# Cleveland Clinic Florida "pay-for performance" reimbursement: why the best care does not always make the happiest patients

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## Introduction

Osmel Delgado, the Chief Operating Officer (COO) of Cleveland Clinic Florida (CCF), known to his friends and colleagues as "Ozzie," was a very busy man in 2019. He was a smart and savvy COO who frequently lunched at his desk, if he had time for lunch at all. Delgado spent countless hours poring over financial statements, trying to cut ever increasing healthcare costs, increase revenues and deliver the best patient care in the country. Delgado joined CCF in 1999 as the Director of Pharmacy, followed by a succession of roles as Administrative Director of Clinical Operations and Senior Director of Operations, before becoming the COO. Delgado's MBA degree added to his ability to establish the workflows for CCF's newly implemented transplant program, design multiple construction projects across the CCF organization and establish an accredited pharmacy residency program.

Outstanding care was the Cleveland Clinic brand. It was more than a brand; it was a mantra. "A patient is the most important person in the institution [. . .] It is our job to satisfy them," stated William Lower, MD, Co-Founder, Cleveland Clinic. Cleveland Clinic acted to support its words. For example, Cleveland Clinic was the first major academic medical center to make patient experience a strategic goal, appoint a Chief Experience Officer, and one of the first to establish an Office of Patient Experience. As the winner of the 2012 Cleveland Clinic Caregiver Award, Delgado was committed to Cleveland Clinic's "patient first" philosophy. Delgado's business and economic decisions were patient centric. Delgado implemented a patient safety strategy designed to prevent after surgery complications, reduce hospital acquired conditions and infections, falls and skin breakdowns. This patient centric initiative decreased hospital readmissions and reduced overall patient treatment costs.

The economic challenges faced by CCF and hospitals all over the country took a new turn in 2010, however, when Congress passed the Patient Protection and Affordable Care Act (ACA). The ACA opened the door to federal regulatory control of hospital reimbursement for billed services which changed the hospital reimbursement environment. Under the new rules, hospital reimbursement moved from a pay-for-services rendered model to a pay-for-performance model based on a new set of "patient experience" metrics embodied in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. CAHPS surveys included the Hospital Consumer Assessment of Healthcare Providers and Systems

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(HCAHPS) for in-patient experience hospital evaluation and the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for out-patient experience provider evaluations. Less than perfect scores on these multiple-choice patient experience surveys meant less monetary reimbursement for patient hospital services rendered regardless of the actual service costs incurred by the hospital or the provider. Scores that improved were good but to avoid the penalty, the scores had to be perfect.

At first, CCF was unconcerned. Delgado expected high patient satisfaction scores given that CCF's clinical rankings, assessing quality of medical treatment for the same period, were excellent (see data below). In terms of quality of care, CCF ranked first in the Miami-Ft. Lauderdale metro region and 5th in the State of Florida, moving up four spots according to US News & World Report's "2016–2017 Best Hospitals" metro area ranking. In the 2017–2018 ranking, it was the second-best ranked hospital in the Miami-Fort Lauderdale area, the highest ranked hospital in Broward County and the eighth ranked hospital in the State of Florida. The entire Cleveland Clinic organization was rated as one of the top five hospitals by US News and World Report for 2013–2014, 2015–2016 and 2018–2019. Delgado expected that patient satisfaction surveys would be fully aligned with the quality of healthcare actually received by the patient.

However, that was not the case. The CCF HCAHPS surveys for the period 2011–2016 reported less than perfect scores and reflected some patient dissatisfaction. Delgado pondered these results. They really made no sense to him. How could the HCAHPS reflect patient dissatisfaction when the CCF's clinical quality rankings reflected that CCF was delivering the highest medical quality care? Leaning back in his chair, Delgado shook his head and wondered incredulously how one of the most famous hospitals in the world could deliver such excellent quality medical care but receive negative patient satisfactions scores on HCAHPS surveys. At that same moment, the reimbursement implications became clear to Delgado as well. At least as far as hospital financial reimbursement from the government was now concerned, payment was no longer based on the clinical definition of quality patient care but instead, was based on patient satisfaction measured by a new set of survey questions prepared by the regulators. Anything less than a perfect patient satisfaction score meant that CCF would stand to lose reimbursement for services rendered and create a measure of uncertainty in future revenues and budgetary planning.

A substantial portion of the total gross patient service revenue at the Cleveland Clinic Health System was subject to the ACA rules. (Gross patient revenue meant the total charges at the hospital's full established rates for the provision of patient care services and included charges related to hospital-based physician professional services). The interim audited consolidated financial statement for the Cleveland Clinic Health System showed that for the year ending 2018, 61% of the total gross patient service revenue for the Cleveland Clinic Health System based on patient mix, which included Medicare and Medicaid patients, was subject to ACA reimbursement rules[1]. No hospital subject to the ACA could provide annual revenue estimates with any reasonable certainty given the uncertainty of this new pay-for-performance reimbursement scheme. This was a national problem. Considering this new challenge of uncertainty in preparing revenue projections for the next fiscal year and beyond and the potential impact on the CCF brand, Delgado called together his quality improvement team, Dr Piloto, the Chief Patient Experience Officer and nurse Dawn Semple, Patient Experience Manager, to brainstorm solutions to the misalignment problem between the actual high quality of patient care and the patient survey perceptions of dissatisfaction. Brand, reputation and reimbursement were at stake.

## The umbrella organization: Cleveland Clinic

In 1921, the Cleveland Clinic Foundation was founded on the east side of Cleveland, OH by four physicians as a physician-led, for profit medical system. Its mission was dedicated to

"provide better care for the sick, investigation into their problems and further education of those who serve." The four founders served in First World War and patterned the Cleveland Clinic on the military model of cooperative medical specialties. In 1924, a 184-bed hospital was added to its outpatient facility. In 2004, the Cleveland Clinic Lerner College of Medicine was opened at Case Western Reserve University.

By 2016, the Cleveland Clinic system had grown to 144 buildings on 67 acres in Ohio, with an additional 150 sites in Northern Ohio. It expanded operations as Cleveland Clinic Florida with eight sites in South Florida, in addition to Cleveland Clinic Nevada, Cleveland Clinic Canada, Cleveland Clinic Abu Dhabi and Cleveland Clinic London, scheduled to open in 2020. Cleveland Clinic was administered by a Board of Governors and a Medical Executive Committee, whose members were physicians elected by staff and key administrators. The Board was advised by a community-based Board of Trustees. During 2016, the Cleveland Clinic had 7.14 million outpatient visits and over 220,000 acute admissions and observations. Its patients came from all 50 states and 185 countries around the world. It employed over 2,000 residents and fellows in training.

Key innovations at the Cleveland Clinic included the first coronary angiography in 1958, the development and refinement of coronary bypass surgery in 1967, the first successful larynx transplant in 1998 and the US's first near total face transplant in 2008. This case examines Cleveland Clinic Florida specifically, within the umbrella organization.

## Delivering world class care: Cleveland Clinic Florida

CCF was in Weston, FL. It was a not-for-profit, multi-specialty, academic medical center that integrated clinical and hospital care with research and education. The medical campus was fully integrated and included diagnostic centers, outpatient surgery and a 24-hour department located in the state-of-the-art hospital.

CCF entered the state in 1988 when it opened physicians' offices in Fort Lauderdale. The system grew to include the main 155-bed hospital with a 74-bed tower expansion in 2018; the Braathan Cancer Center located on-site; the Krupa Center with physicians' offices located across the street from the hospital; the West Palm Beach Florida Cardiology Center; the Tomsich Health and Medical Center of Palm Beach County; physicians and specialty care services in Parkland; Palm Beach Gardens; and, Wellington. The Coral Springs Family Health and Ambulatory Surgery Center opened in 2018. CCF continued to expand through merger and acquisition opportunities with Martin Health in Stuart, FL and Indian River Medical Center in Vero Beach, FL.

Each Cleveland Clinic hospital designed internal operations to meet the needs of the particular community that is served and to that end each hospital verified the health needs of communities by performing periodic health needs assessments. These formal assessments were analyzed using widely accepted criteria to determine and measure the health needs of a specific community. CCF's service area in Broward County had comparatively unfavorable health status and socioeconomic indicators, particularly for minority residents. Migrants from Latin America settled into distinct cultural enclaves in many of the Broward County communities. Because Florida was one of the states that did not extend Medicaid benefits, many of these migrant families were uninsured or underinsured.

Delgado explained CCF's service-based strategic plan based on these community assessments:

> CCF is not intended to be a safety net hospital for the uninsured in the Weston and Broward communities. We have a private preference for providing care for complex care cases. Our strategic plan to increase patient access to our services is essentially two-fold: promote health and wellbeing through preventative treatment; and, narrow the fields of practice offering care because the delivery of basic "sick care" costs more for any hospital.

This strategic plan was also reflected in the CCF 2016 Community Health Needs Assessment Report. CCF provided limited fields of practice and care for complex cases including cancer, digestive disease and surgery, heart and vascular, neurological, gynecological, orthopedic surgery and rheumatology. It employed 240 physicians with expertise in only 35 specialties. Delgado observed that:

> CCF cannot be everything to everyone in the healthcare delivery market. We deliberately chose to limit our service-based commitments to our physician specialties.

The remaining patient population was serviced by public hospitals in the region receiving public funding. The public hospitals served as the safety net for the uninsured delivering more expansive sick care to a greater segment of the community. The patient payor mix at CCF, represented by the percentage of gross patient revenues, is in Table 1 below. CCF's outcomes data are next examined.

## Quality healthcare outcomes data

The data showed that CCF had healthcare outcome scores that were better than or equal to the national averages. For example, CCF's heart attack mortality rates between 2015–2018 met the national average. The following data represented the per cent (rate) of heart attack patients that died within 30 days of going into the hospital. This information was important because one way to tell if a hospital was doing a good job was to see if the death (mortality) rate for heart attack patients treated at that hospital was better than, the same as or worse than the US national average. The death rates also accounted for how sick patients were before they were admitted to the hospital. Lower numbers were better.

| | *July 2015–June 2018* |
|---|---|
| CCF | 12.7% |
| US national average | 12.9% |

The difference between CCF and the national average was not significant. That meant that CCF's heart attack patient death rate was basically the same as the national average.

Another way to tell if a hospital was doing a good job was to see if the readmission rate for heart attack patients was better than, the same as or worse than the US national average. The readmission rates also accounted for how sick patients were before they were admitted to the hospital. Again, lower numbers were better.

| | *July 2015–June 2018* |
|---|---|
| CCF | 14.6% |
| US national average | 15.7% |

The difference between CCF and the national average was not significant. This meant that CCF's heart attack patient hospital readmission rate was basically the same as the national average.

Another significant data point indicating quality of care was percent (rate) of stroke patients that died within 30 days of going into the hospital. This information was important because

one way to tell if a hospital was doing a good job was to see if the mortality rate for stroke patients treated at the hospital was better than, the same as or worse than the US average. The death rates accounted for how sick patients were before they were admitted to the hospital and lower numbers were better.

| *July 2015–June 2018* | |
|---|---|
| CCF | 12.4% |
| US national average | 13.8% |

Patient safety was a very significant concern due to increased injuries and deaths to patients while in the hospital environment. The following data provided how often patients had certain serious, but potentially preventable complications (listed below) related to medical or surgical inpatient hospital care. The data scoring came from documenting certain events in patient medical records. These events were then "coded" by the hospital for billing Medicare. Coded information was sometimes called "administrative" data. Again, one way to tell if a hospital was doing a good job is to look at how often patients experienced certain complications that might have been preventable. Lower numbers were better. CCF was either better than or equal to the national rate in terms of preventing certain serious complications (Table 2).

**Table 1** Cleveland Clinic Health System Interim Unaudited Consolidated Financial Statements and other information for the period ended March 31, 2019

*Payor mix*

*The following table shows payor mix as a percentage of gross patient service revenue for the health system and obligated group as a whole:*

| | *Cleveland clinic health system* | | | | |
|---|---|---|---|---|---|
| | *Based on gross patient service revenue* | | | | |
| | *Year ended December 31* | | | *YTD March 31* | |
| | *2016 (%)* | *2017 (%)* | *2018 (%)* | *2018 (%)* | *2019 (%)* |
| Payor | | | | | |
| Managed care and commercial | 39 | 38 | 37 | 38 | 34 |
| Medicare | 44 | 46 | 47 | 46 | 50 |
| Medicaid | 14 | 14 | 14 | 14 | 13 |
| Self-pay & other | 3 | 2 | 2 | 2 | 3 |
| Total | 100 | 100 | 100 | 100 | 100 |

**Table 2** Death caused by serious complications

| *October 2016–June 2018* | *Rate per 1,000 hospitalized patients* | |
|---|---|---|
| *Serious complication* | *US national average* | *CCF*** |
| Death among surgical patients with serious treatable complications | 163.01 | 119.11*** |
| Collapsed lung due to medical treatment | 0.27 | 0.44* |
| Blood clot in the lung or large vein after surgery | 3.85 | 3.37* |
| Wound that splits open after surgery | 0.95 | 0.73* |
| Accidental cut or tear during surgery or other procedure | 1.29 | 0.64* |
| Eight different complications (combined) | 1.00 | 1.18* |

**Notes:** *Not different than the national rate; ** Worse than the national rate; ***Better that the national rate (Cleveland Clinic Florida, 2019)

Additionally, CCF had a prior history of receiving national recognition for the quality of its primary care. In 2014, Cleveland Clinic's Medicine Institute became the first integrated healthcare delivery system to receive Primary Care Medical Home certification from The Joint Commission after transforming all primary care practices to do population management. Practices moved to top-of-license team-based care with embedded care coordinators to manage high-risk patients, which led to strong performance in multiple quality indicators, top decile performance in patient experience, and significant reductions in hospital admissions, readmissions and emergency room visits.

Based in part on this data, CCF was still not inclined to change staffing patterns. Delgado and his staff believed, based on these quality outcomes, that the staffing patterns supported the efficient and high-quality delivery of medical care. To CCF, it made equal sense that the same staffing patterns should have operated with same efficiency in providing patient satisfaction under the HCAHP criteria. Also, the turnover rate of caregivers in the Cleveland Clinic system between 2005–2017 was only 11.7%, better than the national benchmark of 12.3% (State of the Clinic, 2015). Staffing was not viewed as a contributing factor to the problem. CCF found no correlation between staffing patterns and patient HCAHP responses.

In 2016, CCF clinical quality metrics (CQMs), generated by CMS, were above the 90th percentile. Additionally, Cleveland Clinic listed its quality care accomplishments for the same period: Joint Commission Primary Care Medical Home recertification; No. 1 ranking among first-year Medicare Shared Savings Programs; No. 6 overall ranking among accountable care organizations with $34m in shared savings; improved hypertension control in 10,500 patients, which translated to 131 fewer strokes; 100 fewer heart attacks; and 75 fewer patient lives lost to families and the community; online scheduling capability available to patients to access our primary care providers; automated screening for depression in 162,000 patients through Cleveland Clinic's Knowledge Program; No. 8 ranking of the Center for Geriatric Medicine in US News & World Report; No. 1 US News/Doximity ranking for Internal Medicine Residency Program; and, 40 practices accepted into the CMS Comprehensive Primary Care Plus program (Cleveland Clinic Outcomes, 2016). While rankings and outcomes for CCF were excellent, reimbursements were challenged by pay for performance reimbursement based upon patient surveys.

## The situation: Centers for Medicare and Medicaid services hospital, value-based purchasing and patient (HCAHPs) surveys

The Patient Protection and Affordable Care Act (ACA) opened the door to federal regulatory control of hospital reimbursement for billed services. As a direct result, The Centers for Medicare and Medicaid Services (CMS) implemented the regulations that changed the hospital reimbursement model from fee-for-service to pay-for-performance. The new pay-for-performance ACA model raised the financial reimbursement stakes significantly by reducing medicare reimbursement to hospitals that scored below national performance benchmarks on selected quality measures in patient satisfaction surveys.

### *Patient satisfaction surveys*

The ACA embedded HCAHPS, a standardized survey tool, as the quality metric in the calculation of the value-based incentive payment in the hospital value-based purchasing (VBP) program beginning with October 2012 discharges. The purpose of the survey was three-fold: collect accurate and useful data that could be compared hospital to hospital on patient perspectives regarding the delivery of care; encourage hospitals to deliver a higher quality of care. Because the data would be publicly reported, hospitals would be incentivized to provide higher quality; and increase public accountability of hospitals. Thus, reimbursement would be tied to value in the delivery of healthcare services and the value would be determined by the patient perceptions included in the survey responses. HCAHPs

were used only for measuring the inpatient experience. A set of the HCAHPs survey questions are in Exhibit 1.

Patients' perspectives were measured through their responses to 21 factors. These factors were organized into nine topical areas which were the indicators of patient satisfaction: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment and transition of care. The response choices to the questions only included: "Always," "Usually," "Sometimes," "Never." These performance indicator responses were considered controversial by hospitals nationwide because to earn back the withheld reimbursement by CMS from prior years, the hospitals had to earn perfect scores, which meant that patients had to answer "always" satisfied in response to a survey question. Anything less than "always satisfied" would not fix the reimbursement hold. At the same time, many hospitals argued that a perfectly happy survey patient was not necessarily one who had received the best medical care and vice versa. Thus, hospitals argued that the survey was a flawed and biased accountability tool. The survey tool was thought by the CCF team to be the root cause of the satisfaction problem, not the failure to deliver quality care which the surveys were intended to measure. These patient surveys, which control reimbursement, did not take into account actual healthcare outcomes, but rather the patient's satisfaction in response to the survey questions that did not address actual healthcare outcomes.

The argument had support in the medical community. In 2001, the Institute of Medicine had reported that patient satisfaction survey ratings were not an adequate measure of the delivery of improved quality care. "The surveys need revising; they need to meet patients where they are, and they need to ask meaningful questions," said Shannon Connor Phillips, MD, MPH, chief patient safety and experience officer at Intermountain Healthcare in Salt Lake City. "We need to be able to do all of the required surveys electronically and do more real-time, in-the-moment surveys." Hospital administrators agreed that patient perceptions should be considered when evaluating the delivery of high-quality medical care. However, hospitals should not be held to a perfect standard of accountability (e.g. "always" satisfied) to receive full reimbursement for services rendered.

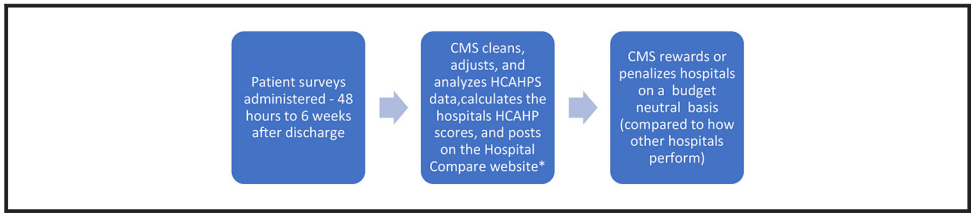
Additionally, the HCAHPs survey did not provide "real time" feedback to the providers. The survey could not be administered while the patient was still in the hospital. Patient sampling, whether by mail, telephone or another option, had to be completed within 48 hours to six weeks following discharge. If the survey was mailed out, the data had to be collected within the six-weeks to be included in the study. Because survey results were not provided on a real time basis, a hospital might not understand that there was a problem until weeks after a patient was released. Delgado was frustrated because these scores were "retrospective," not actionable events for the hospital. He pointed out: "I can't fix today what happened 18 months ago." Conversely, a known problem may have been fixed weeks or months before the survey results indicated that the problem still persisted and had not been fixed.

Nationally, healthcare leaders pointed to created by "snail mail," as the primary culprit. Amy Thorson, director of patient and family experience at Dayton Children's Hospital in Ohio observed: "To improve the patient experience, it is essential to take real-time action when problems occur. In an era of sophisticated technology, data received sometimes months later does not seem to offer meaningful opportunities for improvement." Delgado concluded that the real usefulness of the scores was assistance in trend recognition but not much more than that. Semple agreed and observed that: "We find that when patients answer the surveys in person it is always more positive than when they are responding more than two weeks later at home [2]".

## Patient satisfaction survey flowchart

Dr Piloto identified other unintended consequences of the way in which the survey questions were drafted:

**Survey reimbursement flowchart**




Note: Developed by the authors.

> The pain medication survey question asks how doctors have been managing pain. With the new opioid crisis, we have a problem dispensing pain to drug seekers. Many patients exhibit drug seeking behaviors. If we don't give the pain med, it could have an adverse effect on our HCAHP surveys. So, the survey question might incentivize a doctor to give the med to insure a good score. We don't want that to happen at CCF. So, we will just have to take our lumps because we will never be able to improve our scores on this. We try to look at the patient aspect, not the CMS money aspect. It is really very ironic.

In November 2012, a similar set of survey questions known as CG-CAHPs were issued as the standardized tool to measure outpatient satisfaction and perceptions of care delivered by a provider (e.g. physician, nurse practitioner, physician assistant, etc.) in an office setting. Again, the response choices to the questions were limited to "Always," "Usually," "Sometimes," "Never," with the same consequence if "always" satisfied was not marked by the patient. A set of the CG-CAHPs survey questions are in Exhibit 2. A more detailed explanation of the implementation of HCAHPs and CG-CAHPs is included in Exhibit 4.

## A national problem: the impact of pay-for-performance on hospital reimbursement

The problem of pay for performance reimbursement did not only affect CCF. According to the National Business Coalition on Health, differential reimbursement or "pay-for-performance," was based on the economic principle that "how much we pay for something is determined by its quality." The idea was that "pay-for-performance" would create a powerful business incentive for providers to produce high-quality and efficient services. Pay-for-performance was distinguishable from the pre-ACA fee-for-service reimbursement – the most prevalent payment methodology. The change from fee-for-service reimbursement to a pay-for-performance system was based on the belief that fee-for-service incentivized providers to do more individual units of care, regardless of whether that care was efficient or effective. It was criticized because payment was made to providers for doing "things" to sick people (i.e. running tests), rather than paying providers to get and keep people well. The new ACA program also reimbursed providers for bundles of services (e.g. employers were offered bundled pricing for knee and hip repairs) or complete episodes of illness (such as a year or 90 days after discharge) and would reward providers that efficiently kept patients in good health.

Then, the regulator, the Department of Health and Human Services, decided to base fully 30% of hospitals' Medicare reimbursement on patient satisfaction survey scores, believing that transparency and accountability would improve the quality of healthcare. CMS officials wrote: "delivery of high-quality, patient-centered care requires us to carefully consider the patient's experience in the hospital inpatient setting." Beginning in October 2012, the ACA implemented an additional reimbursement reduction policy withholding 1% of total Medicare

reimbursements – approximately $850m – from hospitals. Each year, only hospitals with high patient-satisfaction scores and a measure of certain basic care standards could earn that money back and the top performers could receive bonus money from the pool.

However, receiving money back was not an easy or predictable calculation for every hospital operating in the program. The reimbursement program was budget-neutral, meaning that a reduction in one hospital's base operating Medicare payments meant other hospitals received those funds based on their total performance scores. In 2017, about 1,612 out of 2,955 hospitals had payment increases. Approximately 1,343 hospitals received a negative payment adjustment. Hospitals could also earn back a value-based incentive payment percentage that was less than, equal to or more than the applicable per cent reduction for that program year. The actual amount depended upon the hospital's total performance, score, its value-based incentive payment percentage and the total amount available for value-based incentive payments.

The data for 2017 and 2018 showed that most hospitals were impacted by these regulations and lost reimbursement. The weighted domains for 2017 were: clinical care outcomes, 25%; process, 5%; patient and caregiver centered experience of care and care coordination, 25% safety 20%; and efficiency and cost reduction, 25%. Hospitals that failed to meet the minimum domain requirements did not have their payments adjusted in the corresponding fiscal year. According to Definitive Healthcare data for 2018, of the 3,401 hospitals that received an HCAHPs star rating, only 215 hospitals achieved 5-stars – approximately 6%, up from just under 4% in 2017. Roughly 31% received a 4-star rating (1,068 hospitals) up from 34% (1,122 hospitals) in 2017. Nearly 45% (1,535 hospitals) received a 3-star rating, which stayed mostly consistent with 44% in 2017. Almost 15% received a 2-star rating (511 hospitals) and about 2% received a 1-star rating (72 hospitals), generally staying consistent with the 2017 metrics (CMS data, 2018).

## State of Florida percentage of charges by payor/Cleveland Clinic Florida percentage of charges by payor

The following data in Table 3 was compiled by the Florida Hospital Association (2017) to illustrate patient mix according to payor reimbursement based on patient mix in 2017. The data was used by CCF as a baseline comparison for its own operation. The level of dependency on Medicare and Medicaid revenues determined the impact on a hospital's bottom line of the reduction in revenue by CMS. Payor mix referred to the percentage of hospital revenue coming from private insurance companies, government insurance programs and/or self-paying patients. Payor mix was an important metric to track because

**Table 3** State averages

| *Total discharges* | *2.7 million* | |
|---|---|---|
| Discharges per 1,000 population | 132.2 | |
| | Patients | % patients |
| Medicare | 1,246,258 | 49.9 |
| Commercial/HMO/PPO | 539,234 | 21.6 |
| Medicaid | 400,411 | 16.0 |
| Uninsured | 214,094 | 8.6 |
| TRICARE/VA | 50,563 | 2.0 |
| Other | 49,435 | 2.0 |
| Total patient days | 11.8 million | |
| Patient days per 1,000 population | 572.8 | |
| Inpatient surgeries | 596,433 | |
| Outpatient surgeries | 1.3 million | |
| ER visits | 8.9 million | |
| Occupancy rate | 55.2% | |

self-paying patients and private insurance companies compensated hospitals at a higher rate than government programs such as Medicare. Practices that serve primarily Medicare and Medicaid beneficiaries, such as safety-net hospitals, relied far more heavily on reimbursement levels than hospitals with a lower percentage of Medicare and Medicaid patients. Table 4 represented the patient mix at CCF according to payor reimbursement during the period 2015 to 2018. CCF, although not a safety net hospital by design, served a substantial percentage of Medicare patients and relied on Medicare revenue in line with the state average. The reliance on Medicaid revenues was slightly less than the state average.

### Impact on Cleveland Clinic Florida financial reimbursement: reimbursement reduction policy

The loss of reimbursement had both direct and collateral consequences to CCF. While the loss of direct reimbursement was important, Delgado was more concerned about other unintended collateral consequences. Delgado explained:

> HCAHPs matter longitudinally and directionally. First, it impacts revenue realization. CCF has certain revenue targets and the penalty reduction due to the results of the patient satisfaction survey scores impacts those EBITA profitability targets. The reimbursement penalty does translate into real dollars, but that is not the most significant consequence to CCF. The biggest loss is not the percentage loss of revenue from CMS. As we see it, the biggest loss is the potential loss of patients and the lost opportunity to serve more patients because of damage to brand. It makes us less competitive. So, it means we must do more patient volume to make up the penalty in a higher performing way. That materially impacts CCF because it either increases potential volume of patient access to services or it requires CCF to cut expenses and that may require cutting services. For any business to remain in business, it must increase revenues or cut expenses or both.

Dr Piloto concurred:

> The patients keep us under a microscope. Every day we have finances that we have to meet. I remind myself that patients are still more important than data. What if it was my family or what if it was me receiving the treatment? But to improve our scores we need to see fewer patients, but the reimbursement penalties force us to seek out more patients. If we hire more physicians, it increases healthcare costs. The system is set up for failure in many ways. Not an easy fix but we have to hang in and remain proactive.

The survey also presented a more complicated challenge for CCF to recover reductions. CMS accorded different importance or weight to each question in the patient satisfaction survey. Not all patient responses were deemed to be equally important metrics. The CMS weighting of survey questions was subject to change without notice to the providers on an annual basis. Thus, what was a priority in year 1 might have shifted to a different priority in year 2. A provider would not necessarily know on a year to year basis where to invest resources to better address ever shifting CMS priorities. The background on reimbursement as a function of patient satisfaction is included in Exhibit 3.

**Table 4** CCF averages 2015–2018

| *% of charges* | *2015 (%)* | *2016 (%)* | *2017 (%)* | *2018 (%)* |
|---|---|---|---|---|
| Medicare/Medicare HMO | 52.10 | 51.80 | 51.90 | 52.50 |
| Medicaid/Medicaid HMO | 12.30 | 12.00 | 12.10 | 11.90 |
| Combined Commercial HMO & PPO | 22.70 | 22.80 | 22.80 | 21.30 |
| All other | 12.90 | 13.40 | 13.20 | 14.30 |

### *Cleveland Clinic Florida's patient survey metrics*

In 2016, CCF CQM, generated by CMS, were above the 90th percentile, however, the results of the HCAHPs and CG-CAHPs showed that patient satisfaction in several survey categories were below CMS and CCF targets of at least 50%. Delgado believed that this dichotomy between the hospital rankings demonstrating excellence in the delivery of medical care and the HCAHP survey metrics that indicated some low patient satisfaction ratings were disconnected and did not accurately tell the story at CCF. Nonetheless, the CCF quality improvement team was committed to finding solutions to patient dissatisfaction. The patient dissatisfaction problem was deemed to be more serious in the HCAHP in-patient responses than in the CG-CAHPs responses. The complete set of in-patient survey response data from the government website is attached in Exhibit 5. CCF comparative data from 2008–2016 is attached in Exhibit 6.

Not all of the survey responses to HCAHP questions were problematic. So, CCF focused its attention on the specific low or lower scoring HCAHP survey metrics. To briefly summarize the longitudinal data: CCF's overall top box rating on the HCAHPs survey, as reported to CMS, had improved from 63% to 83% from 2008–2016 but improvement was uneven and had not followed a smooth trajectory. For example, CCF's nurse and doctor communication question results had improved from 2008 but were both down in 2016 from prior scores. (Patients who answered "always" to the nurse communication question vacillated between 62%–81%, while doctor communication vacillated between 77% to 82%.) The staff responsiveness score, while up from 2008, hovered at the 50% mark in 2015. (Patients answered "always" to staff responsiveness 46% of the time in 2008, and this rose to 67% in 2016.) While the pain management score was at an all-time high of 77% in 2016, the medicine communication score was down to 51% in 2016, from a high of 82% in 2013. Room cleanliness never broke into the 50th percentile or above. Patients reported that the hospital was "always" quiet at night in the 60th percentile or above consistently. Discharge information in 2016 was at 35%, down from a high of 64% the year before. Similarly, the patients who said they would "definitely recommend" CCF vacillated between 71%–85% over the same period. The full set of responses to the "always" questions, as reported to CMS, are listed in Exhibit 6.

In summary, the latitudinal data showed that CCF had results above average in comparison to other Florida hospitals in the CMS comparison database. CCF was above average in comparison to other hospitals nationwide. CCF exceeded the national average in nurse communication, quiet at night, strongly agreed that they understood what to do at home, that the patients would rate the hospital a 9 or 10, and that they would recommend the hospital. CCF tied the national average in doctor communication, room cleanliness and information for care transition at the time of discharge. However, CCF fell below the national average in staff responsiveness and communication on medication. The CCF patient experience improvement team was consulted.

## Solutions tried

Delgado convened his patient experience improvement team, Patient Experience Manager, Dawn Semple and Dr Robert Piloto, an internist at CCF's Krupa Center and CCF's Chief Patient Experience Officer, to implement solutions to improve the patient satisfaction metrics. Dawn Semple was an experienced nurse, armed with an MBA, who joined CCF in July 2014.

However, there was something more important about her and that was her humanness. Semple and her husband had miraculously survived a single engine airplane crash that left Semple with post-crash amnesia and her husband with bones broken in almost every part of his body. As Semple sat by her husband's side, day after day and witnessed his long and painful recovery, she learned firsthand the importance of patient centric care by hospital

caregivers. So, it was no surprise that Semple would have to hold back tears each time that she launched another caregiver training program at CCF to teach the importance of patient satisfaction. She started by telling her own story to new caregivers and hospital staff. Semple told them that she would know within the first few minutes whether the caregiver who entered her husband's room exuded patient concern or acted too busy to care. Semple's training programs were intensive and frequent.

"Responsiveness is our biggest opportunity," according to Semple. She believed that to "change the patient perception that we are responsive all the time will increase our satisfaction scores".

The team observed that staff responsiveness appeared problematic in both datasets. Research indicated that nursing communication was the measure that most directly correlated to a hospital's overall survey rating for staff responsiveness. So, Delgado's quality improvement team decided to start there.

## Cleveland Clinic Florida organizational culture: "start with the heart"

Patient first was the Cleveland Clinic's guiding principle. Michael O'Connell was the vice president of clinical and support services at a Cleveland Clinic hospital and was responsible for hundreds of employees in the departments of radiology, lab, cardiopulmonary services, pharmacy, security, emergency management and facilities. O'Connell explained the introduction of the patient first model throughout the Cleveland Clinic organization and how that model was integrated into the training culture:

> Several years ago, the Cleveland Clinic embarked on a journey to create a "Patient First Culture," which it now refers to as the "Cleveland Clinic Experience." The ultimate vision was to provide excellent patient satisfaction and have highly engaged caregivers serve patients – and fellow caregivers – with high quality, cost-effective, and safe patient care. In fact, leadership realized that if Cleveland Clinic was to continue to be a world-class organization, the culture would need to change. Improving patient experience and employee engagement required a commitment to deep-seated change that would transform Cleveland Clinic's culture, and fundamentally its leadership framework. The Cleveland Clinic team chose to embrace the leadership philosophy model of *The Serving Leader*, written by Ken Jennings and John Stahl-Wert. Its principles were used to develop a training manual specific to Cleveland Clinic staff and served as an outline to start intensive staff training. Once developed, training and other change-related efforts were launched by invitation – instead of a mandate – to executives, leadership, and managers in the organization. to guide staff toward this new perspective, we created a visual map on the "Cleveland Clinic Experience" that illustrated the patient experience from multiple perspectives, the values Cleveland Clinic strived to deliver, and the "Patients First" philosophy.

Employing this model, Semple initiated the "Start with the Heart" training program for all staff.

Semple explained:

> We ask our staff to treat our patients from the heart. Smile and greet in a warm way. We need to do a better job of explaining things to patients, many of whom don't understand or are in pain or recovery. As part of the training, the staff is instructed to set expectations, explain the plan of care, explain possible delays, and check in with the patient when a delay occurs. The survey asks if side effects of medication were explained to the patient. We teach our staff to do that too. We have directly tied our training to the survey questions.

Despite this and other staff training programs, the resulting data still looked more like a "roller coaster" according to Dr Piloto:

> It's difficult because not every solution works, or the solution works for a period of time while we are physically on the floors pushing the nurse supervisors to pay closer attention to the survey issues. For example, the responsiveness scores correlate to the time it takes for a nurse to

answer a call button. We monitored this with a time clock but daily floor conditions with patients made this a variable. The more patients on the floor the longer it might take to respond to a call button. Also, when there is staff turnover, we have to start the training all over again. We could decrease nursing to patient ratios as a solution but that raises costs as we introduce more staff. So, we implemented a team approach where hourly rounding[3] is performed by one nurse on each shift to make sure the patients' needs are being met before a patient resorts to the call button. But this is hard to do when the floors are busy with patients. It's hard to spare a nurse to do only rounding.

## "Hot comments"

Semple also interacted with hospital ombudsmen and received complaints by department, which were prioritized by type and severity. "Hot comments" or real time comments, were received by Semple, Delgado and Alex Espinosa, Senior Director of Hospital Operations. These comments were reviewed and dealt with immediately. The team believed that real time response to patient complaints was more efficacious than the delayed HCAHP and CG-CAHP process.

However, in the end, the patient satisfaction survey results still fell below CMS and CCF targets.

## "Hi-Tech" solutions vs increased staffing

Dr Robert Piloto, an enthusiastic and articulate team leader, was proud to recount that Cleveland Clinic in Ohio had the first patient experience officer in the USA. Like Delgado, Dr Piloto was more concerned with the quality of the patient experience than with the threatened reimbursement reduction associated with patient satisfaction scores. Dr Piloto was confident that "as we improve scores, we'll get better reimbursements, and this is in the back of our minds, but we're really here for the patient, not to make money." Dr Piloto believed that technology was needed to get real time information to ensure real time responsiveness to patient concerns. He envisioned, as an example, the use of smart TVs or electronic devices in each patient's room, to make the process more proactive between the caregiver and patient. While he hoped that technology would improve the experience, he acknowledged that there was no easy fix given the CMS challenge of the "always" satisfied performance baseline measure.

CCF was still not inclined to change staffing patterns. The staff was satisfied that the staffing patterns that resulted in the efficient and high-quality delivery of medical care were equally efficient in providing patient satisfaction under the HCAHP criteria.

## More staffing complications: "swimming in the same direction"

The survey issue of unresponsiveness touched the physician services as well. CCF followed a closed staff business model where CCF employed its own physicians, known as "hospitalists." Only hospitalists could treat patients admitted to the hospital. This model was a dramatic departure from the past physician healthcare delivery model. Historically, hospitals were viewed as custodial facilities, the place where physicians brought their own patients to practice medicine. Hospital administration only had authority to manage the administrative side of the operation. The model evolved dramatically in the late 1990s. Motivated by a search for improved quality and efficiency, many hospitals, including the Cleveland Clinic health system, transitioned from systems in which all primary care providers managed their own hospitalized patients to voluntary or mandatory systems in which patients were "handed off" to the care of an inpatient physician, the "hospitalist." All hospitalists managed medical patients in the hospital and were employed by the hospital.

Delgado concluded, however, as time went on that CFF "could not just use a closed staff model. Pluralistic models were needed to align incentives and goals in meeting the mission of providing quality care to its increasing patient population." That necessitated hiring private practice physicians to service increased patient access to healthcare. Monetary incentives and staff privileges encouraged private practice physicians to refer patients to CCF. However, the entry of self-employed physicians created an internal challenge for CCF in terms of quality control. As non-employees, this group of private practice physicians were not directly answerable to hospital administration. This limited CCF's ability to directly measure physician quality as it did with its own hospitalists. It also became more difficult to indoctrinate the private practice physicians into the CCF "patient first" culture to ensure perfect scores on the HCAHPs and CG-CAHPs.

To address this issue, a program of physician training was implemented with most of the new physicians. However, the program was not successful in aligning private practice monetary concerns with CCF's need to improve patient satisfaction survey scores to increase hospital reimbursement. Dr Piloto observed: "We can't expect much. These physicians come in to perform a service and then leave".

## The Cleveland Clinic Florida quality improvement team looks for more solutions

Delgado wanted to prove that Florida's version of Cleveland Clinic's operations was one of the best in the country and better than its other regional counterparts. However, numbers spoke louder than words, including his own.

Delgado believed that the survey responses had conveyed important feedback and he wanted to see everyone, physicians, nurses and clinical staff at CCF "swimming in the same direction." To that end, Delgado provided the following guidance to all new caregivers:

1. Put the patient at the center of the decision you make.
2. Represent the organization, not yourself. Carry the pride. Carry the brand.
3. The team is more powerful than the individual. So, take time to "look to your left and look to your right."
4. Give back to the community.

Yet, when it came to resolving patient dissatisfaction, Delgado knew the problem was not simple because each patient had a unique sense of what was important to that patient. The challenge for the front-line caregivers was to "sift out" what was important to each patient and then be able to react to patient uniqueness. Delgado was determined to build that process into the culture at CCF with his team as soon as possible. In anticipation of the release of the 2019 HCAHP scores, the quality improvement team huddled over the 2008–2016 HCAHP survey scores. Delgado asked for a plan to better align patient satisfaction scores with quality care rankings given the obstacles created by the ACA survey method.

## Notes

1 https://emma.msrb.org/EP1037622-EP803940-.pdf at 31.

Table 1.

2 www.medicare.gov/hospitalcompare/Data/Overview.html

3 A synthesis of the literature supports a protocol of nurse rounding every one to two hours, although with flexibility because no single strategy of rounding works uniformly in all units and hospitals (Rondinelli *et al.*, 2012).

4 The authors of this case study thank the student participants, Javier Diaz, Nadeige Emile, Matthew Gruskin, Mohammad Memon, Angelo Navarro, Diane Palmer, Maria Fernanda Pena,Manika Phillip, Ingrid Rodriguez, Michael Ospina and Harold Vera.

5 The authors of the case study thank Maria Fernanda Pena, Ingrid Rodriquez, Michael Ospina and Harold Vera. This response is used with their permission.

6 The case study authors thank Matthew Gruskin, Nadeige Emile, Dianne Palmer and Manika Phillip for this answer, used with permission.

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8 The authors of the case study thank Mohammad Memon, Angelo Navarro and Javier Diaz. This answer is used with permission.

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## References


Cleveland Clinic Florida (2019), "Patient experience", July available at: https://my.clevelandclinic.org/departments/patient-experience/depts/quality-patient-safety/performance-reports/cleveland-clinic-florida

Cleveland Clinic Outcomes (2016), available at: https://my.clevelandclinic.org/-/scassets/files/org/outcomes/outcomes-medicine.ashx

CMS data (2018), available at: https://blog.definitivehc.com/top-10-hospital-performance-metrics-you-need-to-know (accessed July 2019)

Florida Hospital Association (2017) available at: www.fha.org/reports-and-resources/facts-and-stats.aspx

State of the Clinic (2015), available at: https://my.clevelandclinic.org/-/scassets/files/org/patients-visitors/information/state-of-the-clinic-2015.ashx?la=en

Rondinelli, J., Ecker, M. and Crawford, C. (2012), "Hourly rounding implementation: a multisite description of structures, processes, and outcomes", *Journal of Nursing Administration*, Vol. 42 No. 6, pp. 326-331. available at: https://pdfs.semanticscholar.org/f065/90554b58bb1801e178151a96ff8c5ced5f49.pdf


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## Exhibit 1. Hospital consumer assessment of healthcare providers and systems survey questions

www.hcahpsonline.org/globalassets/hcahps/survey-instruments/mail/29-item-survey/updated-w-omb-date/2019_survey-instruments_english_mail-updateda.pdf

The patient during a hospital stay is asked to answer the following questions. The possible answers are never, sometimes, usually or always (unless another answer is asked, as indicated).

*Your care from nurses*

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
2. During this hospital stay, how often did nurses listen carefully to you?
3. During this hospital stay, how often did nurses explain things in a way you could understand?

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? (this question adds a fifth answer option, I never pressed the call button).

*Your care from doctors*

1. During this hospital stay, how often did doctors treat you with courtesy and respect?
2. During this hospital stay, how often did doctors listen carefully to you?
3. During this hospital stay, how often did doctors explain things in a way you could understand?

*The hospital environment*

1. During this hospital stay, how often were your room and bathroom kept clean?
2. During this hospital stay, how often was the area around your room quiet at night?

*Your experiences in this hospital*

1. During this hospital stay, did you need help from nurse or other hospital staff in getting to the bathroom or in using a bedpan? Yes or no, if no, go to Question 12.
2. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
3. During this hospital stay, were you given any medicine that you had not taken before? Yes or no, if no, go to question 15.
4. Before giving you any new medicine, how often did the hospital staff tell you what the medicine was for?
5. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

*When you left the hospital*

1. After you left the hospital, did you go directly to your own home, to someone else's home or to another health facility? Own home, someone else's home, another health facility. If another health facility, go to question 18.
2. 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? Yes or no
3. 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? Yes or 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 answer.

1. 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 to 10.
2. Would you recommend this hospital to your friends and family? Definitely no, probably no, probably yes, definitely yes.

*Understanding your care when you left the hospital*

1. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. Strongly disagree, disagree, agree, strongly agree.
2. When I left the hospital I had a good understanding of the things I was responsible for in managing my own health. Strongly disagree, disagree, agree, strongly agree.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications. Strongly disagree, disagree, agree, strongly agree, I was not given any medication when I left the hospital.

*About you*

There are only a few remaining items left.

1. During this hospital stay, were you admitted to this hospital through the emergency room? Yes or no
2. In general, how would you rate your overall health? Excellent, very good, good, fair, poor
3. In general, how would you rate your overall mental or emotional health? Excellent, very good, good, fair, poor
4. What is the highest grade or level of school that you have completed? 8th grade or less, some high school but did not graduate, high school graduate or GED, some college or 2-year degree, 4-year college graduate, more than 4-year college degree
5. Are you of Spanish, Hispanic or Latino origin or descent? No, not Spanish/Hispanic/Latino; Yes, Puerto Rican; Yes, Mexican, Mexican American, Chicano; Yes, Cuban, Yes, other Spanish/Hispanic/Latino
6. What is your race? Please choose one or more. White, Black or African American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska native
7. What language do you mainly speak at home? English, Spanish, Chinese, Russian, Vietnamese, Portuguese, Garman, some other language please print.

Hospital questions not part of the official survey may follow.

### Exhibit 2. Clinician and group consumer assessment of healthcare providers and systems survey questions

www.ahrq.gov/cahps/surveys-guidance/cg/about/survey-measures.html

CAHPS Clinician and Group Survey Measures Version 3.0

*Getting timely appointments, care and information*

- Q6 Patient got appointment for urgent care as soon as needed
- Q8 Patient got appointment for non-urgent care as soon as needed
- Q10 Patient got answer to medical question the same day he/she contacted provider's office

*How well providers communicate with patients*

- Q11 Provider explained things in a way that was easy to understand
- Q12 Provider listened carefully to patient
- Q14 Provider showed respect for what patient had to say
- Q15 Provider spent enough time with patient

*Providers' use of information to coordinate patient care*

- Q13 Provider knew important information about patient's medical history
- Q17 Someone from provider's office followed up with patient to give results of blood test, x-ray, or other test
- Q20 Someone from provider's office talked about all prescription medications being taken

*Helpful, courteous and respectful office staff*

- Q21 Clerks and receptionists were helpful
- Q22 Clerks and receptionists were courteous and respectful

*Patients' rating of the provider*

- Q18 Rating of provider

## Exhibit 3. Background note on healthcare reimbursement as a function of patient satisfaction*

The Affordable Care Act legislation (ACA) and the CMS focus on the need for hospitals and allied care professionals to deliver care that provides a quality patient experience within healthcare systems. The ACA included provisions that would improve outcomes of healthcare through a series of requirements designed to assure quality reporting for such processes as effective case management, care coordination, chronic disease management, etc. Thus, began a major focus on the development of measurement sets designed to collect and report on the quality of evidence-based clinical care within healthcare institutions. Not only would the system measure quality but it would also directly tie reimbursement for services to these quality outcome metrics. The system of reimbursement was changed from paying for services actually rendered to paying based on the quality of performance demonstrated by the provider. The change was from "fee-for-services" actually rendered to "pay-for-performance." Performance measures including HACAHPS were imbedded to determine quality of performance and resulting reimbursement rewards or penalties.

The theory behind differential reimbursement or "pay-for-performance," was based on the economic principle that "how much we pay for something is determined by its quality." The idea was that "pay-for-performance" would create a powerful business incentive for providers to produce high-quality and efficient services. Pay-for-performance was distinguishable from the pre-ACA fee-for-service reimbursement – the most prevalent payment methodology. The change from fee-for-service reimbursement to a pay-for-performance system was based on the belief that fee-for-service incentivized providers to do more individual units of care, regardless of whether that care was efficient or effective. It was criticized because payment was made to providers for doing "things" to sick people (i. e. running tests), rather than paying providers to get and keep people well. The new ACA program also reimbursed providers for bundles of services (i.e. employers were offered bundled pricing for knee and hip repairs) or complete episodes of illness (such as a year or 90 days after discharge) and would reward providers that efficiently brought and kept patients in good health.

Then, the regulator, the Department of Health and Human Services, decided to base fully 30% of hospitals' Medicare reimbursement on patient satisfaction survey scores, believing that transparency and accountability would improve the quality of healthcare. CMS officials wrote: "Delivery of high-quality, patient-centered care requires us to carefully consider the patient's experience in the hospital inpatient setting." Beginning in October 2012, the ACA implemented an additional reimbursement reduction policy withholding 1% of total Medicare reimbursements – approximately $850m – from hospitals. Each year, only hospitals with high patient-satisfaction scores and a measure of certain basic care standards could earn that money back and the top performers could receive bonus money from the pool.

*For an in-depth discussion of measurement of patient satisfaction metrics and performance reimbursement, see Berkowitz, B. The Patient Experience and Patient Satisfaction: Measurement of a Complex Dynamic, OJIN: The Online Journal of Issues in Nursing Vol. 21, No. 1, Manuscript 1 (overview of key concepts involving payment, quality and patient satisfaction metrics).

### Exhibit 4. Hospital consumer assessment of healthcare providers and systems and clinician and group consumer assessment of healthcare providers and systems explained

According to the Agency for Healthcare Research and Quality (AHRQ) in the Department of Health and Human Services, patient-centered care is improved by surveys through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program. The CAHPS surveys were initiated in 1995 and widely used CAHPS surveys include HCAHPS (hospitals), CG-CAHPS (providers) and the CAHPS Health Plan survey. CAHPS survey result users include hospital, health systems, healthcare providers, CMS, the National Committee for Quality Assurance (NCQA), the Veterans Health Administration (VHA) and the Department of Defense (DOD).

According to CMS, HCAHPS was the "first national standardized publicly-reported survey of patients' perspectives of hospital care." HCAHPS, implemented in 2006 and publicly reported first in 2008, allows patients to compare the results of a hospital survey. New survey questions were added in 2013 and in 2018, questions about pain management were replaced with questions about pain. Since 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) had to collect and submit HCAHPS data, and since 2012, under ACA, HCAHP performance was included in the value-based purchasing program. According to CMS, the results are used for comparison of hospitals, but are not endorsed for intra-hospital comparisons, and should not be used to compare caregivers within a hospital. The results are to be used for quality improvement, not marketing.

A hospital's VBP score in fiscal year 2018 was based upon four domains: patient and caregiver experience of care/care coordination; clinical care; safety; and cost reduction and efficiency. HCAHPS data is used for the first domain.

As above, the CGCAHPS survey was used to assess providers in an office or clinic setting. CMS required mandatory CGCAHPS reporting for medical offices with more than 100 eligible medical professionals, for the Physicians Quality Reporting System (PQRS). According to CMS, the results can be used to inform consumers and improve provider care. The 3.0 version of the survey included the following measures: getting timely appointments, care and information; how well the provider communicated with the patient; the provider's use of information to coordinate care (new measure for this survey); helpful, courteous and respectful office staff; and patients' rating of the provider.

### Exhibit 5. Hospital consumer assessment of healthcare providers and systems complete comparative survey data 20162017

CCF HCAHPS Survey Data 10/1/2016–9/30/2017

### Exhibit 6. Hospital consumer assessment of healthcare providers and systems complete survey data 20082016

CCF comparative HCAHP scores 2008–2016

Table E1

Complete data set prepared annually (Table E2)

**Table E1** Complete data set compiled quarterly during the period

| *Measure description* | *Cleveland clinic hospital 3100 WESTON RD WESTON, FL 33331* **Overall rating:** *2 out of 5 stars*[b] *Cleveland clinic hospital(%)* | *Florida average(%)* | *National average(%)* |
|---|---|---|---|
| Patient survey summary star rating. More stars are better | 4 out of 5 stars | | |
| Patients who reported that their nurses "Always" communicated well | 81% | 77% | 80% |
| Patients who reported that their doctors "Always" communicated well | 82% | 78% | 82% |
| Patients who reported that they "Always" received help as soon as they wanted | 66% | 63% | 69% |
| Patients who reported that their pain was "Always" well controlled[a] | Not available | Not available | Not available |
| Patients who reported that staff "Always" explained about medicines before giving it to them | 64% | 62% | 66% |
| Patients who reported that their room and bathroom were "Always" clean | 75% | 70% | 75% |
| Patients who reported that the area around their room was "Always" quiet at night | 65% | 59% | 62% |
| Patients who reported that YES, they were given information about what to do during their recovery at home | 87% | 85% | 87% |
| Patients who "Strongly Agree" they understood their care when they left the hospital | 58% | 50% | 53% |
| Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) | 82% | 69% | 73% |
| Patients who reported YES, they would definitely recommend the hospital | 85% | 70% | 72% |

Notes: [a]CMS is reviewing the pain management questions on the HCAHPS survey for possible revision. [b]Authors' note: From the hospital compare website, the overall rating is a summary of all measures, which may differ from the patients' summary

**Table E2** CMS top box scores by year

| *Survey domain* | *CMS report period* | *CCF* |
|---|---|---|
| Overall rating | 2008 | 63 |
| % 9/10 response rating | 2009 | 68 |
| | 2010 | 74 |
| | 2011 | 77 |
| | 2012 | 73 |
| | 2013 | 80 |
| | 2014 | 79 |
| | 2015 | 80 |
| | 2016 | 83 |
| Recommend | 2008 | 71 |
| % Yes definitely rating | 2009 | 75 |
| | 2010 | 80 |
| | 2011 | 82 |
| | 2012 | 79 |
| | 2013 | 85 |
| | 2014 | 83 |
| | 2015 | 84 |
| | 2016 | 85 |
| Nurse communication | 2008 | 62 |
| % always rating | 2009 | 68 |
| | 2010 | 74 |
| | 2011 | 76 |
| | 2012 | 73 |
| | 2013 | 80 |
| | 2014 | 78 |
| | 2015 | 81 |
| | 2016 | 81 |
| Doctor communication | 2008 | 77 |
| % always rating | 2009 | 76 |
| | 2010 | 81 |
| | 2011 | 81 |
| | 2012 | 81 |
| | 2013 | 82 |
| | 2014 | 83 |
| | 2015 | 82 |
| | 2016 | 82 |
| | | CCF |
| Staff responsiveness | 2008 | 46 |
| % always rating | 2009 | 55 |
| | 2010 | 59 |
| | 2011 | 61 |
| | 2012 | 59 |
| | 2013 | 69 |
| | 2014 | 67 |
| | 2015 | 67 |
| | 2016 | 67 |
| Pain management | 2008 | 61 |
| % always rating | 2009 | 65 |
| | 2010 | 68 |
| | 2011 | 70 |
| | 2012 | 67 |
| | 2013 | 73 |
| | 2014 | 72 |
| | 2015 | 72 |
| | 2016 | 74 |
| Medication communication | 2008 | 52 |
| % always rating | 2009 | 54 |

(*continued*)

**Table E2**

| *Survey domain* | *CMS report period* | *CCF* |
|---|---|---|
| | 2010 | 60 |
| | 2011 | 64 |
| | 2012 | 65 |
| | 2013 | 69 |
| | 2014 | 69 |
| | 2015 | 68 |
| | 2016 | 64 |
| Room cleanliness | 2008 | 57 |
| % always rating | 2009 | 64 |
| | 2010 | 70 |
| | 2011 | 70 |
| | 2012 | 68 |
| | 2013 | 72 |
| | 2014 | 72 |
| | 2015 | 70 |
| | 2016 | 72 |
| Quiet at night | 2008 | 61 |
| % always rating | 2009 | 60 |
| | 2010 | 64 |
| | 2011 | 70 |
| | 2012 | 63 |
| | 2013 | 69 |
| | 2014 | 69 |
| | 2015 | 68 |
| | 2016 | 68 |
| Discharge information | 2008 | 76 |
| % yes rating | 2009 | 77 |
| | 2010 | 81 |
| | 2011 | 83 |
| | 2012 | 82 |
| | 2013 | 84 |
| | 2014 | 86 |
| | 2015 | 88 |
| | 2016 | 86 |
| Care transition | 2013 | 56 |
| % strongly agree rating | 2014 | 55 |
| | 2015 | 57 |
| | 2016 | 58 |