3 Additional HCAHPS Questions
The Impact and Implications

Lyn Ketelsen, RN, MBA
Studer Group Coach
Studer Group Mission and Vision

**Mission:**
To make healthcare a better place for employees to work, physicians to practice medicine and patients to receive care.

**Vision:**
To be the intellectual resource for healthcare professionals, combining passion with prescriptive actions and tools, to drive outcomes and maximize the human potential within each organization and healthcare as a whole.
The Typical Sequence

WHAT

HOW

WHY
The Suggested Sequence

- WHY
- WHAT
- HOW
Opportunity for Improvement

- 20% of patients discharged from hospital experience adverse event within 3 weeks\(^1\)
- Estimated medication errors harm 1.5 million people each year in the United States at an annual cost of at least $3.5 billion\(^2\)
- Within 30 days of discharge, approximately 2.6 million Medicare beneficiaries are re-hospitalized, at a cost of over $26 billion every year\(^3\)
- Direct communication between hospital physicians and primary care physicians occurred infrequently (in 3-20% of cases studied)\(^4\)
- 2.3 million (2%) ED visits are from patients who were discharged from the hospital within the previous 7 days\(^5\)
- A Study of Discharged patients found:
  - Only 41% were able to state their diagnoses
  - Only 37% were able to state the purpose of their medications
  - Only 14% knew the common side effects of all their medications\(^6\)

Endnotes: See slide 30
Expanded HCAHPS Survey

- 5 new HCAHPS survey items made available for voluntary use in July 2012
- These 5 new questions are required in HCAHPS surveys starting with January, 2013 discharges
Expanded HCAHPS Survey – Impact

VBP Reimbursements – How hospitals score on these new questions will affect the calculations for value-based purchasing reimbursement.

- The “Transition of Care” questions will begin to be publicly reported in late 2014 (at the earliest).
- Once they begin to be publicly reported, these questions must be reported for a minimum of 1 full year (per CMS’ own rule) before they can be included in VBP.
Highlight Problems that Lead to Avoidable Readmissions – Additionally, as these questions provide more visibility into the discharge process, they also could highlight problems that lead to avoidable readmissions.
New Care Transition Survey Items

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 the hospital.

2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

The scale for these questions:

1 – Strongly disagree
2 – Disagree
3 – Agree
4 – Strongly agree

For question 3 only: 5 – I was not given any medication when I left the hospital
Scoring

The questions will be scored and reported differently than HCAHPS. Each question has 4 answer options and assigned points as listed below:

- Strongly Agree (4 points)
- Agree (3 points)
- Disagree (2 points)
- Strongly Disagree or Don’t Know/Don’t Remember/NA (1 point)

Creating a 0-100 Score

- Step 1 - Calculate the sum of responses across the 3 items
- Step 2 - Count the number of questions answered
- Step 3 - Calculate the mean response (sum divided by count)
- Step 4 - Use linear transformation to convert to 0-100 score
Example Conversion of Mean Score to 100-point Scale

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<thead>
<tr>
<th>Mean Score on the 1-4 Scale</th>
<th>Conversion Score on 100-Point Scale</th>
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<td>4</td>
<td>100.0</td>
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New “About You” Question #1

1. During this hospital stay, were you admitted to this hospital through the Emergency Room?
   Yes – No

▼ ER admission question will be used as a patient-mix adjustment for HCAHPS Scores

   – This information was collected until June 2010 from hospitals as an administrative code and was used as a patient-mix adjustment for HCAHPS scores.

   – CMS presented evidence that this variable is meaningful and that adding the question to the HCAHPS survey would allow CMS to again use emergency room admission as a patient-mix adjustment variable.
New “About You” Question #2

2. In general, how would you rate your overall mental or emotional health?
   Excellent – Very good – Good – Fair – Poor

Mental health question was added due to requests from hospitals and researchers

- CMS also noted recent studies suggest that up to 20% of hospitalized patients suffer from severe depression. When other mental illnesses are considered, the incidence approaches 50%.

- Research has shown that there was significant decline in HCAHPS scores in patients identified in standardized mental illness assessment questionnaires in the pre- and post-operative ambulatory setting as severely depressed.
Care Transition Measures and VBP

- The “Transition of Care” questions will begin to be publicly reported in late 2014 (at the earliest).
- Once they begin to be publicly reported, these questions must be reported for a minimum of 1 full year (per CMS’ own rule) before they can be included in VBP.
HealthCare.gov
Elements of a Good Care Transition Plan

- Designed to ensure coordination and continuity.
  - Based upon a comprehensive care plan
  - Use of practitioners who have the patients current information
  - Include logistical arrangements and education of patient and family
  - Patient (or caregiver) training to increase self-care skills.
  - Patient-centered care plans – negotiated with patient and family and responsive to the medical and social situation
  - Standardized and accurate communication and information exchange between the transferring and receiving provider in timely manner
  - Medication reconciliation and safe medication practices.
  - Logistical arrangements including transportation for health care-related travel and procurement and timely delivery of medical equipment.
  - Ensuring the sending provider maintains responsibility for care of the patient until the receiving clinician/location confirms the transfer and assumes responsibility.
Care Transition Measure (CTM) Question #1

The hospital 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 the hospital.

- Rooted in communication
- Demands that providers and clinicians have **fully assessed the capacity and capability of the patient and family** to perform the necessary care post discharge and have reached a mutual decision about that plan.
- Includes assessment of physical, psycho-social, emotional and financial needs of the patient.
- Must include **active listening** as providers understand that sometimes the patients and families preferences can be in conflict with the recommended plan by providers and caregivers.
Developing the plan

Armed with information from the assessment, caregivers can now implement a series of best-practices designed to ensure accurate execution of the plan developed. Such activities include:

- Prior to Discharge:
  - Medication reconciliation
  - Interview and introduction to post-discharge care team
  - Comprehensive discharge instruction counseling utilizing basic language and teach back methods for clarifying understanding
  - Seamless and timely communication between hospital providers and follow up care providers
Suggested Assessment Questions

Consider a formalized method of interview with patients and families to assess what their health care needs will be upon discharge. A sampling of the questions that might be included are below:

1. Do you have a family member we should work with along with you to discuss your health care needs at home?

2. Is your primary care provider still Dr. Jones so we can be sure to communicate to him what your follow up care recommendations are?

3. Is there a Pharmacist you work with or case manager to assist with helping to manage your medications after discharge?
Care Transition Measure (CTM) Question #2

When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

During the discharge instruction process, it will be very important to reinforce some specific discharge instructions that will enhance patients ability to take individual responsibility for managing their health and the potential risks or consequences if they don’t. For example:

- Smoking cessation
- Taking medications as prescribed
- Following diet instructions
- Attending all scheduled follow-up appointments
- Using all equipment as ordered
Care Transition Measure (CTM) Question #3

When I left the hospital, I clearly understood the purpose for taking each of my medications.

This will require acute-care setting to ensure that our current methods of medication reconciliation are expanded.

- Side effects aren’t enough – this new question specifically identifies patients knowing the purpose of each of their medications.
- Most current medication lists do not specifically identify the purpose for the medication and this accommodation will need to be made in order to ensure patients leave with this understanding.
Bedside Shift Report

**Enhancement to SBAR**

- In the assessment and background sections of this report, we should be including discussions on readiness for discharge specifically related to purpose and side-effects of medications.

**Engage patient, improve safety & HCAHPS**

- Explanations of medications, side-effects, and purpose
- Explanation of patient’s responsibility for managing care
- Explanation of necessary post-discharge care plan and discussion including patient/family wishes
M in the Box℠

Enhancement to Bedside Shift Report

Engage patient, improve safety & HCAHPS

- Explanations of medications
- Understanding of side effects

Technical Requirements:

1. Board
2. Marker
3. Ability to draw a square and write letter “M”
4. 30 seconds
## Evidence of Effectiveness

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<th>6 South</th>
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St. Alexius Medical Center (Hoffman Estates, IL). December 2012.
Thank you for choosing
SELF REGIONAL
HEALTHCARE

Day: Friday  Date: Jan 20, 2018
(week)

Room #: 4379  Telephone #: 725-8 + Room #
(Area de Habitación)

Nurse: Lyn  #: 2830
(Enfermera)

Nurse Assistant/Tech: Sara  #: 2946
(Asistente de Enfermería)

Hostess:
(Fracción)

Your most recent pain medication was given at
La medicación más reciente fue... (Fecha y hora)

If needed, your next pain medication is available at
Si es necesitado, la siguiente medicación está... (Fecha y hora)

* Remember to ask for your pain medication.*
* Recuerde pedir su medicación de dolor.*

Please see your nurse if you have any questions or concerns.
Por favor vea a su enfermera si tiene alguna pregunta o preocupación.

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Preliminary Comments

Mary Greeley Medical Center
M in the House feedback from staff:

- We love having something so visual to guide the discharge process
- Patients are responding very positively to it
- Families love the heart
- We should always make the heart red
- Physicians began asking about it – we should have informed them prior to piloting
M in the House feedback from patients:

- I love it and so does my family!
- My nurse has told me that when my plan is finalized that I can draw the heart around my house – I can’t wait!
- The nurses are asking me about my house during their change of shift in my room – it’s a great concept and I know it represents my discharge plan and my family’s involvement in that
Influence of Communication About Medicines on Readmission Rates

Average Heart Failure Readmission Rates by Hospital Results on Communication About Medicines

- 0-24th Percentile: 25.160
- 25-49th Percentile: 24.658
- 50-74th Percentile: 24.579
- 75-99th Percentile: 24.576
Readmissions: Patients Called vs. Patients Not Called

Represents total readmissions for each unit over a 4-month period, equaling 100%

Source: University of Alabama Birmingham
Impact of Interactive Care

- 74 percent reduction in Heart Failure readmission rate 30 days post-discharge
- An overall readmission rate of 5 percent
- 43 percent improvement in patient satisfaction

Source: Getwell Network White Paper: Improving Heart Failure Outcomes through Interactive Patient Care: June, 2009
Inpatient Admit within 30 Days of Inpatient Discharge (Any APR-DRG)

Data Source: Crimson

Source: Cheyenne Regional Medical Center
Acute Care Admit within 30 Days of Acute Care Discharge

Source: Cheyenne Regional Medical Center
Readmission Data: Impact of Post-Visit Calls

Source: Cheyenne Regional Medical Center
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June 4-5 • San Antonio, TX
December 4-5 • Chicago, IL

Excellence in the Emergency Department: Hardwiring Flow and Patient Experience
June 19-20 • Chicago, IL
November 6-7 • Dallas, TX

The Physician Partnership Institute: A Path to Alignment, Engagement and Integration
Sept. 4-5 • San Francisco, CA

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Hard Work – True. But there is Joy and Reward
Questions?

Lyn Ketelsen RN, MBA
850-934-1099
lyn.ketelsen@studergroup.com
www.studergroup.com


