



HCAHPS SUMMIT

3 Additional HCAHPS Questions The Impact and Implications

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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 weeks¹
- Estimated medication errors harm 1.5 million people each year in the United States at an annual cost of at least \$3.5 billion²
- Within 30 days of discharge, approximately 2.6 million Medicare beneficiaries are re-hospitalized, at a cost of over \$26 billion every year³
- 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 days⁵
- 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 medications⁶

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

Expanded HCAHPS Survey – Impact

- ▼ **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

Mean Score on the 1-4 Scale	Conversion Score on 100-Point Scale
1	0.0
1.5	16.7
1.75	25.0
2	33.3
2.5	50.0
2.75	58.3
3	66.7
3.5	83.3
3.75	91.7
4	100.0

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

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 BoxSM

- ▼ 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

	5 North		6 South	
	3Q12	4Q12	3Q12	4Q12
Communication about Medications	60.16	72.06	57.89	78.37
Medication Explanation	84.38	90.63	68.75	93.10
Medication Side Effects	43.75	61.29	54.84	71.43

St. Alexius Medical Center (Hoffman Estates, IL). December 2012.

Thank you for choosing
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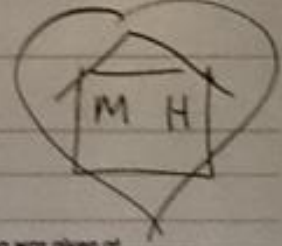
Day: Friday Date: Jan 20, 2018

Room #: 4379 Telephone #: 725-8 + Room #

Nurse: Lyn # 2830

Nurse Assistant/Tech: Sara # 2946

Hostess:



Your most recent pain medication was given at

If needed, your next pain medication is available at

• Remember to call for your pain medication. •
• Remember to call for your medication when in doubt. •

We hope our goal to provide best patient care and to keep you informed. We will continue to work hard. Please notify your nurse if you have any concerns about your care.



Preliminary Comments

Mary Greeley Medical Center

Nashville, TN | May 14 - 15, 2013

Mary Greeley Medical Center

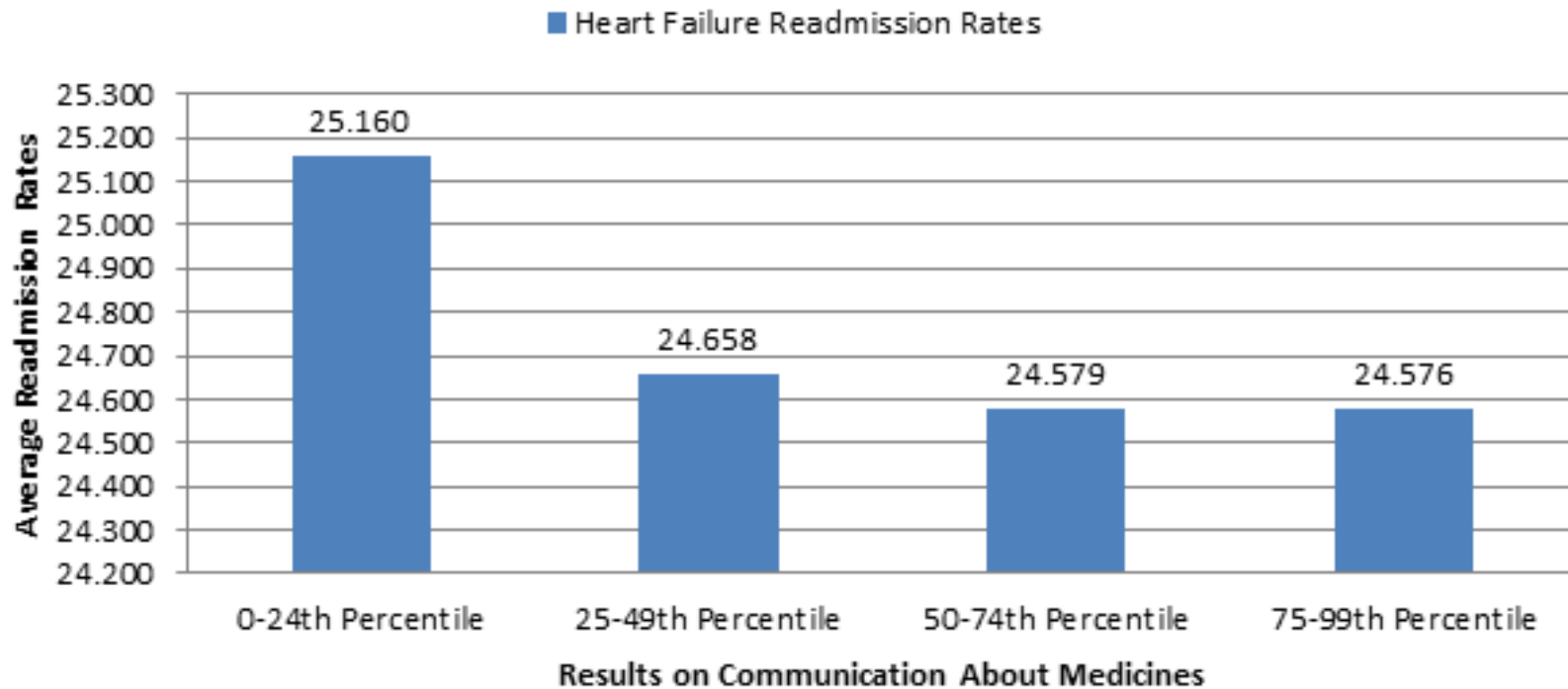
- ▼ M in the House feedback from staff:
 - ▼ We love having something so visual to guide the discharge process
 - ▼ Patients are responding very positively to it
 - ▼ Families love the heart
 - ▼ We should always make the heart red
 - ▼ Physicians began asking about it – we should have informed them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

Mary Greeley Medical Center

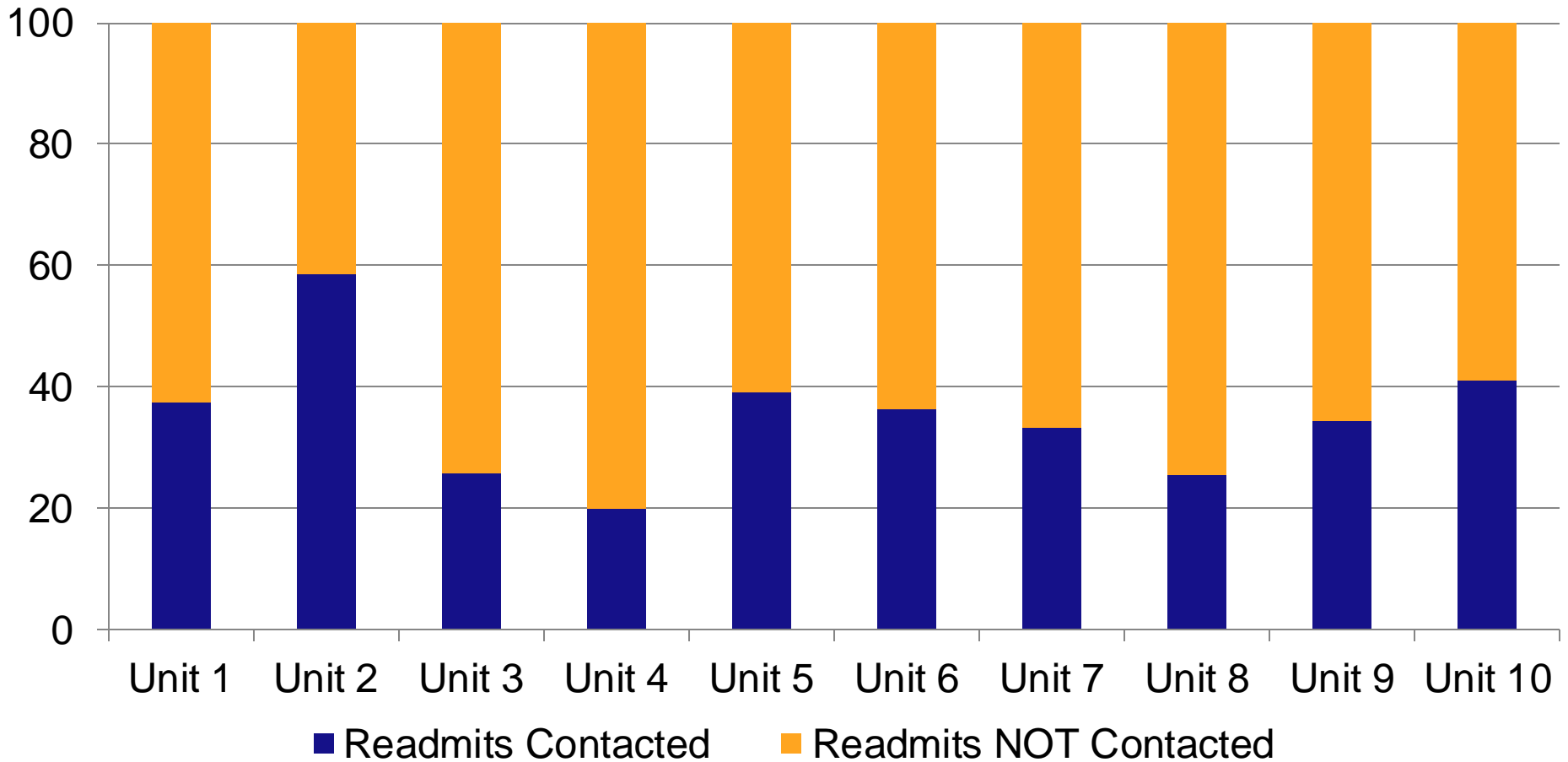
- ▼ M in the House feedback from patients:
 - ▼ I love it and so does my family!
 - ▼ My nurse has told me that when my plan is finalized that I can draw the heart around my house – I can't wait!
 - ▼ The nurses are asking me about my house during their change of shift in my room – it's a great concept 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

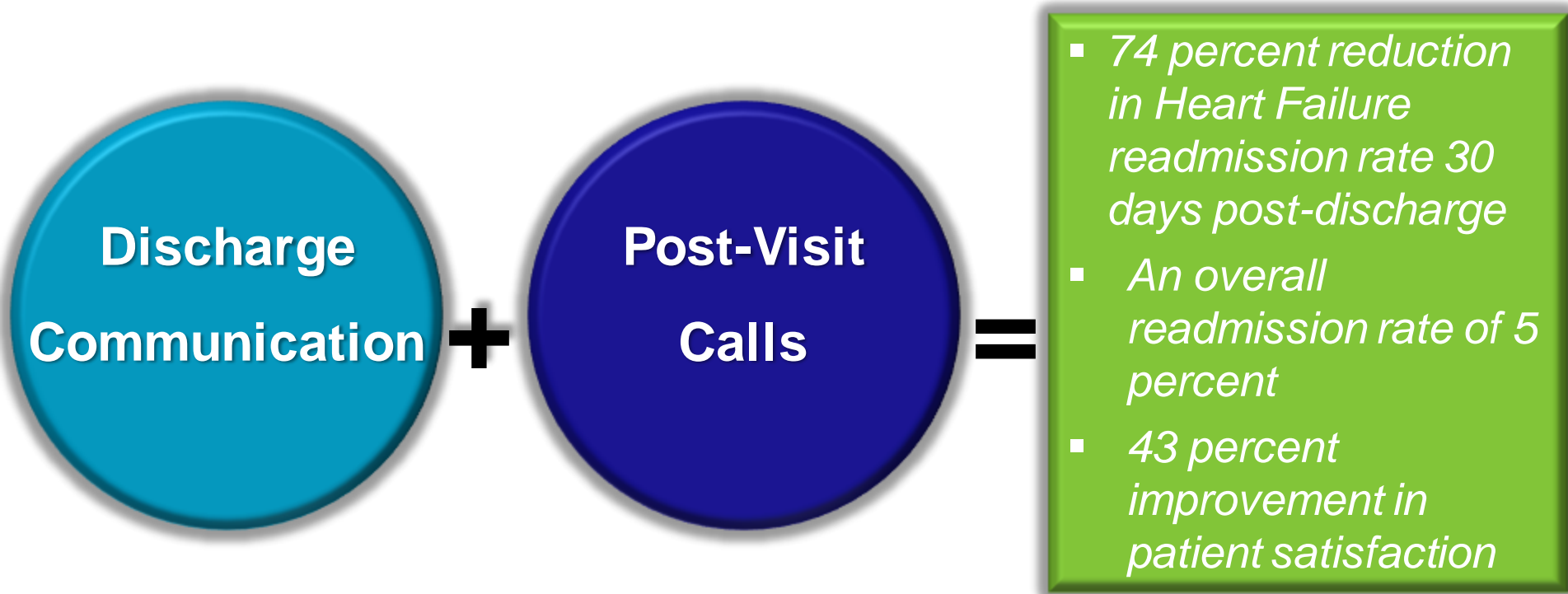


Readmissions: Patients Called vs. Patients Not Called



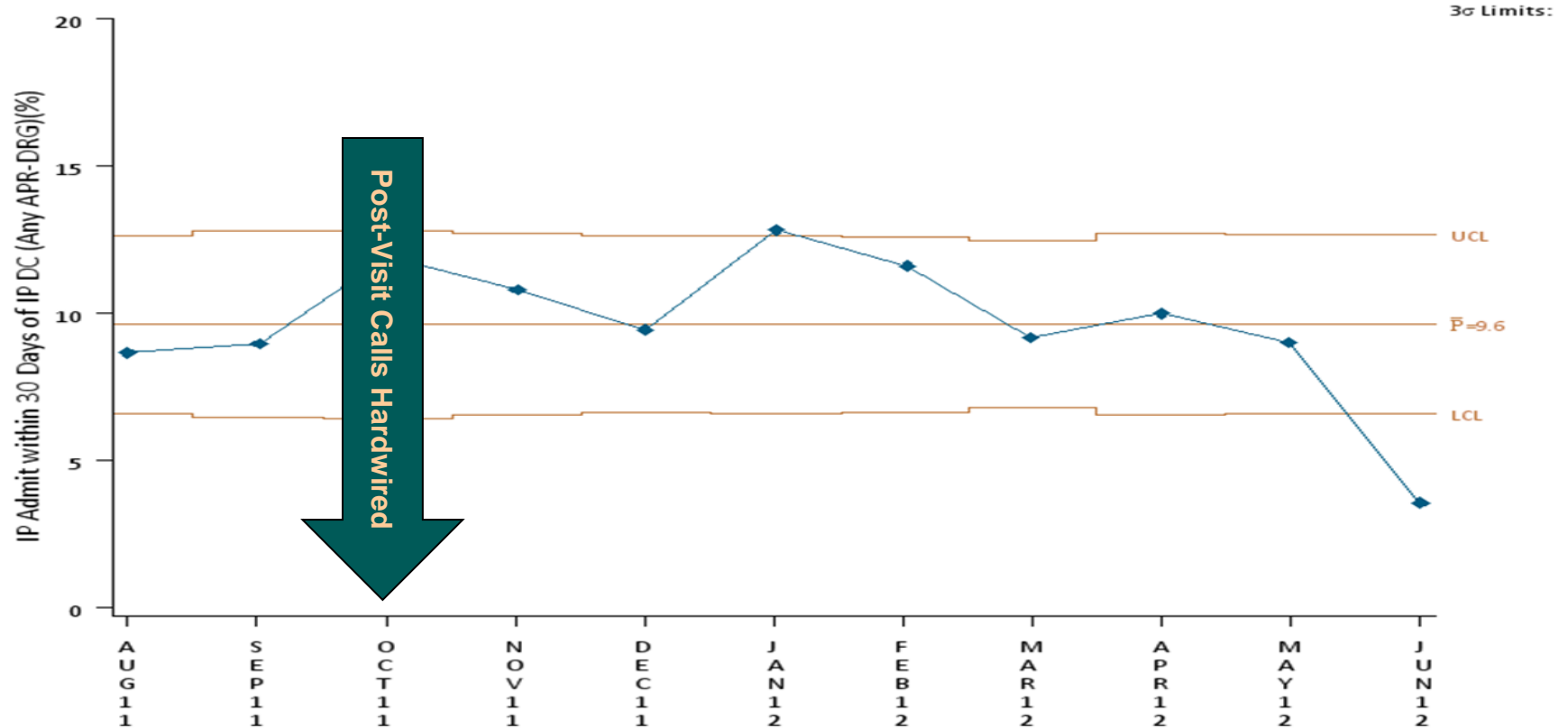
Represents total readmissions for each unit over a 4-month period, equaling 100%
Source: University of Alabama Birmingham

Impact of Interactive Care



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)



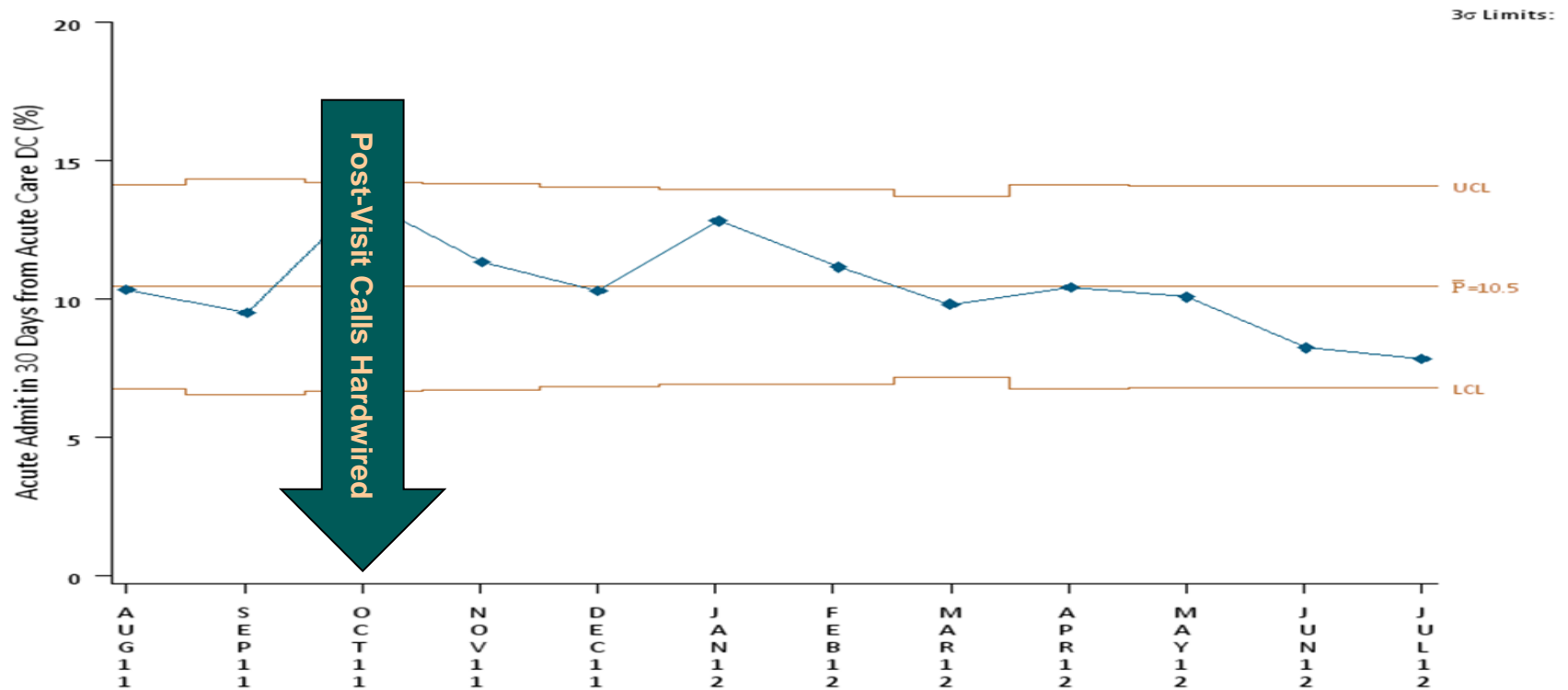
Data Source: Crimson

Source: Cheyenne Regional Medical Center

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Acute Care Admit within 30 Days of Acute Care Discharge

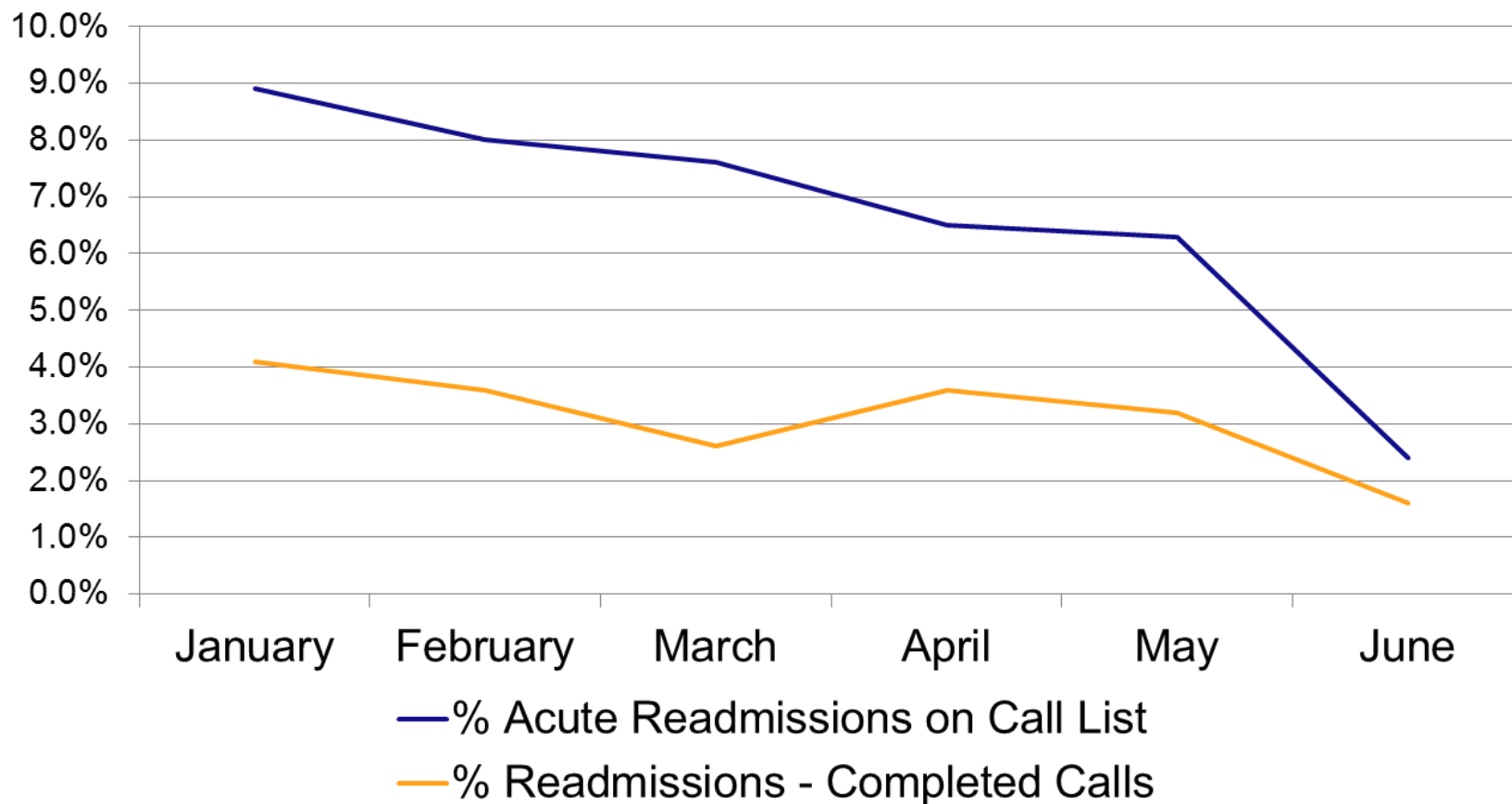


Source: Cheyenne Regional Medical Center



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Readmission Data: Impact of Post-Visit Calls



Source: Cheyenne Regional Medical Center



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Questions?

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Nashville, TN | May 14 - 15, 2013

Endnotes

1. Source: Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med* 2003;138(3):161-167.
2. Source: Harris G. Report finds a heavy toll from medication errors, *N.Y. Times* (July 21, 2006). Available at:
<http://www.nytimes.com/2006/07/21/health/21drugerrors.html?ex=1311134400&en=8f34018d05534d7a&ei=5088&partner=rssnyt&emc=rss>
3. Source: Medpac.gov websites, http://www.medpac.gov/chapters/jun07_ch05.pdf
4. Source: Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA* 2007;297(8):831-841.
5. Source: Burt CW, McCaig LF, Simon AE. Emergency department visits by persons recently discharged from US hospitals. *National Health Statistics Reports*, July 24, 2008; Number 6.
6. Source: Maniaci MJ, Heckman MG, Dawson NL. Functional health literacy and understanding of medications at discharge. *Mayo Clin Proc.* 2008 May;83(5):554-558.