Press Ganey & HCAHPS: Improving Outcomes

Deborah Wittrock
Improvement Manager
Press Ganey Associates

Patient Satisfaction Matters

- Patient loyalty
- Reputation / Word-of-Mouth advertising
- Recruitment of new physicians
- Improved retention & morale
- Improved efficiency & productivity
- Reduced length of stay
- Patient compliance with health directives
Session Objectives

- HCAHPS 101
- Public Reporting
- Value Based Purchasing
- Moving from Measurement to Action
  - Focusing Improvement Efforts

HCAHPS 101
What is CAHPS?

**Consumer Assessment of Healthcare Providers and Systems**

- Produce comparable data for public reporting
- Create incentive for agencies to improve
- Enhance public accountability and transparency

**Hospital CAHPS**
**Home Health Care CAHPS**
**Clinician and Group CAHPS**

... more to come!

CAHPS provides an apples to apples metric for public reporting—additional measurement may be needed for ongoing quality improvement activities and monitoring.

Why is CAHPS® Important?

- Consumers have access to the data
  - Consumers relate more easily to CAHPS® than to clinical data
  - Some will use CAHPS® data to choose hospitals
  - Will have volume, revenue, and reputation implications

- CAHPS® will be in the public eye
  - Media coverage
  - Promotion by hospitals themselves

- Participation linked to reimbursement
"HCAHPS is a tool to be used for public reporting of major areas of hospital performance...to support consumer choice"

"HCAHPS is not a stand-alone quality improvement tool"

Available at: http://www.cms.hhs.gov/HospitalQUALITYINITS/30_HOSPITALHCAHPS.ASP
# HCAHPS Survey Format

## Evaluative Questions

<table>
<thead>
<tr>
<th>YOUR CARE FROM NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During this hospital stay, how often did nurses treat you with courtesy and respect?</td>
</tr>
<tr>
<td>○ Never</td>
</tr>
<tr>
<td>○ Sometimes</td>
</tr>
<tr>
<td>○ Usually</td>
</tr>
<tr>
<td>○ Always</td>
</tr>
</tbody>
</table>

## About You Questions

<table>
<thead>
<tr>
<th>27. What language do you mainly speak at home?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ English</td>
</tr>
<tr>
<td>○ Spanish</td>
</tr>
<tr>
<td>○ Some other language (please print):</td>
</tr>
</tbody>
</table>

## Global Rating Questions

<table>
<thead>
<tr>
<th>22. Would you recommend this hospital to your friends and family?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Definitely no</td>
</tr>
<tr>
<td>○ Probably no</td>
</tr>
<tr>
<td>○ Probably yes</td>
</tr>
<tr>
<td>○ Definitely yes</td>
</tr>
</tbody>
</table>

## Screening Questions

<table>
<thead>
<tr>
<th>YOUR EXPERIENCES IN THIS HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
</tr>
<tr>
<td>○ Yes</td>
</tr>
<tr>
<td>○ No  → If No, Go to Question 12</td>
</tr>
</tbody>
</table>
### Public Reporting

- Reported for consumers on Hospital Compare ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov))
- Data are shown as performance frequencies
  - For each domain area and global overall questions
- National and state average performance frequencies
- No rankings or significant differences noted
- HCAHPS data updated each quarter for rolling 12 months
  - Current data October 2008 – September 2009 discharges

### HCAHPS Public Reporting

#### Domains
- Communication with Doctors
- Communication with Nurses
- Responsiveness of Hospital Staff
- Pain Control
- Communication about Medicines
- Discharge Information

#### Questions
- Cleanliness of Physical Environment
- Quiet of Physical Environment
- Overall Rating of Care
- Willingness to Recommend
Public Reporting And Transparency

<table>
<thead>
<tr>
<th>Time Line</th>
<th>HCAHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Implementation</td>
<td>October 2006</td>
</tr>
<tr>
<td>Required Implementation</td>
<td>July 2007</td>
</tr>
<tr>
<td>First Publicly Reported Results</td>
<td>March 2008</td>
</tr>
<tr>
<td>Funds at Risk for Non-Participation</td>
<td>July 2007–September 2012</td>
</tr>
<tr>
<td>Fundled at Risk</td>
<td>2% of Medicare Reimbursement</td>
</tr>
<tr>
<td>Value-Based Purchasing</td>
<td>October 2012-2% of Medicare Reimbursement</td>
</tr>
<tr>
<td>Funds at Risk</td>
<td></td>
</tr>
</tbody>
</table>

Graphs - Percentage of “Always” Responses

How do patients rate the hospital overall?

These results are from patients who had overnight hospital stays from October 2008 through September 2009.

After answering all other questions on the survey, patients answered a separate question that asked for an overall rating of the hospital. Ratings were on a scale from 0 to 10, where “0” means “worst hospital possible” and “10” means “best hospital possible.”

Bar below tells the percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (worst) to 10 (highest).

How do patients rate the hospital overall?

- The yellow bars indicate the National & State averages.
- The blue bars indicate the averages for facilities selected.
Future Direction of HCAHPS

Value-Based Purchasing –
Common Terminology

- Different names with the same goal: rewarding quality
  - Pay for performance
  - Paying for quality
  - Value based purchasing

- Attainment – 50th to 95th- Rewarding providers for how well they perform compared to their peers

- Improvement - baseline to 95th- Rewarding providers for improvements in their performance
Hospital Value Based Purchasing - Measures

- Future Measures
  - Average Medicare Spending per Beneficiary
  - Healthcare Associated Infections

- HCAHPS
  - Attainment (50th to 95th)
  - Improvement (Baseline to 95th)

- Clinical (Process Measures) – Topped Out Measures
  - Attainment (60% performance to 90% performance)
  - Improvement (Baseline to 90% performance)
Hospital Value Based Purchasing – Amount of Money at Risk

- Payment Implementation
  - 2013 → 1% of payment
  - 2014 → 1.25%
  - 2015 → 1.5%
  - 2016 → 1.75%
  - 2017 → 2%

Estimated Timeline:
- **January – December 2010** – Base year for Value Based Purchasing.
- January – December 2011 – Initial performance period for value based purchasing. This time period represents the most current data available to CMS that is complete and appropriately adjusted.
- October 1, 2012 (FY 2013) – MS-DRG base payments are adjusted by CMS based on value based purchasing perform incentive payment
Future Developments

- Home Health CAHPS
- Home Health VBP
- Quality Measures for Inpatient Rehabilitation Hospitals
- Quality Measures for Cancer Hospitals
- VBP for Ambulatory Surgery Centers

Measurement to Action
Hospitals Continue to Improve

"Rate this Hospital" Avg Top Box %

*Represents results from 1287 Press Ganey clients based on received date.

Hospitals Continue to Improve

"Communication with Nurses" Domain Avg Top Box %

*Represents results from 1289 Press Ganey clients based on received date.
National HCAHPS data by Service Line

Overall Rating Top Box Scores by Service Line

Based on responses from 1,315,600 patients at 1,000 facilities discharged January 1 - December 31, 2006. Only facilities with at least 30 responses are included in the analysis.

Focusing Improvement Efforts
Step 1: Identify a Goal

[S] Specific. Exactly what is it you wish to accomplish?

[M] Measurable. Identify the means by which you will achieve each goal. How will you know when you have reached it? Keep in mind that you will always have more control over performance than you will over outcome so set performance goals whenever possible.

[A] Action-oriented. Describe your goals using action verbs. What will you do (step by step) to reach your goal?

[R] Realistic. Choose goals that are possible and achievable. Who do you know who has achieved goals similar to yours? Goals set too high will discourage while goals set too low will not challenge and motivate.

[T] Timed. Determine deadlines for each of your goals. Deadlines can be flexible & adjusted as needed but deadlines help keep you focused and moving.
Step 2: Identify the Cause

- Look at patient comments for trends or patterns
- Conduct patient & employee focus groups
- Fishbone Diagram at a high level

- “5 Why’s”
  - What is causing area of poor performance?
- Root cause analysis
  - I.e. Mager-Pipe Performance Analysis

Cause-Solution Relationship

- Thinking backwards from the score itself
  - What is the perception of patients?
    - What do they experience? (long wait, different information from different staff, being alone, in pain, etc.)
    - How does it make them feel? (unvalued, confused, uncertain whom to trust, lonely, afraid, stressed, etc.)
- Causes don’t create a score, they create an environment in which a patient feels a certain way- that is what shapes how they evaluate care
- Determining cause is extremely important- it ensures you are efficient in your choice of strategy for improvement
Step 3: Recommend a Solution

- Which causes are you trying to address?
- Which causes do you have control over?
- Will you modify a cause or shape perception?

- Does the selected solution address the causes or perceptions you have control over?
- Will the selected solution be visible to patients?
- Will it be big enough to change?

- Will it impact all patients?

- Is there anything you need to fix first, before you can implement this solution?

HCAHPS Opportunities & Solutions

1. Question: Staff listened carefully to you:
   - Initiative: Hourly rounding

2. Question: Staff explained things in a way you could understand:
   - Initiative: Scripting

3. Domain: Responsiveness of hospital staff:
   - Initiative: Formal service recovery program

4. Domain: Received discharge information:
   - Initiative: Discharge Calls
The better the communication between patient and caregivers, the more the patient believes he or she has received excellent medical care.

-Bayer Institute for Health Care Communications, West Haven, CT

Nurses listen carefully to you

“How often did nurses listen carefully to you?”

- Encourage questions
- Provide calm & clear explanations, information & acknowledge their question, this can rapidly ease fears
- Develop list of phrases not to be said in front of patients, families, or visitors
  - “We are short staffed”, “That’s not my department”, “Are you sure?”
- Think about the non-verbal cues:
  - checking your watch, fidgeting, loud exhales, etc.
- Re-state patient questions to check for accuracy & validate their emotions
Nurses listen carefully to you

- Rounding
  - Hourly rounding by RN, CNA, or combination
  - Develop protocol: complete scheduled tasks; pain, potty, positioning; everything within reach; additional requests
  - 40% - 60% reduction in call lights
  - Decreased falls and ulcers
  - Less walking by nurses (5.2 to 4.3 miles)
  - Improved patient satisfaction


Staff explained things in a way you could understand

“How often did nurses explain things in a way you could understand?” or
“How often did doctors explain things in a way you could understand?”

- Avoid medical jargon when possible, try to make the explanations as simple as possible
- Try not to say: “Do you understand?”
  - Most patients will say yes automatically or out of embarrassment for not knowing
- Instead try: “This is very important so I want to make sure I explain this clearly…”
- Provide patients with a notepad for a “Daily Journal”
  - To keep track of daily conversations with all staff
Scripting

Scripting is used when:
- There is an important message all patients should receive
- The message is commonly forgotten by staff
- The message should be delivered during the normal course of care

Make sure a script is:
- Clear, short, and easy to understand
- Sounds natural and can be customized by staff to fit the situation and their own personalities
- Designed to convey a specific message

Scripting is just one piece of communication, it is a start (not an end) to communication

Limit 4-5 scripts per staff member
Not designed to pressure patients to give higher ratings

Responsiveness of Hospital Staff

“During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?”
“How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted it?”

- Evaluate staffing patterns. Are you understaffed at the times when the volume of patient requests peak? What are ways to cope with this?
- How do you manage patient expectations (wait time) regarding the call light?
- Determine standards for response time for call lights. Are you able to track how long the call light has been on, before someone responds?
- Make all employees responsible for answering the call lights. Non-clinical needs can be addressed by any employee & clinical needs must be referred to the nurse.
Service Recovery

Key Success Factors
1. Create Service Teams
2. Employ a strategy
3. Design a tool kit
4. Empowerment and accountability
5. Select Pilot unit
6. Train Pilot unit
7. Make it easy to complain/Track Complaints
8. Reward and recognize staff
9. Review and Roll-out

Received Discharge Information

“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?”

- Provide a notepad to write down questions regarding discharge & home care prior to the discharge process
- Ensure the patients have a better understanding of their illness at discharge than before they arrived at the facility
- Ensure another caregiver (if possible) is present while you provide the discharge instructions to the patient
- Try to create discharge resources that consider the different types of learning styles (visual, auditory, kinesthetic)
- Provide a decision tree for patients to help them decide if they need to reach their physician or hospital immediately
### Discharge Phone Calls

**Guidelines:**
- Allow patient to determine length of call
  - Calls are short, simple, & demonstrate caring
  - Not meant to replace the CAHPS survey
- Place call within 72 hours after encounter
  - Within 24 hours is ideal
- Three attempts per patient
  - No voicemail messages

**Script:**
- Opening the call
  - State your name and facility name
  - Confirm patient name and date of visit
  - Explain the purpose of the call and obtain patient’s consent
- Develop scripts for common issues
  - Medical complications (e.g. fever, rash, dizziness)
  - Probing questions about symptoms
  - Call 9-1-1 for medical emergencies

### Which Questions to Ask?

1. **General health questions**
   - "How have you been feeling since you returned home?"
   - "Did you understand your discharge instructions?"
2. **Basic pain questions**
   - Scale of 0-10
   - Better/Worse/Same
3. **Verify if a follow-up appointment was scheduled**
   - Be able to answer time/date/location questions
4. **Assess understanding of medication instructions**
   - Ask if prescriptions were filled as ordered
5. **Assess understanding of discharge instructions**
   - Ask if they are having difficulties with home care
6. **Unique questions by unit, department, specialty**
7. **Topics related to current facility initiatives or projects**
   - CMS guideline against pre-surveying of patients
Implement a Solution

- Two main phases:
  1. Preparation
     - a) Project team & roles
     - b) Communication
     - c) Development of training
     - d) Preparing measurement
     - e) Preparing accountability
     - f) Prepare logistics
  2. Execution
     - a) Educate
     - b) Roll-out: follow through on your plan

Monitor & Review

Monitor:
- Measure Behavior
  - Tracking
  - Observation
  - Self-Reporting
  - Auditing
  - Feedback

Review:
- Did you meet your Goal?
  - Yes
    - Celebrate
    - Increase Goal or Sustain
  - No
    - Why Not?
“We all know it’s really all about the patient’s perception. If we don’t have good patient satisfaction scores, we know we’re not going to have good patient outcomes – they work in tandem, and we expect them all to move in a positive direction.”

- Celeste Twardon, Senior VP of Quality and Chief Clinical Officer at Home Nursing Agency