HealthTech Management Services

CEO Update

August 2015

Improving the Patient Experience—Reducing Noise

Special points of interest:

- Patient Experience—Reducing Noise
- Grant Opportunity
- Hospital Quality Star Ratings
- Ways & Means Committee review of Rural Healthcare Disparities
- IPPS Final Rule

Oftentimes, HCAHPS scores reflect a noisy environment which many find difficult to remedy. In January 2016, the Joint Commission will enact a National Patient Safety Goal of alarm safety and alarm fatigue which can be directly related to some of the noise experienced by patients. Let's examine the impact of noise on the patient experience and healing.

In 1859, Florence Nightingale spoke about noise in her quote, *"Necessary noise is that which damages the patient...Unnecessary noise is the cruelest absence of care which can be inflicted on either the sick or the well"* Certainly there is reason to point out the differences between 19th century hospitals and those today, however one can suggest that some brilliant person saw value in Ms. Nightingale's *Notes* along with current research which identifies rest as a major healer of illness. As a result, quietness in the hospital is one of the HCAHPS metrics.

Noise affects humans in the following ways:

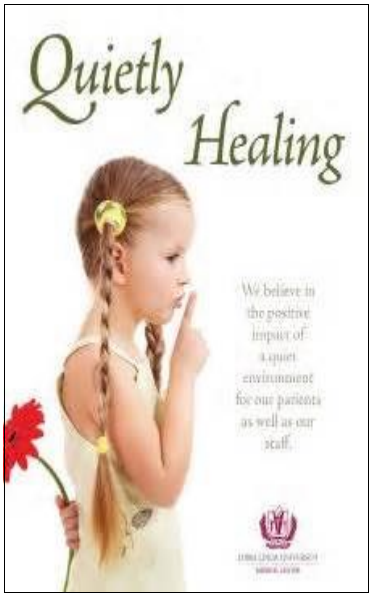
- ◊ Physiologically—Can contribute to longer lengths-of-stay and delayed healing
- ◊ Psychologically—Hearing conversations about self or others that may be interpreted incorrectly
- ◊ Cognitively—No one can listen to two conversations at once. With multiple sounds/noise, there is reduced productivity, impaired communication, likelihood of increased errors, and privacy concerns.
- ◊ Behavioral—Noise can cause irritability, aggression

All of the above factors can cause a financial impact to the organization, therefore it is important to determine ways to remedy noise::

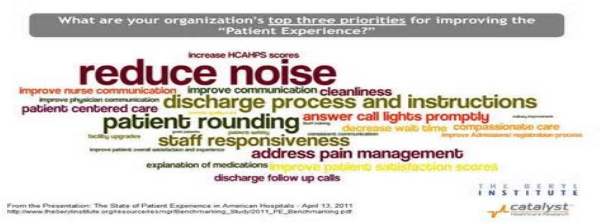
1. Improve acoustics through installing acoustic treatments, using design zones, and use of high Sound Transmission Class devices for privacy.
2. Reduce noise by purchasing equipment that has alternative methods of notifying staff of alarms. Check mobile equipment, such as carts, to eliminate squeaks. Use devices such as stop light indicators that pick up decibels that staff can see when noise is becoming too loud.
3. If noise poses a challenge for your organization, add this topic to your quality committee agenda to develop strategies to reduce noise.
4. Use soundscape music that is calming and soothing.

Potential outcomes of controlling noise:

1. Shorter lengths of stay since healing occurs
2. Lower doses of pain medication
3. Happier, healthier and improved productivity of staff
4. Better privacy
5. Improved patient satisfaction



Grant Opportunity



THE BERYL INSTITUTE

The Beryl Institute Opens Applications for 2015 Patient Experience Grant and Scholar Programs

Annual Programs Support Research Efforts to Improve the Patient Experience

Dallas, Texas (July 30, 2015) – The Beryl Institute announces its sixth annual Patient Experience Grant Program and fourth annual Institute Scholar Program. In partnership with Patient Experience Institute, these offerings reinforce the commitment to help frame and expand the field of patient experience, develop leaders on the front lines and throughout the experience movement, and provide information and research to support expanded focus and measured impact of patient experience in healthcare.

The grant and scholar programs are intended to encourage and support research into the:

- Value of focusing on the patient experience before, during and after care (e.g., ROI, satisfaction or quality outcomes)
- Impact of service efforts on the healthcare experience
- Influence of culture on the patient experience, service and outcomes
- Integrated review of key factors that support positive healthcare experiences

"Since their inception in 2010, the Patient Experience Grant and Scholar Programs have provided funding to over 50 organizations and individuals seeking to expand the conversation, learning and sharing around patient experience improvement," said Stacy Palmer, vice president, strategy and member experience, The Beryl Institute. "We are pleased to continue this support as part of our commitment to help generate, collect and share ideas and proven practices to further the patient experience movement."

Healthcare leaders and staff engaged in managing or improving patient experience, or graduate students, and/or university faculty members may apply. Research should be relevant to the topics outlined by the grant program and can be in proposal stage, in process or near completion. All recipients will be required to complete their research within one year of the grant being awarded and to develop a research paper, to be published through the Institute. Recipients will also be asked to present their findings at The Beryl Institute Patient Experience Conference.

The deadline to apply for each program is October 2, 2015. Recipients will be announced late October 2015. To access the Grant /Scholar application, overview and list of previous grant recipients, visit: http://www.theberylinstitute.org/?page=GrantProgram.

Centers for Medicare and Medicaid Services (CMS)

Hospital Quality Star Ratings

CMS is proposing that Hospital Quality Star Ratings are calculated for all non-federal, short-stay, acute care hospitals, including critical access hospitals. To receive a summary score and star rating, a hospital must publicly report a minimum of three measures per group from a minimum of three measure groups. At least one measure group reported must be an outcomes group to receive a star rating.

The Overall Hospital Quality Star Ratings are calculated based on 75 of the 106 measures potentially available for public reporting in the April 2015 Hospital Compare dataset. The measures span seven groups:

- Outcomes—Mortality
- Outcomes—Safety
- Outcomes—Readmission
- Patient Experience
- Process—Effectiveness
- Process—Timeliness
- Efficiency—Imaging.

As part of the dry run that CMS is conducting , they will provide a hospital-specific report that includes hospital rating results and the measures used in the calculation. CMS is inviting comments on the Overall Hospital Quality Star Ratings methodology. In past dry runs, such feedback contributed to the enhancement of measure methodology. CMS indicated that it welcomes feedback about the dry run process to make it as productive and helpful as possible.

CMS is hosting an **MLN Connects National Provider Call on Thursday, August 13, from 1:30 to 3 p.m.,** to discuss the Overall Hospital Quality Star Ratings methodology, hospital-specific reports, and lessons learned from the dry run. Please register online at cms.gov

It is important to note that increasing numbers of consumers are using the Quality Star Ratings to determine where they will go to receive healthcare services. In July, the CEO Update focused on the patient experience, and this month there is more information about controlling noise in facilities which can affect the patient experience. Recently, there has been data reported that half of the hospitals in the country have been penalized because they are unable to meet the readmission metric. That will be one of the measures that will be rated on the Quality Star Ratings, so it is wise to determine how to change approaches so that your facility does not have a penalty imposed.

If your organization struggles with improving quality, there are options available to you that you may not naturally think about:

1. HealthTech abounds with resources to help you think through different ways to improve performance. Oftentimes, being so close to the challenge stifles innovation where another set of eyes can clearly identify innovative approaches.
2. Be aware of organizations that have instituted novel and creative methods that you can modify and use. Actively participating in your State hospital associations can help you create an important network.

From the Hill

Rural Healthcare Disparities Examined

The U.S. House Ways and Means Subcommittee on Health held a hearing to examine rural healthcare disparities, the second in a series as the committee works to develop a broad "hospital" bill this fall, component parts of which were made public in the form of three separate bills covering Graduate Medical Education (GME), Disproportionate Share Hospital (DSH), and inpatient/outpatient payment site-neutrality.

At the hearing, the discussion focused on overly burdensome regulations that impede the ability of hospitals to provide care for their patients and disrupt access for Medicare beneficiaries in rural communities. Representatives from hospitals and health systems throughout the country encouraged the subcommittee to support several bills that would protect crucial programs and payments for rural hospitals.

Some of those who spoke specifically called for key protections for Critical Access Hospitals (CAHs), including aligning the law with the way the so-called "96-hour rule" has long been interpreted and applied. The Critical Access Hospital Relief Act of 2015 (S. 258/H.R. 169) would remove the 96-hour certification physician requirement as a condition of payment for CAHs, but leave intact the condition of participation requiring a 96-hour annual average length of stay. The speakers voiced support for the Protecting Access to Rural Therapy Services Act (H.R. 1611/S. 257), which would adopt a "general supervision" standard (rather than "direct supervision") to allow supervision by a physician or non-physician practitioner for many outpatient therapeutic services. Similarly, legislation recently approved by the Senate Finance Committee would alleviate direct supervision requirements on a limited basis for CAHs and other small rural hospitals through 2015.

Witnesses Criticize GME Allocations

A panelist testifying on behalf of the Arizona Center for Rural Health scrutinized the distribution of Medicare GME payments and called for changes to address variation in the program between states. In contrast, Representative Danny Davis (D-IL) argued that the current distribution of GME funds to more urban areas helps ensure the nation is training the best physicians possible by providing opportunity for individuals to get sufficient experience with complex patients.

Subcommittee Chair Kevin Brady (R-TX) reiterated his interest in considering GME reform, which he raised during the Medicare Payment Advisory Commission (MedPAC) hearing on hospital payment issues. Groups like MedPAC continue to scrutinize the character and levels of GME payments to teaching hospitals, failing to recognize the full range of benefits teaching hospitals and academic medical centers bring to bear for the entire healthcare system.
Source: waysandmeanscommitte website and hanys.org

Fiscal Year 2016 Final Inpatient and Long-term Care Hospital policy and payment changes (CMS-1632-F)

On July 31, 2015 the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update fiscal year (FY) 2016 Medicare payment policies and rates under the Inpatient **Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective** Payment System (PPS). The final rule, which will apply to approximately 3,400 acute care hospitals and approximately 435 LTCHs, will affect discharges occurring on or after October 1, 2015. The final rule will be published in the Federal Register on August 17, 2015, and can be downloaded from the *Federal Register* at https://www.federalregister.gov/public-inspection. Comments are due September 29, 2015 and the rule is effective October 1, 2015.