



HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) TOOLKIT

MEDICARE BENEFICIARY QUALITY IMPROVEMENT PROJECT





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The West Virginia Hospital Association CAH Network, with support from the State FLEX program, administrated by the WV State Office of Rural Health, working with Cynosure Health, is pleased to provide a best practice HCAHPS Measures toolkit to support your CAH as you move forward with your quality improvement program.

I hope you find this toolkit useful, and I look forward to your feedback.

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HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) TOOLKIT

BACKGROUND

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients’ perspectives of hospital care. While many hospitals collect information on patient satisfaction, HCAHPS created a national standard for collecting and public reporting information that enables valid comparisons to be made across all hospitals to support consumer choice.

Three broad goals shape the HCAHPS survey. First, the survey is designed to produce comparable data on patients’ perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve quality of care. Third, public reporting services to enhance public accountability in health care by increasing transparency.

The HCAHPS survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness of the hospital environment, quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital and likelihood to recommend the hospital; four items to skip patients to appropriate questions; three items to adjust for the mix of patients across hospitals; and two items to support congressionally mandated reports. On average, it takes respondents about seven minutes to complete the HCAHPS survey items.

DRIVER DIAGRAM

A driver diagram visually depicts the causal relationship between your overall aim and the primary drivers, secondary drivers and change ideas that “drive” the improvement. This driver diagram is provided to help you and your team identify potential change ideas to implement at your hospital as you work to improve care transition documentation.

AIM	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea
		Secondary Driver	Change Idea

	Primary Driver	Secondary Driver	Change Idea
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AIM: A clearly articulated goal describing the desired outcome. It should be specific (What), measurable (How Much), and time limited (by When).

PRIMARY DRIVER: System component for factor that directly contributes to achieving the aim.

SECONDARY DRIVER: Processes, actions that are necessary to achieve the primary driver.

CHANGE IDEAS: Specific interventions, changes that support the secondary driver

DRIVERS IN HCAHPS IMPROVEMENT

AIM	PRIMARY DRIVER	SECONDARY DRIVER	CHANGE IDEA
Improve the composite HCAHPS scores by 10% by September, 2018	Organizational Will	Secure Leadership Commitment	CHANGE IDEAS <i>See below</i>
	Organizational Culture	Create a patient-family centered culture	CHANGE IDEAS <i>See below</i>
	Using Data for Improvement	Routine review of data related to HCAHPS to identify areas for improvement and focus	CHANGE IDEAS <i>See below</i>

Drivers for improvement in the Hospital Consumer Assessment of Healthcare Providers and Systems include strategies that can bring positive and sustainable change to critical aspects of the hospital experience. Many challenges currently face leaders, managers and clinicians. Involvement at the leadership level is a key ingredient in the patient experience improvement process. Organizational Will may lead to commitment and focus, which is essential for positive patient experiences.

Standard practices and processes will lead to less variation. Transparency with data and involvement of staff in strategies to drive improvements will promote a collaborative environment and staff engagement.

Health care professionals typically take great pride and exert painstaking effort to meet patient needs and provide the best possible care. A common problem regarding hand-offs, or hand-overs, centers on communication: expectations can be out of balance between the sender of the information and the receiver.

<p>PRIMARY DRIVER:</p> <p>Create Organizational Will</p>	<p>SECONDARY DRIVER:</p> <p>Secure Leadership Commitment</p> <p>The commitment involves written leadership support, clear communication strategies, education and training opportunities, and time to perform the necessary functions to improve the transfer communications.</p> <p>CHANGE IDEAS:</p> <ul style="list-style-type: none"> • Identify the leadership structure including informal front- line staff to support HCAHPS <ul style="list-style-type: none"> • Identify a physician and nursing champion to be executive sponsors • Report the HCAHPS data to leadership on a regular basis <ul style="list-style-type: none"> • Identify realistic time frames for the improvement efforts • Implement strategies to engage leaders and staff • Create will by implementing patient stories about their patient experience. • Celebrate successes by rewarding and recognizing staff and leaders <p>https://www.ruralcenter.org/resource-library/mbqip-measures</p> <p>http://www.hpoe.org/resources/ahahret-guides/807</p>
<p>PRIMARY DRIVER:</p> <p>Organizational Culture</p>	<p>SECONDARY DRIVER:</p> <p>Create a patient-family centered culture</p> <p>CHANGE IDEAS:</p> <ul style="list-style-type: none"> • Develop a patient-family advisory committee <ul style="list-style-type: none"> • Engage the patient-family advisory committee in identifying key areas on the HCAHPS survey to improve • Invite members of the patient-family advisory committee to round with leaders and staff • Develop scripting when rounding to solicit patient’s feedback on their experiences. • Develop and employ a staff recognition program. <p>www.ahrq.gov</p> <p>http://www.ipfcc.org/resources/Advisory_Councils.pdf</p> <p>http://planetree.org/wp-content/uploads/2017/09/Patient-Engagement-in-Research-A-Toolkit-for-PFACs.pdf</p>

	http://www.patient-experience.org/Resources/Best-Practices/Case-Studies/Patient-Advisory-Council-Toolkit.aspx
<p>PRIMARY DRIVER:</p> <p>Using Data for Improvement</p>	<p>SECONDARY DRIVER:</p> <p>Routine review of data related to HCAHPS to identify areas for improvement and focus</p> <p>CHANGE IDEAS:</p> <ul style="list-style-type: none"> • Form a team that includes front line staff and leaders to review the data. • Analyze the data: identify strengths and opportunities at the organizational level • Analyze the data by care units/settings • Prioritize opportunities • Identify best practices <ul style="list-style-type: none"> • Communication with Nurses <ul style="list-style-type: none"> • Use patient whiteboards to communicate with patients • Develop a nurse bedside shift report to help ensure the safe handoff of care between nurses • Scripting: Use AIDET, a Studer tool: Acknowledge, Introduce, Duration, Explanation, Thank you. • Daily multidisciplinary huddles: Discuss patient safety issues, patient census, staffing, patient satisfaction, etc. • Responsiveness of hospital staff <ul style="list-style-type: none"> • Hourly rounding: purposeful patient visits to check on status of patients: Use 4 “P’s”: Pain, potty, position and personal effects • No Pass Zone: Patient requests for non-clinical support are immediately taken care of by any employee • Technological devices: call light systems, two- way speakers, nurse communication devices • Pain Management <ul style="list-style-type: none"> • Add pain scales, pain goals, time of last pain dose to whiteboards • Set expectations and goals with the patient • Consider alternative therapies for pain control • Use electronic reminders to check on patients for effectiveness of pain treatments • Share/report results at all levels of the organization • Post the results in the ED. Review the results as part of team huddles, staff meetings, etc.

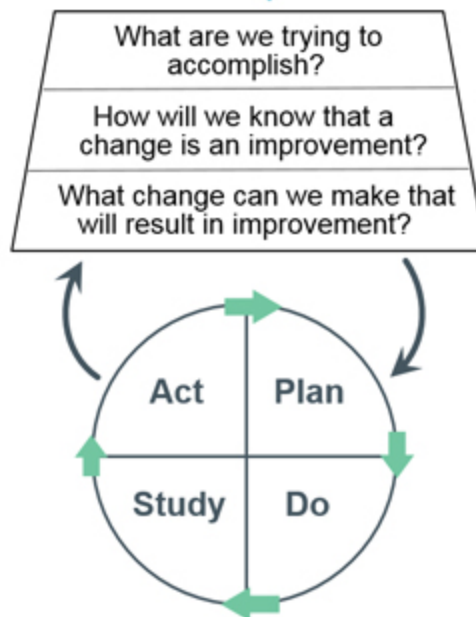
	<ul style="list-style-type: none"> • Create positive change by celebrating organizational, team, and individual successes. <p>https://www.ruralcenter.org/category/ship-investment-resources/hcahps</p> <p>http://www.flexmonitoring.org/wp-content/uploads/2017/12/DSR24.pdf</p>
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QUALITY IMPROVEMENT PRINCIPLES

All improvement requires change. Unfortunately, not all change results in improvement. System changes intended to improve quality must be tested and assessed to determine whether they produce successful outcomes. This process of identifying needed change, planning for and making change, and then testing the outcomes of that change to evaluate effectiveness is fundamental to performance improvement in healthcare. Effective change requires an understanding not only of how one part of a system functions, but of how all the system parts are linked together and coordinated. For example, education and training for staff to enhance their knowledge and skills will only improve a system if the lack of such knowledge and skills was the major cause of deficient performance in that system. If the system has other unaddressed problems, such as lack of resources, inadequate staffing, or ineffective management or communication structures, even well-trained staff will not be able to accomplish their duties to the best of their abilities. Changes in one specific area may not lead to quality improvements if they do not significantly affect the overall quality of care the system provides.

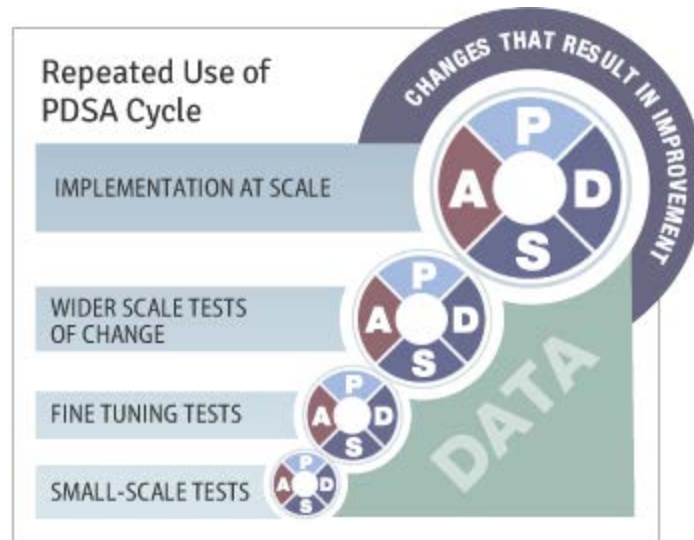
The first step in the quality improvement process is the identification and prioritization of improvement needs, identification of an AIM statement, or improvement goal, followed by the identification of team members tasked with leading the improvement process. Key to success in team identification is the inclusion of team members involved with the system being analyzed, organizational leadership with the ability to provide resources and direction, as well as team members with expertise in quality improvement principles. Once the team is formed, the quality improvement process starts with a series of questions, followed by short, rapid cycle tests of change called the “PDSA Cycle”, as demonstrated with the graphics below.

Model for Improvement



Source: The Institute for Improvement, *How to Improve*, retrieved at:
<http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>

It is important that the team tasked with leading improvement be willing to test multiple ideas on a small scale, while searching for the changes that result in improved care at the local level. In quality improvement models, these multiple small tests of change are referred to as the PDSA, or Plan Do Study Act cycle. The PDSA cycle is an improvement tool which promotes improvement via the implementation of rapid-cycle tests among an increasingly larger population and a wider range of conditions. The “Plan” step in the cycle involves identifying and planning the change to be tested. The “Do” portion of the cycle is the actual act of carrying out the test on a small scale. The “Study” phase of the PDSA cycle involves rapid data collection that is done during testing through a “huddle” or “debrief” with the staff or patients involved in the newly designed process. Finally, the “Act” portion of the cycle occurs when the decision to Adapt, Abandon or Adopt is made, based on the analysis of rapidly-collected information. If revisions and changes are indicated, the process is revised or “adapted,” and a new testing cycle is instituted. If the trials have been unsuccessful, the change idea may be “abandoned.” The decision to “adopt” a new process occurs after it has been tested broadly under various circumstances and settings. PDSA cycles should be run among smaller groups (for example, one nurse, one physician, and during one shift to start) before gradually expanding to a larger population within the system or organization if the change is determined to be successful.



Source: Coaching and Leading <https://coachingandleading.wordpress.com/presentation1/pdsa-and-types-of-change/>

Quality improvement initiatives are best implemented by designated improvement teams composed of representatives from the relevant departments, units, or groups involved in the process or system to be addressed. Project management includes identification of team leadership and membership; creation of AIM statements; development of a Project Plan; selection of Tests of Change and tools for implementation, measurement, and analysis of change efforts; and communication with relevant stakeholders including senior management, medical staff, front-line staff, and patients and families about the progress and success of the improvement project. In the small hospital setting, large improvement groups may not be possible. In this setting a “hub and spoke” model for improvement work can be effective. Instead of convening large teams for every improvement initiative, one core quality and patient safety committee (the “hub”), led by a chairperson, initiates and oversees multiple improvement activities by designating a leader (or “spoke”) for each initiative. Individual project leaders can be selected based on topic expertise, enthusiasm, or proximity to the process being improved. Active project implementation can be conducted in ad hoc working sessions, with the leader attending quality and patient safety meetings only upon request, if the leader is not a standing member of the quality and safety committee. This allows for improvement work to commence without interruption of duties for large groups of staff members.

BARRIERS AND CHALLENGES TO IMPROVEMENT

Partnering together to improve quality and safety is challenging work. In addition to what feels like a regular onslaught of new and competing priorities, getting on board with meaningful improvement requires a culture that supports the work, and eliminates barriers. A safety culture that supports this work requires an understanding of change management at all levels of the organization, because improvement requires change. One group that plays a significant role in the success or failure of an improvement initiative is middle managers. Without buy-in and effective leadership by middle managers to operationalize culture change, healthcare organizations will face many barriers to improvement. Few people relish the idea of changes to the comfortable status quo.

To exact positive change in the work that we do to keep patients and staff safe and improve outcomes, it takes small, incremental changes by all individuals in our organization that will build up to the large cultural shift that is needed for reliable improvement. Our frontline staff members are the eyes and ears of our organizations. Organizational leadership and middle managers can help to make this work safer and processes more reliable by listening to the frontline workforce when barriers and challenges are brought up and acting on the suggestions made. Organizational leadership input, encouragement and follow up can be the key to successful change.

A few keys to successful change management, and eventual cultural shifts includes the following:

- Create a sense of urgency: you are part of something big, we must make a difference now – reference not only what we know from research about the vast number of errors we are missing, but stories from actual events in your organization and your own department.
- Build a guiding coalition: organize opinion leaders and those in authority to help spread the message. Work with the willing before trying to engage those who are opposed to anything new. Let those who are enthusiastic about the new processes become the unit champions and help to spread the message.
- Form a strategic vision to help steer the change initiative: do you have a unit-specific strategic vision that is built by staff? Create that vision together at the outset.
- Enlist a volunteer army: Work with the willing. The others will come as they see enthusiasm grow.
- Enable action by removing barriers: what can you do to leverage work that is already being done? How can you help staff create time to make this a priority? Can you include a discussion about the new process in daily shift huddles and department meetings?
- Generate short term wins: Publicly celebrate the small, individual steps being made. Together they make a significant impact.
- Sustain acceleration: Keep the attention on the cultural shift by celebrating near misses that are caught and safety issues that are identified.
- Institute change: Hardwire new processes by showing how the new way of doing things has made a positive impact. Use the power of storytelling.

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6. <https://www.nursingtimes.net/clinical-archive/patient-safety/tools-and-techniques-to-improve-teamwork-and-avoid-patient-harm/7014105.article>

7. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4547690/> (Hourly rounding)

RESOURCES

To assist you, we have identified a few of the key resources that you may find helpful for rural hospitals:

<https://www.ruralcenter.org/srht/rural-hospital-toolkit/quality-improvement>

<https://www.ruralcenter.org/resource-library/quality-improvement-implementation-guide-and-toolkit-for-cahs>

<https://www.ruralcenter.org/resource-library/hrsa-quality-toolkit>

http://www.wsha.org/wp-content/uploads/CommEngagementToolkit_1_1.pdf

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/HVBP-Trend-Analysis.pdf>

<https://greatplainsqin.org/wp-content/uploads/2014/09/Rural-Healthcare-Organization-Resources.pdf>

General Improvement Tools:

<https://www.beckershospitalreview.com/quality/4-strategies-to-boost-hospitals-hcahps-scores.html>

<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-partnertoolkit.pdf>

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=TopicLandingPage&utm_source=IHI

<http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>

<http://www.planetree.org>

<http://www.aha.org/aha/content/2005.pdf/assessment.pdf>