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The University of Southern Mississippi

VALUE BASED PURCHASING:

POSITIONING A HEALTHCARE ORGANIZATION FOR THE FUTURE

by

James Dale Heard

Abstract of a Capstone Project
Submitted to the Graduate School
Of The University of Southern Mississippi
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Nursing Practice

December 2012

ABSTRACT

VALUE BASED PURCHASING:

POSITIONING A HEALTHCARE ORGANIZATION FOR THE FUTURE

by James Dale Heard

December 2012

In 2005, the Deficit Reduction Act introduced Value Based Purchasing (VBP) into the healthcare system as a means of hospital reimbursement for acute care hospitals receiving reimbursements from the Centers of Medicare and Medicaid (CMS). The purpose of this Capstone Project was to increase the knowledge of healthcare executives concerning Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and VBP and the effect it will place on the organization though the utilization of a consultant program. The role of the consultant in this project is to provide expert advice to healthcare executives about the impacts of HCAHPS and provide organizational strategies to increase hospital reimbursements related to CMS and VBP.

The nurse consultant theory used in this project is central to the process of health service modernization, helping to provide clients with services that are organized and structured and served as the framework for this capstone project. Robb's (2006) guiding principles and techniques were used to guide the framework through its entirety. Additionally, using the American Association of College of Nursing's (AACN) (2006) Doctoral of Nursing Practice (DNP) Essentials II and V supported this capstone through system changes related to healthcare policy redesign.

The entire senior leadership team (7 members) of a rural acute care hospital in southwest Mississippi participated in the consultant program. A post-implementation

evaluation was utilized by the DNP to give the organization a starting point for performance improvement. The DNP in this project will continue to monitor the organization for one year post implementation of the project. Information will be provided to the DNP through the Performance Improvement Committee initiated in this project. The Performance Improvement Team will use original HCAHPS scores from September 2012 and provide monthly feedback of new scores until September 2013. After this time the Performance Improvement Team will only submit data to their senior leadership team.

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2012

The University of Southern Mississippi

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POSITIONING A HEALTHCARE ORGANIZATION FOR THE FUTURE

by

James Dale Heard

A Capstone Project
Submitted to the Graduate School
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Nursing Practice

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LIST OF ABBREVIATIONS

AACN	American Association of Colleges of Nursing
AHRQ	Agency for Healthcare Resource and Quality
APU	Annual Payment Update
CMS	Centers for Medicare and Medicaid
DNP	Doctorate of Nursing Practice
DRA	Deficit Reduction Act
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HHS	U.S. Department of Health and Human Services
IPPS	Inpatient Prospective Payment System
MMA	Medicare Modernization Act
P4R	Pay for Reporting
PDSA	Plan Do Study Act
PI	Performance Improvement
PIC	Performance Improvement Committee
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
TPS	Total Performance Score
VBP	Value Based Purchasing

CHAPTER I

INTRODUCTION

Problem Statement

In 2002, the Bush Administration launched the Hospital Quality Initiative that was intended to improve patient healthcare quality through accountability and public disclosure of patients' perceptions of their overall quality of care. The disclosure of the quality of care information was designed to empower and allow consumers to make more informed decisions about their healthcare (Federal Register, 2011). This disclosure of patient care information was also directed to encourage healthcare providers and clinicians to improve the quality of healthcare they were providing.

Beginning in 2002, the Centers for Medicare and Medicaid Services (CMS) partnered with the Agency for Healthcare Resource and Quality (AHRQ), another agency in the federal Department of Health and Human Services, to develop and test the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (HCAHPS, 2008). The HCAHPS survey is the first national, standardized, publicly reported survey of patients' perceptions of the overall quality of their care. While many hospitals have collected information on patient satisfaction for their own use, until HCAHPS, there was no national standard for collecting or publicly reporting information about patient experience of care that allowed valid comparisons to be made about hospitals locally, regionally, or nationally.

The enactment of the Deficit Reduction Act (DRA) of 2005 called Value Based Purchasing (VBP) created an additional incentive for acute care hospitals to participate in HCAHPS. Beginning in July 2007, hospitals that receive reimbursements through the

Inpatient Prospective Payment System (IPPS) must collect and submit HCAHPS data in order to receive their full annual payment update (HCAHPS, 2008).

The Affordable Care Act requires Medicare hospitals and healthcare providers to have in place VBP programs by the beginning of the 2013 fiscal year, which starts Oct. 1, 2012 (Federal Register, 2011). The VBP program initially places a one percent decrease to hospitals' Medicare IPPS payments, but increases this to two percent by the 2017 fiscal year. This program marks the first time hospitals will be paid for inpatient acute care services based on care quality and not just the quantity of services provided. According to the U.S. Department of Health and Human Services (HHS), this program will impact more than 3,500 hospitals across the nation and could cause a decrease in reimbursements of $100 per patient (Centers for Medicare and Medicaid Services, 2011).

Purpose of the Project

The purpose of this Capstone Project was to increase the knowledge of healthcare executives concerning HCAHPS and VBP and the effect it will place on the organization though the utilization of a consultant program. The role of the DNP in this project is to provide expert advice to healthcare executives about the impacts of HCAHPS and provide organizational strategies to increase hospital reimbursements related to CMS and VBP. The aim was to have healthcare executives embrace the changes and help the organization increase reimbursements from CMS and future insurance carriers. Even before the passage of healthcare reform legislation in early 2010, experts were predicting that healthcare organizations would need to assess and adjust their business philosophies and practices to take advantage of the many opportunities that would follow reform. It is now crucial for healthcare executives to be aware of HCAHPS and VBP and to

promote change within the organization to help facilitate reimbursement losses or gains for the future of the organization (Meyer, Rybowski, & Eichler, 2010).

Framework

The nurse consultant theory used in this project is central to the process of health service modernization, helping to provide clients with services that are organized and structured and served as the framework for this Capstone Project. The DNP nurse consultant is responsible for developing personal practice, being involved in research and evaluation, and contributing to educational training and development (O'Connor, 2008). The DNP nurse consultant has knowledge of professional nursing theory, techniques, practices and procedures and has considerable knowledge of medical terminology. They also hold general knowledge of state and federal rules and regulations governing financial reimbursement and general knowledge of professional nursing care practices and principles across the nursing continuum (Jones & Rattray, 2010).

The guiding principles of the DNP consultant plan in this Capstone Project are (a) focus the organization on the issues that are most important; (b) help management and employees think strategically not just day to day; (c) generate consensus, commitment and teamwork by involving key management and staff; (d) provide specific action plans and goals, giving direction to the entire team; (e) help the team deal with internal and external barriers; (f) teach the organization how to address difficult issues and determine positive, effective solutions; (g) reassure all stakeholders that steps are being taken so that the organization will continue to thrive and prosper; and (h) help to create a unique market position that will differentiate the organization in the healthcare marketplace (Robb, 2006).

Objectives of DNP Consultant Plan

The framework for improving performance describes a global model for structure, process, and outcomes measurement and improvement. The framework incorporates several key assumptions: (a) performance means what is done and how well it is done, (b) quality means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge, (c) patients and others judge the quality of health care based on health outcomes and sometimes on their experiences with the care process and level of service provided, and (d) patients, purchasers, regulators, and other stakeholders expect and use quantitative/explicit data and qualitative/implicit perceptions to judge quality and value of health care (O'Connor, 2008).

Goals of DNP Consultant Plan

The DNP consultant plan focuses on the measurement, assessment, and improvement of performance and work processes to (a) improve the safety of the healthcare systems and work processes; (b) identify indicators of quality related to structure, process, and outcomes of patient care; (c) measure clinical practice against best practices or benchmarks appropriate to other hospitals; (d) design or redesign care processes based on best practices; (e) improve coordination and communication across patient conditions, services, and settings; and (f) the evaluation and improvement of systems and work process involved in the provision of patient care and the improvement of financial reimbursement (Robb, 2006).

Scope and Integration of DNP Consultant Plan

The scope of this consultant program is organization wide, but the main focus was geared towards hospital executives. All personnel and departments are expected to be actively involved in the program after the implementation phase.

The program will provide a framework for continuously monitoring and improving the quality of care and services provided to the patients. It will provide integrating measurement of clinical and operational performance with those of strategic planning and operations management. It will also facilitate the redesign of clinical care and key processes to achieve ready access and optimal outcomes at the lowest possible cost.

Roles and Responsibilities of DNP Consultant Plan

The hospital executives have the ultimate responsibility for the quality of care and service provided. Their accountability for quality is discharged through its performance of three major responsibilities: (a) demonstrating a top-down commitment to high quality and to the organization's programs for quality management, (b) requiring that objective measures be used to gauge the quality of care and services being provided, and (c) ensuring that quality management programs are in place and are working effectively to monitor and improve quality (O'Connor, 2008).

Hospital executives play a central role in fostering improvement through planning, educating, setting priorities, providing support, such as time and resources, and empowering staff (Institute of Medicine, 2001). The DNP nurse consultant in this project will work with hospital executives to develop a Performance Improvement Committee (PIC) that will focus on HCAHPS scores and the VBP incentives. The hospital executives will delegate to the PIC the central authority for managing the performance

improvement (PI) program. The PIC is made up of the Chief Executive Officer, the Medical Staff Director, the Chief Nursing Officer, the Chief Financial Officer, and the Performance Improvement Coordinator.

The responsibilities of the PIC include (a) coordination and oversight of the hospital wide program; (b) provision of a framework for a planned, continuous, systematic and organization wide approach to designing, measuring, assessing, and improving performance; (c) identification of organizational trends or opportunities for improvement projects from reports received throughout the organization; and (d) reporting to the hospital executives quarterly and annually the results of the quality activities and the PI process including the financial impact of the projects and program (Dingwall & Allen, 2011).

The PIC will provide oversight and function as the central clearing house for quality data and information collected throughout the facility. It will track trends and aggregate data from all sources to prepare reports for the hospital executives.

DNP Essentials related to Consultant Plan

The American Association of Colleges of Nursing's (AACN) (2006) Doctoral of Nursing Practice (DNP) essentials used as the framework which supported this Capstone were DNP Essentials II and V.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking. In a recent study by Health Leaders Media CFO Exchange, just over half (54%) of respondents had modeled possible revenue gains and losses based on current VBP quality metrics, while 25% had not yet started planning (Health Leaders Media CFO Exchange, 2012). This 25% is what worries healthcare leaders. Organizations that are in good shape today should be fine with many of these metrics, but

that may not be the case for hospitals already in direct need of funds, especially to upgrade facilities to help boost patient satisfaction scores (Davis, 2001). The thought prompts these leaders to wonder how the healthcare environment may change if such organizations sustain large payment reductions. Moreover, the leaders are looking ahead to a time when the quality gap between their organization and others may narrow, and wonder how the government might alter these metrics and how that could affect their standing and reimbursements in the future (Davis, 2001).

Essential V: Health Care Policy for Advocacy in Health Care. In 2006, Congress passed Public Law 109-171, the Deficit Reduction Act of 2005, which under Section 5001(b) authorized CMS to develop a plan for VBP for Medicare hospital services commencing FY 2009 (Centers for Medicare and Medicaid Services, 2007). Along with this measure found under Section 5001(a), the DRA specified new requirements for Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, which is a pay-for-reporting (P4R) program that uses Medicare payment as an incentive for hospitals to report on the care they provide all adults, regardless of payer. As originally mandated under the 2003 Medicare Modernization Act (MMA), the RHQDAPU provision required that Inpatient Payment Prospective Payment System (IPPS) hospitals report on a specified set of 10 clinical performance measures in order to avoid a 0.4 percentage point reduction in their Annual Payment Update (APU) for inpatient hospital services (CMS, 2011). Hospitals have been submitting performance data under this provision since 2004. Using the RHQDAPU the DRA increased both the measures and magnitude of incentive payment. These AACN essentials promote advocacy in healthcare by utilizing the ability to facilitate organizational wide changes in

practice delivery, communicate and evaluate accuracy, timeliness, and appropriateness of healthcare consumer information (Chism, 2010, pp. 16-17) (see Appendix A for DNP Essentials).

Evaluation of DNP Consultant Plan

The DNP nurse consultant will evaluate the program after the initiation of the project to give the organization a starting point for performance improvement. The DNP will continue to work with the PIC for up to one year post implementation to monitor successes within the organization. The PIC will provide the DNP monthly scores of focus areas to monitor score increases or decreases and track trends. The following year the PIC will evaluate the organization's success in achieving the goals and annual objectives of the program. The annual report will be a summary of the year's activities including the role of leadership in the program, the results of the Medical Staff activities, a review of the quality assessment, and performance improvement activities related to each objective established for the year. An assessment of the overall effectiveness of the plan and program will be made by the PIC and forwarded to the hospital executives with recommendations for improvement (see Appendix B for evaluation form).

Assumptions

A key assumption for this Capstone Project was healthcare executives lack the knowledge needed to prepare their organization for the future regarding healthcare reform. It was also assumed that healthcare executives have the resources needed to prepare their organization for this change, but they do not know how to utilize them. Another assumption was that by utilizing a DNP nurse consultant to educate hospital executives on healthcare reform, these executives would realize how to use the resources effectively to promote change within the organization.

CHAPTER II

REVIEW OF LITERATURE

An extensive literature search was conducted using the terms *value based purchasing, HCAHPS, healthcare reform,* and *patient satisfaction* using databases, such as Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Library, MEDLINE, British Nursing Index, EBCSO, Google Scholar, Agency of Healthcare and Quality (AHRQ), and Social Sciences Citation Index.

The literature search was conducted to address issues related to value based purchasing and the use of HCAHPS within a healthcare organization. Due to the broad scope of the literature review, sources were cited under 3 sections: (1) value based purchasing defined, (2) HCAHPS defined, and (3) correlation of value based purchasing and HCAHPS.

Value Based Purchasing Defined

On April 28, 2011, the U.S. Department of Health and Human Services (HHS) formally launched a new initiative designed to adjust Medicare reimbursement on the basis of quality measurements. The hospital VBP program, administered by CMS, marks an unprecedented change in the way Medicare pays healthcare providers for their services (Centers for Medicare and Medicaid Services, 2011). The VBP seeks to reward hospitals for improving the quality of care provided, by redistributing Medicare payments among hospitals with higher performance scores in terms of quality. The hospitals with higher scores will receive a greater proportion of the VBP payment than those with lower performance scores.

Hospitals are scored for each measure according to a 10-point scale defined between the measure's achievement threshold and a benchmark (Winslow, 2008). The

achievement threshold is the minimum level of performance for consideration, and the benchmark is set according to the highest levels of performance among hospitals during the baseline period (Centers for Medicare and Medicaid Services, 2007). More specifically, for fiscal year 2013, the achievement thresholds are set at the 50th percentile of overall hospital performance during the baseline period, and the benchmarks are the mean of the top box scores in the overall hospital score. Halasyamani and Davis (2007) reported that hospital scoring for the fiscal year 2013 VBP program is based on the performance period from July 1, 2011 through March 31, 2012. The corresponding baseline period used for setting thresholds and benchmarks are July 1, 2010 through March 31, 2011. CMS has indicated that future program years may be based on a 12-month performance period, if feasible (Shoemaker, 2011).

Each hospital is scored based not only on its achievement, but also on its improvement for each measure. A hospital's score on each measure is the higher of its two scores. As noted previously, the achievement score is based on how a hospital's current performance compares with the performance of all other hospitals during the baseline period (Centers for Medicare and Medicaid Services, 2007). Points are awarded for achievement based on a 10-point scale evenly calibrated between the hospital's baseline score and the benchmark for a measure. The improvement score is based on how a hospital's current performance compares with its prior performance during the baseline period. The scale is uniquely determined for each hospital, and an improvement score is possible only if the current performance is better than its prior performance for a measure (Centers for Medicare and Medicaid Services, 2007).

Each hospital may also earn consistency points ranging from zero to 20 based on its scores for patient expectations (Lipson & DeSa, 2011). Consistency points are

intended to encourage hospitals to focus on all eight measures of patient expectations. No points are earned if a hospital's performance on any one of the eight measures is as poor as the worst-performing hospital's performance on the same measure during the baseline period. Twenty points are earned if all eight measures are at or above their achievement thresholds. Otherwise, consistency points are awarded proportionately based on the single lowest of the eight measures when compared with its achievement threshold.

The actual score is based on the distance between the achievement threshold and the floor. The total performance score (TPS) is calculated for each hospital by combining its scores for all the measures, using the greater of the achievement score or improvement score for each measure (Lispon & DeSa, 2011). All clinical process scores are combined as one domain, and all patient experience scores are combined as another domain. For the fiscal year 2013 VBP program, the clinical process domain is weighted at 70% and the patient experience domain is weighted at 30%. The factored domain scores are then added together to arrive at the hospital's TPS. CMS will use a linear exchange function to calculate the incentive payment for each hospital based on its TPS (Centers for Medicare and Medicaid Services, 2011).

Hospitals with higher TPSs will receive higher incentive payments than those with lower scores. Each hospital will be notified of its estimated incentive payment for fiscal year 2013 through its QualityNet account at least 60 days prior to October 1, 2012. CMS will notify each hospital of the exact amount of its incentive payment on November 1, 2012 (Centers for Medicare and Medicaid Services, 2011). The details of the TPS calculation are somewhat complicated, but yield a single, whole number that will be used

for comparing the quality of different hospitals to determine the amount of incentive payment, if any, each hospital should receive (see Appendix C for VBP worksheet).

Even though the final rule for the fiscal year 2013 VBP program has been promulgated, the corresponding Medicare claims data for the baseline period were not available to the public at the time of publication (Lipson & DeSa, 2011). The assertive timetable for implementation of the VBP program makes it difficult to forecast its impact on hospitals. Although the final rule provides some cursory statistics, the data is insufficient to provide a basis for accurately projecting the effects of the program. It appears that any reliable study of the program's effects must wait to be performed on a retrospective basis after data becomes available (Lipson & DeSa, 2011). The cursory statistics seem to indicate that smaller hospitals will fare better than larger hospitals, but this effect is far from certain. Because the thresholds for earning incentive points are set at the 50th percentile, it would be reasonable to expect that about half of all participating hospitals will experience reduced Medicare payment.

HCAHPS Defined

"HCAHPS is a game changer. It will transform the way hospitals do business" (Studer, 2010, p. 2). This is a bold statement by Quint Studer, especially given the emphasis on financial reform by the Obama Administration. Yet HCAHPS could be one of the silver bullets that people are looking for to fix healthcare. Healthcare executives who focus on improving their HCAHPS scores should see improved results, including better clinical outcomes (Becher & Chassin, 2001). This, in turn, could reduce costly readmissions and hospital-acquired infections while generating higher patient satisfaction scores and improved employee satisfaction in their work environment.

The HCAHPS survey was developed by CMS and AHRQ to create a uniform method of accumulating information about patient's perceptions of their hospital care. HCAHPS is the result of nearly four years of development that involved creating a survey instrument, testing the instrument with hospitals and patients, allowing public feedback, and conducting a pilot test to ensure accuracy and reliability in the data (Owens, 2011).

Since March 2008, CMS has been publicly reporting data from the HCAHPS survey. HCAHPS is designed to measure patient perceptions of care so that consumers can make informed decisions when choosing a hospital. Use of HCAHPS is required by CMS for general acute care hospitals to maintain eligible for full reimbursement updates. A majority of the hospital quality of care information gathered through the HCAHPS program is available to health care consumers on the Hospital Compare website. The website states the following:

Hospital Compare is a consumer-oriented website that provides information on how well hospitals provide recommended care to their patients. On this site, the consumer can see the recommended care that an adult should get if being treated for a heart attack, heart failure, pneumonia, or having surgery. The performance rates for this website generally reflect care provided to all U.S. adults with the exception of the 30-Day Risk Adjusted Death and Readmission measures that only include Medicare beneficiaries hospitalized for heart attack, heart failure, and pneumonia. (U.S. Department of Health & Human Services, 2010, p. 1)

The goal of HCAHPS is to financially encourage hospitals to take steps to make care safer for patients. The questions designed in the survey are represented by quality measures that are known to improve the quality of care patients receive during inpatient

visits to the hospital. Deirdre Mylod, Ph.D., vice president of hospital services at Press Ganey stated the following:

HCAHPS has been a defining moment for hospitals. The Centers for Medicare and Medicaid Services had said it knew HCAHPS wouldn't by itself improve quality of care, but it had hoped it would be a catalyst for improvement. And by and large, that has been borne out. Consumers may not be using the data to make health care decision yet, but it does seem that providers' attention and resources, and the level at which they are addressing patient-centered care, has really changed (Press Ganey Associates, 2010, p. 1) (see Appendix D for HCAHPS survey).

Correlation of Value Based Purchasing and HCAHPS

The hospital VBP program links a portion of IPPS hospitals' payments from CMS to performance on a set of quality measures. The hospital VBP TPS for FY 2013 has two components: the Clinical Process of Care Domain, which accounts for 70% of the TPS, and the Patient Experience of Care Domain, which represents 30% of the TPS (Centers for Medicare and Medicaid Services, 2011). The HCAHPS survey is the basis of the Patient Experience of Care Domain.

Eight HCAHPS measures are employed in hospital VBP: the six HCAHPS composites (communication with nurses, communication with doctors, staff responsiveness, pain management, communication about medicines, and discharge information); one new composite that combines the hospital cleanliness and quietness survey items; and one global item (overall rating of hospital) (HCAHPS, 2008). The percentage of a hospital's patients who chose the most positive, or *top-box*, survey response in these HCAHPS dimensions is used to calculate the Patient Experience of Care Domain score. Hospital VBP utilizes HCAHPS scores from two time periods: a baseline and a performance period.

For fiscal year 2013, the baseline period covers patients discharged from July 1, 2009 through March 31, 2010, and the performance period from July 1, 2011 through March 31, 2012 (Centers for Medicare and Medicaid Services, 2011).

The Patient Experience of Care Domain score is comprised of two parts: the HCAHPS base score (maximum of 80 points) and the HCAHPS consistency points score (maximum of 20 points). Each of the eight HCAHPS dimensions contributes to the HCAHPS base score through either an improvement or an achievement score. Improvement is the amount of change in an HCAHPS dimension from the earlier baseline period to the later performance period (HCAHPS, 2008). Achievement is the comparison of each dimension in the performance period to the national median for that dimension during the baseline period. The larger of the improvement or achievement score for each dimension is used to calculate a hospital's HCAHPS base score. The second part of the Patient Experience of Care Domain is the consistency points score, which ranges from 0 to 20 points. Consistency points are designed to target and further incentivize improvement in a hospital's lowest performing HCAHPS dimension. The Patient Experience of Care Domain Score is the sum of the HCAHPS base score (0-80 points) and HCAHPS consistency points score (0-20 points), thus ranging from zero to 100 points and comprising 30% of the hospital VBP TPS (HCAHPS, 2008).

CHAPTER III

PROJECT DESIGN

Description of Project

This Capstone value based nurse consultant project was approved by The University of Southern Mississippi's Institutional Review Board (IRB) to inform healthcare executives about value based purchasing and its effect on the future of healthcare organizations (see Appendix E for IRB). Robb's (2006) guiding principles for the nurse consultant were used to provide key information regarding changes in healthcare reimbursement to healthcare executives.

The DNP consulting program was a five-day consulting project that described how HCAHPS data should be used in context with other information for organizational performance and increased reimbursements. The project took place in the executive meeting room of a rural acute care hospital in southwest Mississippi the week of July 9-13, 2012 from 8:30 a.m. to 4:30 p.m. and was presented by the DNP student. Each day consisted of three, two-hour lectures filled with highlights of cultural elements necessary to build a firm foundation for HCAHPS success. The entire senior leadership team, which consisted of seven members, attended the sessions.

Consultation Program

Day 1: Understand HCAHPS Data

Using the Hospital Compare website the organization's current HCAHPS data was presented via PowerPoint presentation. Each member of the senior leadership team was asked to record his or her current focus area results. Understanding HCAHPS data requires knowing more than an organization's current performance on the 10 publicly reported HCAHPS indicators. Behind those numbers is a wealth of information that

leaders need to understand and use to guide improvement efforts (Rhew, 2012). Besides the current performance, leaders should pay particular attention to trending, benchmarking, and unit analysis. Furthermore, leaders should pay attention to bottom-box performance (the least positive) response category on the HCAHPS survey. They should examine if the organization has a higher percentage than the national bottom-box score; doing this will help leaders start setting priorities (Rhew, 2012).

Day 2: Set Improvement Priorities

Once hospital leaders have an understanding of the HCAHPS data within the organizational context, the next step is to identify improvement priorities. Other than willingness to recommend, performance on all other HCAHPS metrics is incorporated into VBP (Shoemaker, 2011). The team was asked to choose three focus areas it wished to focus on. For example, the hospital CNO chose nurses listen, respect from nurses, and staff explained medication. These were three areas she oversees within the organization and wanted to set these as her top priorities.

In fiscal year 2013, HCAHPS performance accounts for 30% of a hospital's VBP payments, with clinical measures accounting for the other 70% (HCAHPS, 2008). Because of the financial component, hospital leaders should pursue multiple improvement initiatives simultaneously. A focused approach to improvement will help to align efforts and contribute to success.

When identifying HCAHPS improvement priorities, health care leaders should consider the VBP implications of the performance and the correlations between HCAHPS measures. Also, encompassing the opportunities for improvement identified by other feedback from patients, families and staff have proven to be beneficial (Studer, 2010).

Day 3: Identify and Implement Targeted Interventions

After identifying priority areas for improving the patient experience, organizations should determine performance-improvement interventions. When choosing interventions the team is advised to involve a combination of external and internal review.

External review. In selecting improvement interventions, leaders should consider the successful practices that other organizations have implemented (Rhew, 2012). Organizations should review successful and unsuccessful processes and common characteristics of hospitals that have already improved their HCAHPS performance. Simply deciding to adopt a practice is not enough. Careful attention must be paid to how to do it consistently and effectively in each organization.

Since HCAHPS is a relatively new survey, additional research and case studies are being released on a regular basis. Leaders should monitor emerging developments, such as through the Agency for Healthcare Research and Quality's Innovation Exchange and the American Hospital Association's Hospitals in Pursuit of Excellence, which regularly profiles organizations implementing innovative practices to improve the patient experience (AHRQ, 2008). An article was provided to the team from the Agency for Healthcare Research and Quality Innovation Exchange about successful interventions that other organizations have proven successful.

Internal review. In selecting improvement interventions, leaders should actively tap into the expertise within their own hospital. Leaders should familiarize themselves with the differences in practices between high and low performing units in the priority area to determine if there are unit based innovative practices that could be replicated throughout the organization (Studer, 2010). Team trades, where a staff member from a high

performing unit exchanges places with a colleague in a low performing unit for a few hours, can be an effective way of identifying the differences between the units (Studer, 2010). The team was asked to form of a list of champions within the organization who have proven expertise in a given area and could be beneficial to the organization's success.

Day 3 and 4: Engage the Team

HCAHPS success depends not only on understanding the data, but also on engaging and motivating the right team. Each team member, clinical and non-clinical, must understand what their role is in creating an ideal experience for patients and should be provided with the appropriate tools and training to support their work.

Involving patients, families, and frontline staff in improvement. Patients, families, and frontline staff provide invaluable perspectives on HCAHPS improvement. Hospital improvement teams should include patients, families, and frontline staff working together to understand the patient experience and offering ideas to improve the experience (Press Ganey, 2010). Rather than attempting to implement an intervention across the entire hospital at one time, it is often a better strategy to implement an intervention on one unit. Starting small enables the team to address barriers on a more manageable scale (Press Ganey, 2010). Plans tend to be more developed, more realistic, and more successful when moved to full hospital implementation. In addition, if the intervention does not have the desired effect of improving the patient experience, it can be modified or discontinued before too many resources and too much time is invested (Ashish, 2008).

Starting small also makes it possible for organizations to build momentum by engaging staff. For example, one hospital team worked on reducing noise levels and implemented every suggestion made by frontline staff, even if it was only piloted by one

nurse with one patient on one shift (Kelly, 2012). Engaging a multidisciplinary team in the improvement process and acting on staff ideas can build enthusiasm for the work.

Providing appropriate tools and training. Using data effectively is not a skill that is intuitive for all, so it is essential to offer appropriate tools and training to promote effective use of the HCAHPS data. In many organizations, HCAHPS data is unwittingly misused by managers who are trying hard to improve the patient experience, but lack the necessary foundational knowledge of how to use data effectively (Ashish, 2008). Common data mistakes include making comparisons with sample sizes that are too small to be reliable, isolating individual patient comments to use in performance reviews and overreacting to changes in percentiles that do not reflect changes in actual organizational performance. These common errors can discourage team members and impede HCAHPS improvement.

Motivation and communication. Understanding what motivates individual members of the team is critical to success. Some team members may be motivated by VBP implications, but others may lose enthusiasm if finances seem to be the primary driver for improvement (Shoemaker, 2011). Frontline clinical staff may be motivated by connecting the patient experience to quality and safety. One hospital found that physicians' interest in patient satisfaction reports increased when the hospital demonstrated the relationship between satisfaction, complaints, and malpractice (Ashish, 2008).

Communicating both the goal and the strategic vision behind the goal is important. Every staff member should know what is expected of him or her. Leaders need to make a clear connection for staff to understand how daily tasks contribute to creating an optimum patient experience. All departments, such as pharmacy and

environmental services, have a direct bearing on several of the HCAHPS questions (HCAHPS, 2008). Although improving HCAHPS performance is a desired outcome, successful patient-centered organizations often articulate a broader vision for patient-centered care.

Reports utilizing HCAHPS data should be designed to enable staff members to quickly understand the organization's current performance, how the data are trending, and the improvement priorities and strategies (Ashish, 2008). Communication about improvement techniques is an essential, but often forgotten task. Many organizations broadly disseminate the HCAHPS data without sharing information about improvement strategies. Furthermore, many organizations don't create opportunities for improvement discussions. Effective HCAHPS improvement work requires a coordinated effort to address the opportunities for improvement identified by the data; simply disseminating the data is not an effective way to spur change (Ashish, 2008).

Day 5: Measure and Monitor Success

Use of HCAHPS measures should be embedded into the organization's overall quality improvement program. Each improvement cycle should include ongoing measuring and monitoring for success. The impact of patient experience interventions can be measured by using HCAHPS data, along with other organizational metrics related to the patient experience, quality, and safety (HCAHPS, 2008). Staff metrics may provide valuable insights into what aspects of patient experience improvement initiatives are working and what aspects should be refined or abandoned.

Leaders should ensure that managers are provided with appropriate tools and training to improve quality using rigorous, well-designed processes, rather than a scattershot approach. There are many methods for quality improvement, such as the

Plan-Do-Study-Act (PDSA) or Six Sigma methods. Leaders should determine what quality improvement methodology will be used to improve HCAHPS performance and provide managers with guidance and support in using the methodology (Ashish, 2008). The PDSA model was used for the implementation of this project (see Appendix F for PDSA model).

The team was asked to record each of the three focus areas it had chosen onto the PDSA cycle form. The DNP student led the members of the team through the PDSA cycle and assisted them in formulating complete performance improvement initiatives. The team will use these initiatives as a basis for evaluating the performance of its focus areas and how well its HCAHPS scores improved by implementing these plans. Also, the DNP introduced the formation of the PIC to monitor the successes of the plan and to be the communication board between the organization and the DNP student after implementation.

Organizations are famous for planning and implementing performance improvements, and for forgetting to follow through after the initial implementation. An ongoing systematic approach to evaluation is one way to ensure that successful practices will be disseminated broadly throughout the organization. Furthermore, given limited time and resources, knowing what to stop doing is sometimes as important as knowing what to implement.

Data Analysis

One month after implementation of the project into the organization the hospital executives used information from Hospital Compare to prove an increase in HCAHPS scores. Due to the lack of time between the implementation of the program and the next month's scores, the team was asked to focus on the following month's scores, as well.

The information used to analyze an increase in the publically reported HCAHPS scores was May 2012 to August 2012, but was extended to encompass September 2012. The researcher expected that the overall HCAHPS scores should increase from the initial survey in May 2012 to August 2012, as hospitals would want to receive their full reimbursement from CMS. Table 1 portrays the organization's actual scores in May 2012, August 2012, and September 2012.

Table 1

HCAHPS Survey Average Scores

Category	May 2012	August 2012	September2012
Nurse	74%	76%	79%
Doctors	79%	82%	82%
Staff responsiveness	77%	84%	88%
Cleanliness and hospital environment	65%	69%	72%
Pain management	72%	72%	74%
Communication about medications	80%	81%	81%
Discharge information	90%	92%	91%
Overall rating of hospital	76%	84%	87%
Recommendation of hospital	85%	89%	92%

As expected, there is only a slight increase in August 2012 scores due to time, but September portrays a slightly larger increase in HCAHPS scores. Each of the eight dimensions showed an increase of 1-2% with overall rating of the hospital increasing by 11 points and communication on medications and discharge information showing the least improvement of only one point. Cleanliness of the hospital and recommendation of

the hospital, which were two of the focus areas the Chief Operating Officer chose in the consultation project, both increased by seven points.

The organization will now be able to place these scores into the VBP worksheet and examine potential increases or decreases in incentive payments. Because of the slight increase of scores from August to September, the DNP can only assume that scores will continue to increase from month to month as staff becomes more accustomed to changes implemented from the Capstone Project

Limitations

One limitation of the study was the short amount of time between the introduction of the project and the implementation into the organization. Another limitation was that each hospital will be notified of its estimated incentive payment for fiscal year 2013 through its QualityNet account at least 60 days prior to October 1, 2012, which was after the project was introduced to the organization, meaning that the organization at hand did not have a guide for incentive payments to follow. Also, CMS will notify each hospital of the exact amount of its incentive payment on November 1, 2012, which again was after the introduction of the project.

Discussion of Successes

The introduction of the project was an informal and nonthreatening method to gain information regarding the organization's culture and current HCAHPS scores. All the senior leaders in the sessions participated in the discussion and were able to offer valuable insight into the acceptance of healthcare reform and their plans for improving their VBP scores. All of the senior leaders participating in the sessions believed that by increasing their HCAHPS scores they will in turn increase their reimbursements from CMS, along with building a strong sense of quality among their employees and patients.

The consultant program was embraced by all senior leaders, who believed that the information presented will help lead their organization into the future of healthcare reform.

CHAPTER IV

SUMMARY

Summary and Conclusions

Even before the passage of healthcare reform legislation in 2010, experts were predicting that healthcare organizations would need to assess and adjust their business philosophies and practices to take advantage of the many opportunities that would follow healthcare reform. Reform is now a reality. The healthcare industry is inherently complex and facing significant structural changes that require every provider to organize around a new set of standards including value, accountability, quality, efficiency, and transparency (Federal Register, 2011).

This project proved that if hospitals want to thrive in the environment of HCAHPS, hospitals will need to implement strategies that focus on standardizing the level of adherence to evidence-based clinical process measures, especially those that have been shown to improve hospital HCAHPS and VBP scores. The DNP graduate will be the driving force to provide healthcare solutions designed to help clients optimize their performance in a short time and prepare for inevitable strategic, operational, and financial challenges of the future (Packham, 2003).

This Capstone Project does not address all issues related to the problems and solutions in healthcare, but it does recognize the benefit of a DNP nurse consultant to facilitate programs to lead healthcare organizations in the future of system change. The evidence gathered through the building of this project points to an extensive and diverse portfolio of activities relating to expert practice and educational practice development of the nurse consultant and a DNP graduate. It also shows the urgent requirement to support consultant nurses and DNP graduates in developing their leadership potential and their

skills in researching practice. Explicating how consultant nurses and DNP graduates achieve their goals is paramount to ensure succession planning for future clinical leaders. This project provides the building blocks for the educational preparation of future leaders, as well as contemporary consultant nurses and DNPs who want to support and develop in their roles. Strategic vision to develop nursing and its contribution to health care requires nurses who are confident and competent in bringing this to fruition through effective leadership (Redwood, 2012).

Plans for Disseminating the Project

The consultant program utilized in this Capstone Project can be continued by implementing new focus areas to provide an increase in VBP incentives. The clinical process of care domain (Core Measures) is the other 70% of the VBP incentive. This system is more complex and detailed than the HCAHPS piece, which will in turn require more research and time than allowed in this program.

The plan for the future of this project is to continue to build each focus area until its completion of 100% of the VBP incentive. The DNP graduate will also continue to monitor the implementation of this project in the participating organization for the next year to see continuous successes or areas for improvement. Many organizations throughout the area surrounding the participating organization have asked that the DNP graduate come present the first part of the project with intentions of returning once the second part is complete. This project will continue to evolve even after the CMS standards are initiated, due to the interest of private insurance companies in the value based program.

APPENDIX A

ESSENTIALS OF DOCTORAL EDUCATION FOR
ADVANCED NURSING PRACTICE

Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006)	Relates to Capstone Project
Essential I: Scientific Underpinnings for Practice	The project expands the discipline of nursing by promoting an understanding of how to change practice behavior for nurse consultants to improve the overall good of a healthcare system.
Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking	The project extends and assesses new approaches for quality improvement that will help manage present and potential requirements for a healthcare organization.
Essential III: Clinical scholarship and analytical methods for evidence-based practice	The project provides the opportunity to critically appraise and evaluate literature to support implementing evidence based organizational centered strategies for improvement in healthcare outcomes.
Essential IV: Information Systems/Technology and Patient Care Technology	The project promotes the DNP graduate to design and implement programs associated with improving healthcare quality.
Essential V: Healthcare Policy for Advocacy in Health Care	The project involves the DNP graduate in committees, boards and interdisciplinary team groups at the local, state, and national levels as an expertise in policy issues associated with the new healthcare system.
Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes	The project promotes the DNP graduate as a consultant in the role of Quality Improvement Initiator at the local and national level.
Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health	The project promotes the DNP graduate role in improving health care outcomes for all patients. Promotes quality healthy outcomes.
Essential VIII: Advanced Nursing Practice	The project allows the advancement of the nursing practice by promoting the DNP graduate as a consultant for healthcare systems.

Note: (American Association of Colleges of Nursing, 2006).

APPENDIX B

PIC EVALUATION FORM

YOUR HOSPITAL
DEPARTMENT/TEAM PERFORMANCE IMPROVEMENT ANNUAL EVALUATION

EVALUATING PERFORMANCE IMPROVEMENT FUNCTIONS FOR Department/Team:

Completed by:

1 Have improvements been made over the past year as a result of your Performance Improvement activities? ☐**Yes** ☐**No**

a If so, what improvements were made?
b Did the improvement/s involve improving a process? ☐**Yes** ☐**No**
c Did the improvement/s improve a patient outcome? ☐**Yes** ☐**No**
d Was the improvement directly related to the Performance Improvement measures you chose? ☐**Yes** ☐**No**

2 How did you choose your performance improvement measurements?

3 Have any Performance Improvement activities involved other departments or teams? ☐**Yes** ☐**No**
a If so, were the other departments or teams involved in the measurement process or informed of the findings? ☐**Yes** ☐**No**
b Were the other departments or teams involved in development of the performance measures or collection of data? ☐**Yes** ☐**No**

4 Have you used any statistical tools – charts or graphs in analyzing the your data? ☐**Yes** ☐**No**

5 Has the scope of your department or team changed over the last year? ☐**Yes** ☐**No**

a Has anything been added? If so, what? ☐**Yes** ☐**No**
b Has anything been deleted? If so, what? ☐**Yes** ☐**No**
c Has performance been measured for new services provided? ☐**Yes** ☐**No**

6 Over the past year, has it been necessary for you to prioritize any of your Performance Improvement activities due to multiple areas for improvement being identified? ☐**Yes** ☐**No**

a If so, how did you determine which area was the priority?

7 Were the performance measures reviewed with the staff in your department or team members before data collection was initiated? ☐**Yes** ☐**No**

8 How often were findings of your Performance Improvement efforts reviewed with the staff in your department or with team members?

9 When problems or opportunities for improvement were identified, was input requested from the those performing the functions involved in order to make the necessary changes for improvement?

☐**Yes** ☐**No**

10 ***Departments Only***: Are the results obtained from Performance Improvement activities used for employee evaluations in your department?

☐**Yes** ☐**No**

11 ***Departments Only***: Has your department/service been involved in any team performance measurement activities?

☐**Yes** ☐**No**

a If so, has data directly relating to your department been collected ☐**Yes** ☐**No**

b What Team/s is your department involved in?

12 What suggestions do you have for improving the current Performance Improvement Reporting System?

APPENDIX C

VBP WORKSHEET

Anywhere Hospital

VBP Program Patient Experience of Care (HCAHPS) Measures

Baseline Period: July 1, 2009 to March 31, 2010

Performance Period: July 1, 2011 to March 31, 2012

	Hospital: Baseline Period		Hospital: Peformance Period		National Scores			Points Attained			
(A) Measure	(B) Number of HCAHPS Surveys in Baseline Period *	(C) Baseline Period Score	(D) Number of HCAHPS Surveys in Performance Period *	(E) Performance Period Score	(F) Floor (Minimum) Used to Calculate Consistency Points *	(G) Achievement Threshold *	(H) Benchmark *	(I) Achievement Points *	(J) Improvement Points *	(K) Earned Points *	(L) Used to Calculate Lowest Dimension Score *
Communication with Nurses	300	81%	300	88%	38.98%	75.18%	84.70%	10	alculated	10	1.35
Communication with Doctors		83%		86%	51.51%	79.42%	88.95%	7	5	7	1.24
Responsiveness of Hospital Staff		70%		76%	30.25%	61.82%	77.69%	9	7	9	1.45
Pain Management		79%		83%	34.76%	68.75%	77.90%	10	alculated	10	1.42
Communication About Medicines		60%		70%	29.27%	59.28%	70.42%	9	9	9	1.36
Hospital Cleanliness & Quietness		68%		74%	36.86%	62.80%	77.64%	7	6	7	1.43
Discharge Information		80%		85%	50.47%	81.93%	89.09%	4	5	5	1.10
Overall Rating of Hospital		67%		78%	29.32%	66.02%	82.52%	7	7	7	1.33
HCAHPS Base Score #											64
Number of Dimensions Where Score in Performance Period is Greater than or Equal to the Achievement Threshold #											8
Number of Dimensions Where Score in Performance Period is Less than or Equal to the Floor (Worst Performing Hospital) #											0
Lowest Dimension Score #											N/A
HCAHPS Consistency Score #											20
HCAHPS Score #											84

APPENDIX D

HCAHPS SURVEY TOOL

HCAHPS Survey (HCAHPS, 2008)

SURVEY INSTRUCTIONS

♦ You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
♦ Answer all the questions by checking the box to the left of your answer.
♦ You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes
☐ No ☐ *If No, Go to Question 1*

You may notice a number on the survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.
Please note: Questions 1-22 in this survey are part of a national initiative to measure the quality of care in hospitals.

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

2. During this hospital stay, how often did nurses listen carefully to you?
1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?
1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always
9☐ I never pressed the call button

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

6. During this hospital stay, how often did doctors listen carefully to you?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

9. During this hospital stay, how often was the area around your room quiet at night?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
1□ Yes
2□ No□ If No, Go to Question 12

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

1□ Never
2□ Sometimes
3□ Usually
4□ Always

12. During this hospital stay, did you need medicine for pain?
1□ Yes
2□ No □ If No, Go to Question 15

13. During this hospital stay, how often was your pain well controlled?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

15. During this hospital stay, were you given any medicine that you had not taken before?
1□ Yes
2□ No □ If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
1□ Never
2□ Sometimes
3□ Usually
4□ Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?
1□ Own home
2□ Someone else's home
3□ Another health facility □ If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
1□ Yes
2□ No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
1□ Yes
2□ No

OVERALL RATING OF HOSPITAL
Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. 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?
0□ 0 Worst hospital possible
1□ 1
2□ 2
3□ 3
4□ 4
5□ 5
6□ 6
7□ 7
8□ 8
9□ 9
10□10 Best hospital possible

22. Would you recommend this hospital to your friends and family?
1□ Definitely no
2□ Probably no
3□ Probably yes
4□ Definitely yes

ABOUT YOU

There are only a few remaining items left.

23. In general, how would you rate your overall health?
1□ Excellent
2□ Very good
3□ Good
4□ Fair
5□ Poor

24. What is the highest grade or level of school that you have completed?
1□ 8th grade or less
2□ Some high school, but did not graduate
3□ High school graduate or GED
4□ Some college or 2-year degree
5□ 4-year college graduate
6□ More than 4-year college degree

25. Are you of Spanish, Hispanic or Latino origin or descent?
1□ No, not Spanish/Hispanic/Latino
2□ Yes, Puerto Rican
3□ Yes, Mexican, Mexican American, Chicano
4□ Yes, Cuban
5□ Yes, other Spanish/Hispanic/Latino

26. What is your race? Please choose one or more.
1□ White
2□ Black or African American
3□ Asian
4□ Native Hawaiian or other Pacific Islander
5□ American Indian or Alaska Native

27. What language do you mainly speak at home?
1□ English
2□ Spanish
3□ Chinese
4□ Russian
5□ Vietnamese
6□ Some other language (please print): _____

APPENDIX E

THE UNIVERSITY OF SOUTHERN MISSISSIPPI

INSTUTIONAL REVIEW BOARD

APPROVAL

THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.6820 | Fax: 601.266.4377 | www.usm.edu/irb

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months. Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: **12072401**
PROJECT TITLE: **Value Based Purchasing: Positioning a Health Care Organization for the Future**
PROJECT TYPE: **New Project**
RESEARCHER/S: **James Dale Heard**
COLLEGE/DIVISION: **College of Health**
DEPARTMENT: **Nursing**
FUNDING AGENCY: **N/A**
IRB COMMITTEE ACTION: **Expedited Review Approval**
PERIOD OF PROJECT APPROVAL: **07/24/2012 to 07/23/2013**

Lawrence A. Hosman, Ph.D.
Institutional Review Board Chair

APPENDIX F

PERFORMANCE IMPROVEMENT PROGRESS REPORT

NAME OF REPORT
REPORTER **DATE**

PI MODEL

(Please check the cycle of PDSA you are reporting on below:)

Plan = Objective Questions, Predictions (WHY) Plan to implement the cycle (WHO, WHAT, WHERE, WHEN)	Tools: ❑ brainstorming ❑ suggestion ❑ observation ❑ surveys ❑ new service/function/process ❑ other_____
DO = Carry out the plan Document problems and unexpected observations Begin data analysis	Tools: ❑ checklist/check sheet ❑ data-collection form ❑ sampling ❑ survey ❑ statistical diagram ❑ other_____
Study = Complete analysis of data Compare data to predictions Summarize what was learned	Tools: ❑ Compile findings ❑ presentation ❑ procedure/policy ❑ education/training ❑ other_____
Act = What changes need to be made? (What worked? What didn't?) Next Cycle?	Tools: ❑ Education/training ❑ presentation ❑ building support ❑ follow-up for continuous improvement ❑ other_____one on one training_____

PROGRESS SINCE LAST REPORT:
Findings:
Trends:
Plan of Action/Recommendations:

THIS SHEET WILL BE COMPLETED EACH TIME A PROGRESS REPORT IS SUBMITTED

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