Why Does Improving Patient Experience and Hospital Financial Performance Begin with Strategic and Leadership Development?

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- Questions


CFA
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Background of the Study

State of the U.S. Population Health

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

Triple-Aim Initiative
(Berwick, Nolan, & Whittington, 2008; IHI, 2009)

- 1. improve the experience of care,
- 2. improve the health of populations, and
- 3. reduce per capita costs of health care.

Background of the Study

Patient Protection and Affordable Care Act (ACA)

- A shift in reimbursements from volume to value (***HVBP***=Hospital Value-Based Purchasing)
- Patient experience survey (***HCAHPS***=Hospital Consumer Assessment of Healthcare Providers and Systems)

Financial Challenges of U.S. Hospitals

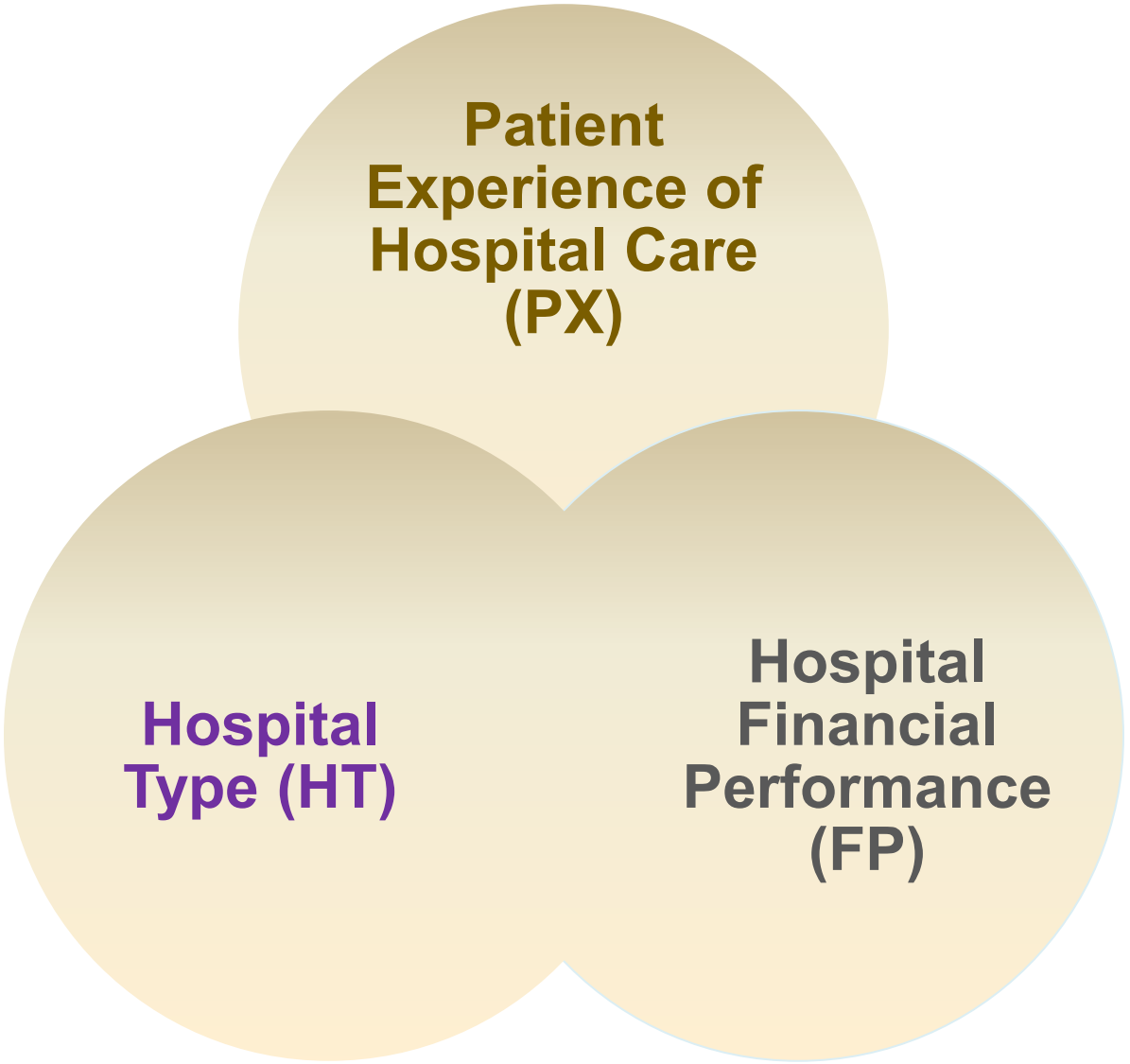
- A top concern of U.S. hospital CEOs for more than 10 years (ACHE, 2013, 2014, 2015, 2016).

Two Study Objectives

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

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

Three Players: Patient Experience, Financial Performance, and Hospital Type



To Answer Two Research Questions

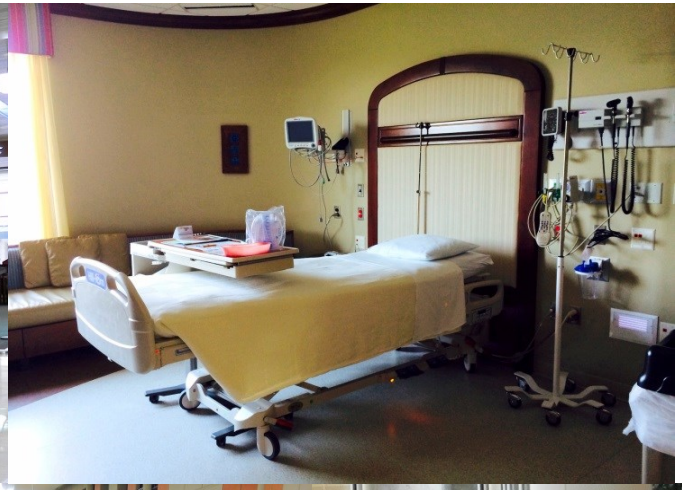
Research Question 1

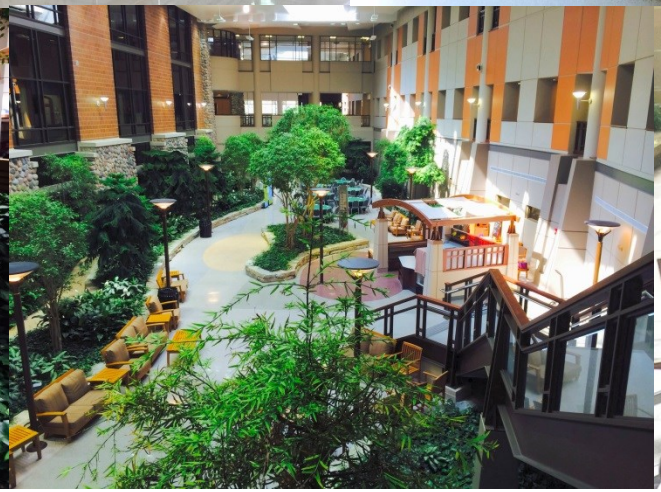
What is the relationship between patient experience of hospital care and financial performance of U.S. hospitals?

Research Question 2

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

What Is Patient Experience?





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

Patient Experience Remains a Top Priority

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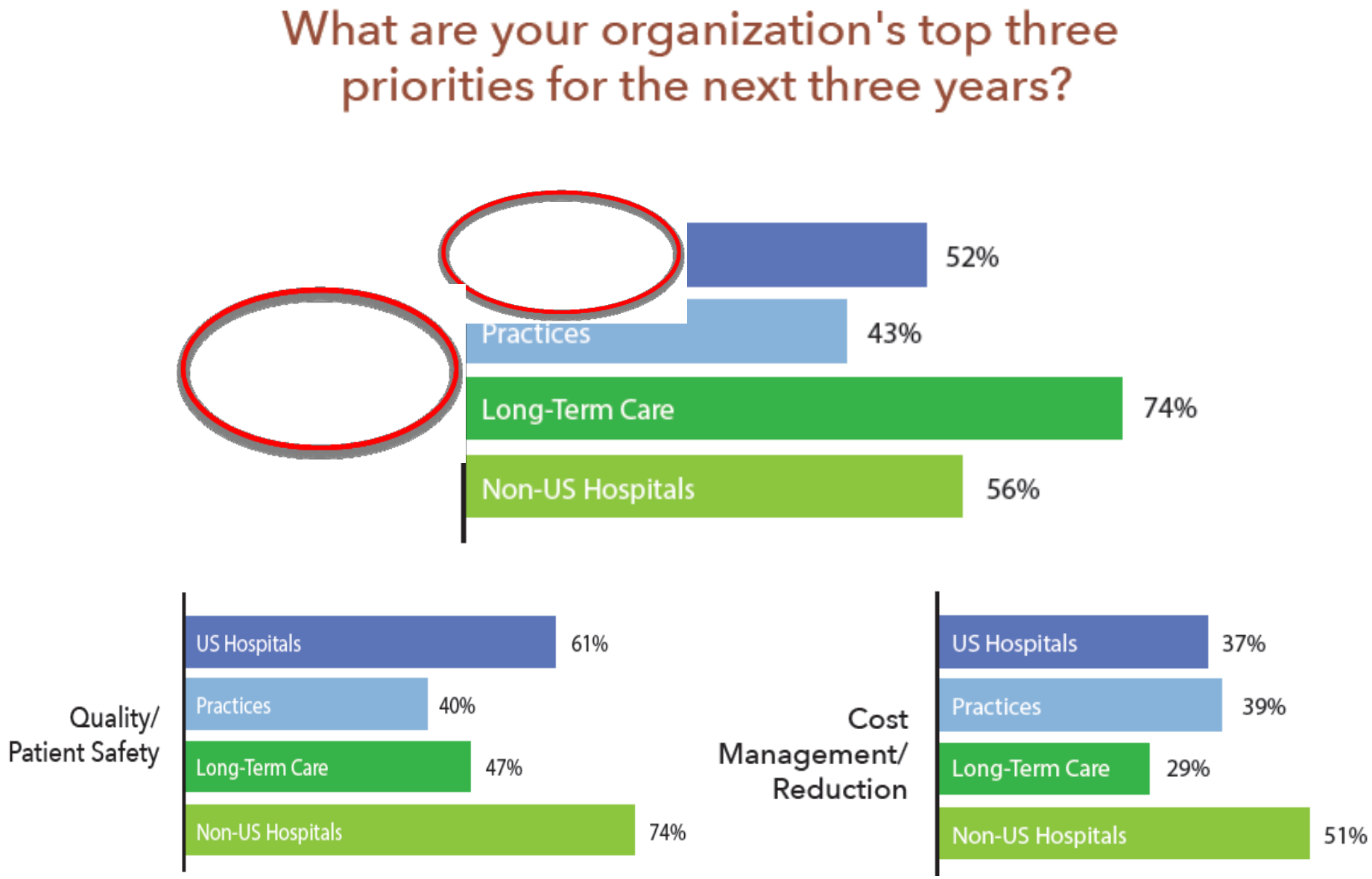

Patient Experience in Primetime Drama: Heartbeat

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Dr. Casey Callahan, a surgeon at the fictional St. Matthew's Hospital in Los Angeles, CA

Dr. Millicent Patel, hospital administrator of the fictional St. Matthew's Hospital in Los Angeles, CA

Dr. Callahan asks, "Dr. Patel, I am a people person, so I think you should name me as St. Matthew's Chief Patient Experience Officer…"

Patient Experience:
Two Leading Organizations | Two Leading Journals
One Certified Professional Designation

The Beryl Institute

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

The Association for Patient Experience (AfPE)

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

How Is Patient Experience Measured?

Two Prevailing Measurements

Measurement 1

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey:

It is the “first national, standardized, publicly reported survey of patients' perspectives of hospital care” (CMS, 2013b, p. 1) since 2008

Measurement 2

Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) Survey:

It is a standardized tool for measuring patient perceptions of care by physicians in an office setting (Press Ganey, 2015)

HCAHPS' 4 Dimensions of Patient Experience

Clinical Services

- Most hospitalized patients receive care from nurses, doctors, and clinical support staff across departments such as pathology, imaging, pharmacy, and rehabilitation (White & Griffith, 2016).

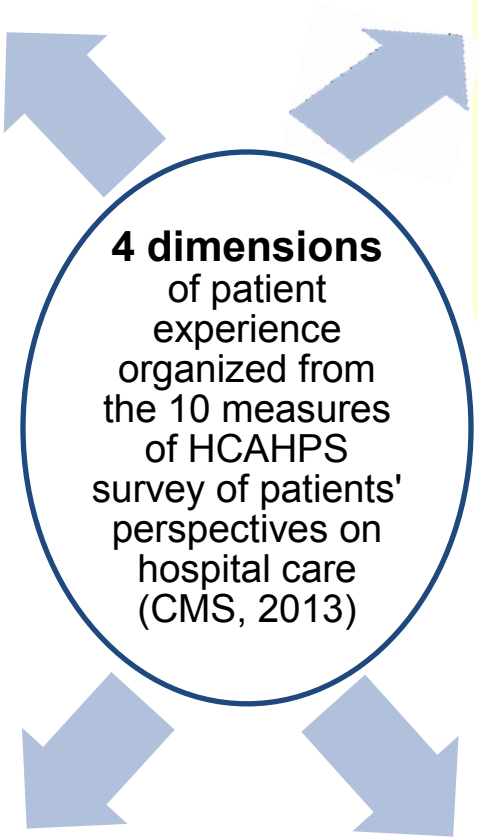
- Targeting "team-based care—matching resources to patient and family needs—is essential to maximize value-based care" (Anderson et al., 2014, p. 11).

Care Environment

- Patient satisfaction survey results informed U.S. hospitals: physical care environment (e.g., facility cleanliness and quietness) was more important to patients and families than prior general beliefs (Fottler et al., 2011).

- A hospital facility's cleanliness can predict patients' perceptions of a hospital's quality of care (Gupta, 2008).

- Lowering noise levels around patient rooms and improving sleep resulted in less stress and faster recovery (Ulrich et al., 2004).



Communication

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

Perception

- When asked to evaluate their inpatient care, most patients will first speak of the nurses, not the doctors, who have provided care; and they are more likely to rate the entire hospital experience favorably if their perceptions of nurse care are good (White & Griffith, 2016).

- Dissatisfied patients are more likely to write comments to report negative perceptions of hospital experiences (Huppertz et al., 2014) and give the hospitals lower overall ratings.

Three Hospital Types

Source: CMS (2011)

For-Profit Hospitals

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

Non-Profit Hospitals

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

Government Hospitals

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

Five Hospital Financial Performance Indicators

Operating Profit Margin (OPM)

- A ratio of operating income to total operating revenue, indicating profits solely from a hospital's operations (Nowicki, 2015).

- It "measures the amount of operating profit per dollar of operating revenues and focuses on the core activities of a business" (Gapenski, 2012, p. 694).

Non-Operating Profit Margin (NOPM)

- It equals Total Profit Margin minus Operating Profit Margin

- Total Profit Margin (TPM) is a ratio of net income to total revenue that is the sum of operating revenue and non-operating income (Gapenski, 2012).

- TPM measures the amount of total profit per dollar of total revenue from a hospital's patient services and non-operating activities such as investing (Nowicki, 2015).

Cash Flow Margin (CFM)

- A ratio of the sum of NI and depr. expense to total revenue (Zhao et al., 2008).

- It measures a hospital's ability to generate sufficient cash flow from its operations in order to maintain financial viability (Alexander et al., 2006).

Return on Assets (ROA)

- A ratio of NI to total assets (Gapenski, 2012), indicating "the dollars of earnings per dollar of book asset investment" (p. 697).

- It measures a hospital's efficiency in asset utilization to generate income and control expenses (Tennyson & Fottler, 2000).

Return on Equity (ROE)

- A ratio of NI to total equity (Gapenski, 2012), indicating "the dollars of earnings per dollar of book equity investment" (p. 697).

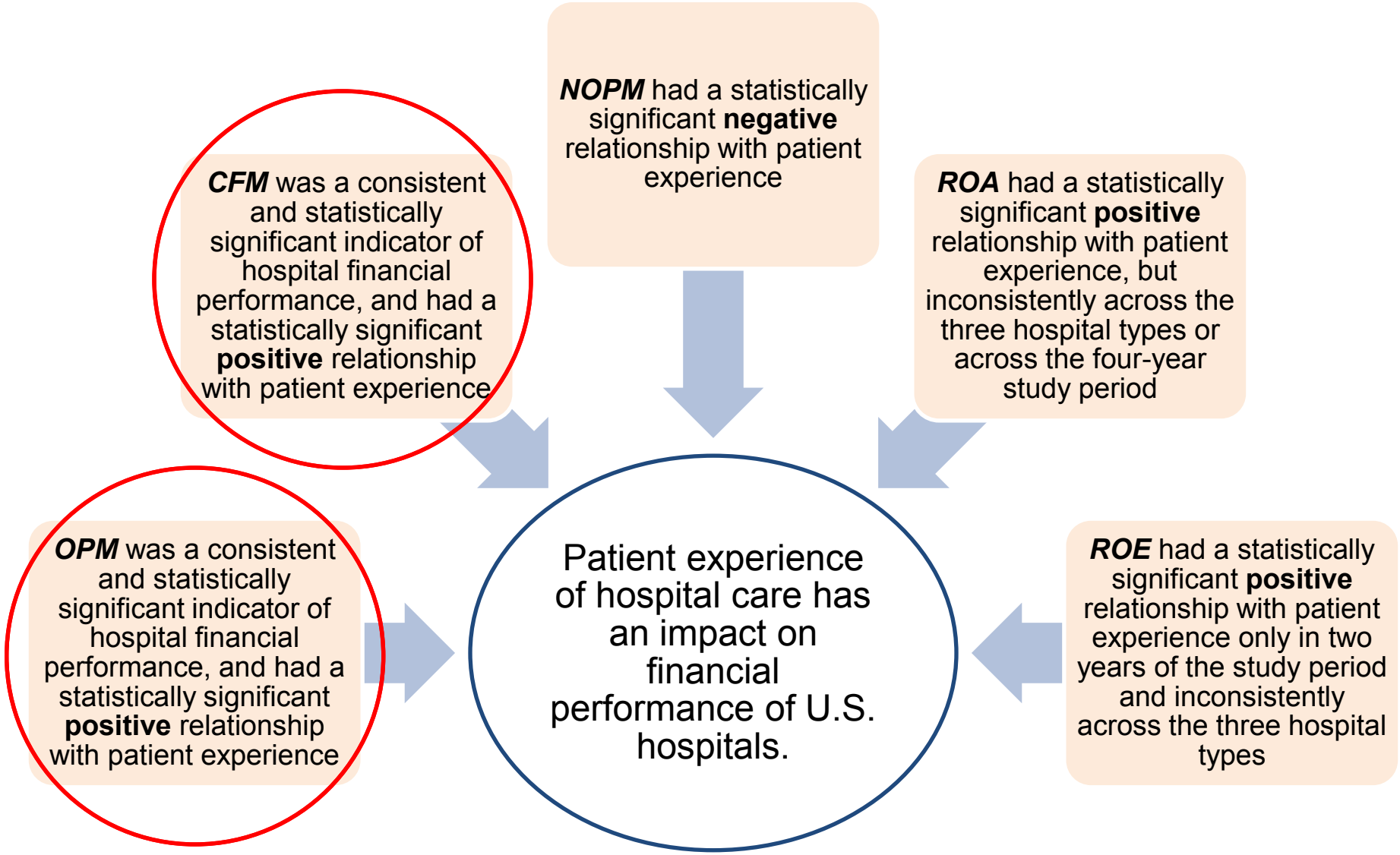
- Was a more relevant indicator of hospital financial position (Cleverley, 1995).

- A far less often used indicator (Pink et al., 2007).

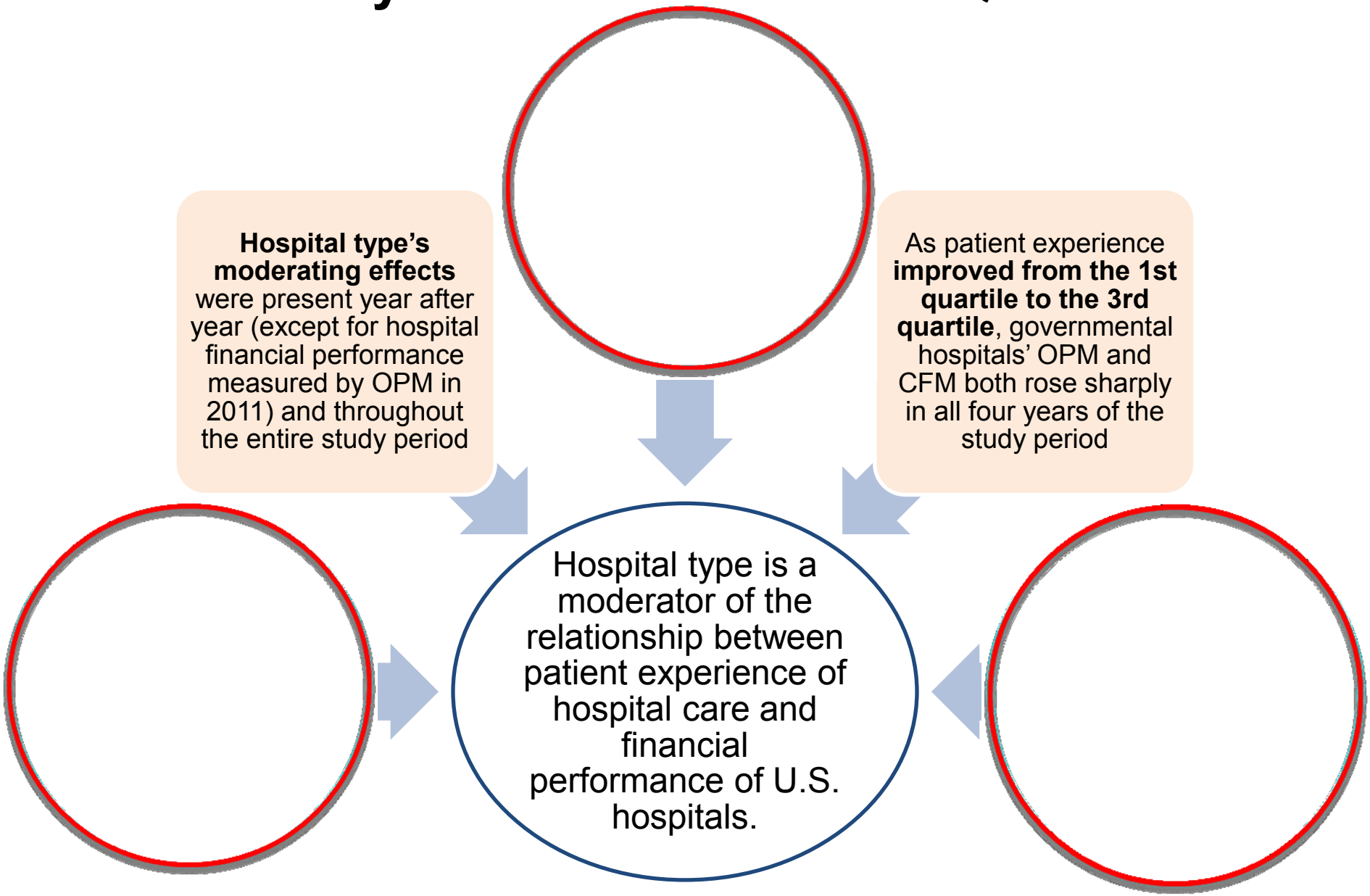
Study Methodology Overview

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

The Study Answered Research Question 1



The Study Answered Research Question 2



Five Important Descriptive Findings

1. Patient experience improved gradually from 2009 to 2012.

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

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

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

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

Three Main Empirical Findings

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

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

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

Five Implications for Practitioners

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

Study Findings Informing Practitioners

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

Recommendations for Practitioners: *Board Engagement*

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

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

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

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

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

Recommendations for Practitioners: *Leadership Engagement*

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

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

Recommendations for Practitioners: *Employee Engagement*

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

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

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

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

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

Recommendations for Practitioners: *Patient Engagement*

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

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

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

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

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

Four Main Limitations of the Study

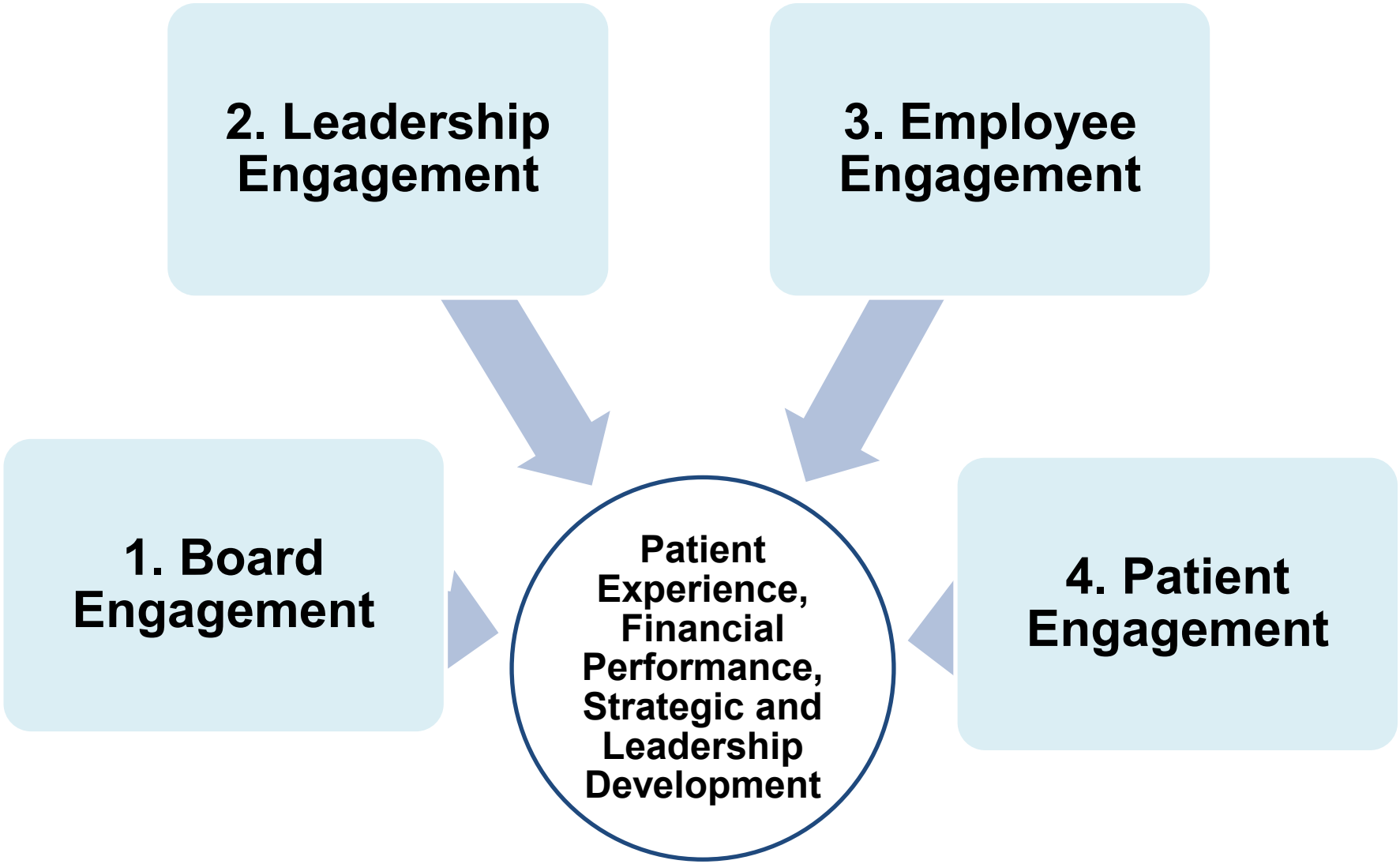
Data were from a random sample of adult inpatients who completed the CMS' HCAHPS survey after discharge from Medicare-certified inpatient acute care hospitals. Data accuracy is unverifiable.

Aggregating patient data may have been done by the approved survey vendors, or the sample hospitals if approved by the CMS. Reliability and validity of the data aggregation were not confirmed. HCAHPS as a measurement of patient experience may be limited in scope, target population, and historical range.

The hospital-level financial data were compiled in the CMS' HCRIS data files available to the public. The accuracy of these hospital self-reported financial data is unverifiable.

FP had 5 indicators (OPM, NOPM, CFM, ROA, and ROE). Over 60% of the sample hospitals were non-profit (NP). Free cash flows may be added since it was a true FP indicator of closely held NP hospitals (Phillips, 2003) and positively associated with patient revenue and collection speed of bond-issuing NP hospitals (Singh & Wheeler, 2012).

Put It All Together



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Thank You for Your Participation in This Discussion!
Questions?