all staff on surveys, what the questions mean and what the scores reflect. Then, she and her colleagues, along with a Press Ganey client improvement manager, met with agency leaders, teaching them how to use Press Ganey Online, how to create ad-hoc survey data reports, and how to read data and comment reports.

Kothari also leads monthly conference calls with designated point people from each region, a leader of Kaiser Permanente's data team, the service director in the national office and Press Ganey. "We try for group consensus around what we are going to be doing to improve," she says. "This is really trying to replicate what we found in our hospitals – when improvement efforts were driven regionally and nationally with consistency, that's when we saw broad-based improvement in patient experiences and increases in patient satisfaction scores."

## CASE STUDY

So far, Kaiser Permanente hasn't established numerical goals for scores. "Right now we have a lot of energy and engagement on improving. If we focus too much on the numbers right away, we think we will lose that focus and enthusiasm," Kothari says.

### Home Care and Rehospitalizations

One of the big quality-of-care efforts in Kaiser Permanente home care, reflecting Medicare's new focus, is on reducing avoidable hospitalizations. "It's kind of a large, 10,000-foot-view quality measure, but we think it is a good one," Kothari says. "Because you can say, 'Oh, well, I did that or I did this to improve care,' and that's great, but if the patient is winding up back in the hospital, you didn't do enough. If you can keep patients happy and healthy in their homes, that's good for everyone."

That effort has found particular expression in Hawaii, where the home care team on Oahu is partnering with the Hawaii Permanente Medical Group director to improve care transitions from hospital to home health and to the primary care physician.

"Over a year ago, we started testing the idea of having our medical director – who is a continuing care physician and therefore covers the hospital as well – be a bridge for all referrals from the hospital," says Gary A. Wong, MSPT, CHCA, Kaiser Permanente's administrator for home health and rehab services in Hawaii. The medical director signs off on all home health patient plans of care, if referred from the hospital; discusses high-risk/complex patients with the home health staff during an intra-disciplinary one-hour weekly meeting; adjusts, terminates and creates new orders for the patients to ensure timely and optimal care; and does just-in-time training/instructions for home health providers to improve competencies and knowledge.

"These key elements have helped improve our ability to care for our high-risk patients and reduce our hospitalization rate," Wong says.

In 2010, Kaiser Permanente-Oahu achieved a non-case mix adjusted hospitalization rate of 15%, which was in the top 15th percentile in the nation.

# Methodology

## Clinical Performance

The trends and analysis presented in the clinical section of this report come from Press Ganey's Quality Performer<sup>SM</sup> patient-level core measures database, which includes data from more than 600 hospitals that use Press Ganey to meet regulatory and accreditation reporting requirements. Composite scores for core measures sets are calculated using the CMS composite methodology, which puts the sum of the numerator cases for each measure in a set (e.g., acute myocardial infarction over the sum of the denominator cases for each measure in a specific set).

## Inpatient

Press Ganey's Inpatient Insights<sup>SM</sup> survey gives recently hospitalized patients the opportunity to provide feedback about their hospital stay. The survey is used by acute-care hospitals across the United States to improve the quality of the service and care they deliver. Press Ganey's survey consists of 38 standard questions organized into 10 sections: admission, room, meals, nurses, tests and treatments, visitors and family, physician, discharge, personal issues, and overall assessment.

Patients are surveyed soon after their discharge from the hospital, while their hospital experiences are still fresh in their mind. Upon receipt by Press Ganey, completed surveys are processed and added to a national database. Press Ganey complies with the Health Insurance Portability and Accountability Act, which establishes national standards for the security and privacy of health data.

## Outpatient

Press Ganey's Outpatient Insights<sup>SM</sup> and Ambulatory Surgery Insights<sup>SM</sup> surveys give patients who have been treated in various outpatient settings the opportunity to provide feedback about their experiences. The surveys are used by medical practices, ambulatory surgery centers and outpatient facilities across the United States to improve the quality of the service and care they deliver.

Each Press Ganey survey consists of a set of standard questions organized into sections. The outpatient services survey contains 17 standard questions within five sections: registration, test or treatment, facility, personal issues, and overall assessment. The outpatient surgery survey contains 29 standard questions within six sections: registration, nursing, physicians, facility, personal issues and overall assessment.

## Emergency Department

Press Ganey's Emergency Department Insights<sup>SM</sup> gives patients who have been treated and released from emergency departments the opportunity to provide feedback about their stay. The survey is used by emergency departments across the United States to improve the quality of the service and care they deliver. Press Ganey's survey consists of 31 standard questions organized into eight sections: arrival, nurses, doctors, tests, family or friends, personal/insurance information, personal issues and overall assessment. Data discussed in this report – including data on time spent in the ED – are patient-reported.

Surveys are sent to patients shortly after they visit the emergency department, while the experience is still fresh in their mind. Only patients who are discharged from the emergency department receive a questionnaire; those admitted to the hospital are not eligible for an emergency department survey. Upon receipt by Press Ganey, completed surveys are processed and added to a national database. Press Ganey complies with the Health Insurance Portability and Accountability Act (HIPAA), which establishes national standards for the security and privacy of health data.

## Employee Partner

Press Ganey's Employee Partner<sup>SM</sup> survey gives health care employees the opportunity to provide feedback about their employment situation. The survey is used by health care facilities across the United States to improve the quality of their employees' workplace experiences. Press Ganey's survey consists of 39 standard ratings questions organized into seven sections: systems and leadership, resources, teamwork, direct management, my work, our work and our organization.

Clients may administer surveys to groups of their employees; alternatively, employees may receive a survey, or a letter containing an Internet address and PIN that connects to a survey, through the mail. Upon receipt by Press Ganey, completed surveys are processed and added to a national database. Press Ganey maintains employee confidentiality and does not report results for groups of fewer than three employees.

## Physician Partner

Press Ganey's Physician Partner<sup>SM</sup> survey consists of 20 questions organized into four sections: quality of patient care, ease of practice, relationship with leadership and overall assessment. Client hospitals supply Press Ganey with a list of physicians on their active medical staff. Press Ganey mails a survey to each physician on the list. The physician may choose to complete and return the printed survey or may complete it on the Internet.

## Medical Practice

Press Ganey's Patient Visit Insights<sup>SM</sup> medical practice survey gives patients the opportunity to provide feedback about their experiences. The surveys are used by medical practices across the United States to improve the quality of the service and care they deliver. The Patient Visit Insights survey consists of standard questions organized into the following sections: access to care, during your visit, your care provider, personal issues and overall assessment.

Patients are mailed surveys or are called within three to five days of their office visit, while their experiences are still fresh in mind. Upon receipt by Press Ganey, completed surveys are processed and added to a national database. Press Ganey complies with the Health Insurance Portability and Accountability Act (HIPAA), which establishes national standards for the security and privacy of health data. Press Ganey recently introduced electronic surveying (eSurvey) which involves administering a web-based survey delivered via e-mail to a patient right after a visit. The eSurvey approach allows a practice to capture feedback quickly and efficiently, complementing the mail survey methodology.

## Home Care

The Home Health Insights<sup>SM</sup> survey is used by private duty nursing and traditional home care agencies to improve the quality of their service. This survey consists of 38 standard questions in six sections: background, arranging your care, managing your care, nurses, personal issues and overall ratings. Press Ganey recommends that patients receive their survey after the first month of service.

Surveys are mailed to patients soon after discharge, while their experiences are still fresh in mind. Upon receipt by Press Ganey, completed surveys are processed and added to a national database. Press Ganey complies with the Health Insurance Portability and Accountability Act (HIPAA), which establishes national standards for the security and privacy of health data.

## For All Sections – Excluding Clinical

### Definition and Calculation of Mean Score

Surveys received by Press Ganey are processed and added to the client's electronic data storage area. Processing takes place immediately to provide clients with up-to-the-minute information about their service quality. Responses to survey questions are converted to a series of 100-point maximum scales so that clients can compare different aspects of their performance on a common yardstick. First, for each person who took the survey, responses to the survey questions are transformed from a five-point scale to the 100-point scale. Items rated "Very Good" are awarded 100 points; those rated "Good," 75 points; items rated "Fair," 50 points; "Poor," 25 points; and any items rated "Very Poor" are awarded zero points. Next, each respondent's individual item scores within a survey section (see above) are averaged to become scores for each section. Finally, section scores are averaged to become that respondent's overall satisfaction score. The average of all respondents' overall satisfaction scores is called the client's overall mean score and is stored electronically and made available to the client.

### Definition of Correlations

A correlation indicates how much a change in one variable (e.g., an item score) is associated with a concurrent systematic change in another variable (e.g., overall satisfaction). A correlation represents the strength and direction of the relationship between two variables numerically, expressed using a correlation coefficient (called *r*) which can range from -1.0 to +1.0. The greater the distance from zero, the stronger the relationship is between the two correlated items. A positive correlation coefficient indicates that as the value of one variable increases, the value of the other variable also increases. A negative correlation coefficient indicates that as the value of one variable increases, the value of the other variable decreases. It is important to recognize that when two variables are correlated it means that they are related to each other, but it does not necessarily mean that one variable causes the other.

### Priority Index Calculation

The Priority Index is an ordered list of survey items that shows the areas needing the most improvement. Survey items on the Priority Index are arranged from the "first item to work on" to the "last item to work on." The Priority Index reflects service issues on which clients are performing poorly that are important to their patients. It is calculated by looking at two aspects of each survey item's data: (1) its average score, and (2) how well it mirrors the respondent's overall satisfaction score, as determined above. Survey items that (1) have low average scores, indicating that the facility's quality for that aspect of its care is lacking relative to other care aspects, and (2) faithfully mirror the respondent's overall satisfaction score, will have high Priority Index scores.

# About Press Ganey

Recognized as a leader in performance improvement for 25 years, Press Ganey partners with more than 10,000 health care organizations worldwide to create and sustain high performing organizations, and, ultimately, improve the overall health care experience. The company offers a comprehensive portfolio of solutions to help clients operate efficiently, improve quality, increase market share and optimize reimbursement. Press Ganey works with clients from across the continuum of care – hospitals, medical practices, home care agencies and other providers – including 50% of all U.S. hospitals. For more information, visit [pressganey.com](http://pressganey.com).

All data and findings represent surveys returned by patients and physicians to Press Ganey clients.

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