



Improving Care Transition and HCAHPS Scores

Part 1: December 1, 2015

Part 2: December 2, 2015

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- Discuss HCAHPS Survey
- Discuss the questions associated with composite 7
- Define and Discuss Transition of Care



Action
Changes
Things

- Evaluate best practice *actions* for improving Care Transitions



Action
Changes
Things

What Is the HCAHPS Survey ?

HCAHPS stands for “Hospital Consumer Assessment of Healthcare Providers and Systems.”

The survey is designed to produce data about patients’ perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to consumers

Public reporting of the survey results creates new incentives for hospitals to improve quality care

Public reporting serves to enhance accountability in healthcare by increasing transparency of the quality of hospital care provided in return for the public investment

What Is the HCAHPS Survey ?

- Standardized survey instrument and data collection methodology
- Uses “apples to apples” approach
- Currently, 32 questions in length
 - 21 patient perspectives on care
 - Includes 7 Composite set
- Administered by
 - Mail only
 - Telephone only
 - Mixed (mail followed by telephone)
 - Active Interactive Voice Response (IVR)



What Is the HCAHPS Survey ?

- Intended for patients of all payer types that meet the following:
 - 18 years or older at the time of admission
 - At least one night stay in the hospital as an inpatient
 - Non-psychiatric MS-DRG/principal diagnosis at discharge
 - Alive at discharge
- Sampling procedure is random
 - Patients surveyed 48 hours to six weeks after discharge
 - Data collected throughout each month of a 12-month reporting period
 - Data aggregated quarter (a rolling 4 quarters)
 - Most recent 4 quarters reported publicly-

Our Focus- Composite 7 Care Transition

- Section: Understanding your care when you left the hospital
 - Composite 7 is different in the scoring methodology
 - Contains three questions
 - Aimed at measuring the patients' perception regarding the aspect of care that leaves the walls of our facility.



Summary of HCAHPS Survey Results: January 2014 to December 2014 Discharges

State	Comm. with Nurses	Comm. with Doctors	Responsiveness of Hospital Staff	Pain Management	Comm. About Medicines	Cleanliness of Hosp. Env.	Quietness of Hosp. Env.	Discharge Information	Care Transition	Overall Hospital Rating	Recommend the Hospital	Publicly Reporting Hospitals	Survey Response Rate**
AK	74	75	67	68	65	69	58	84	49	65	70	16	25%
AL	81	86	69	73	67	72	71	85	52	73	71	85	30%
AR	79	84	68	70	64	73	66	83	50	70	68	64	28%
AZ	77	78	66	70	64	70	58	87	51	70	70	70	32%
CA	75	78	62	69	61	70	51	87	49	68	70	310	27%
CO	79	81	69	72	67	75	63	85	54	74	75	64	31%
CT	80	80	65	70	63	73	53	86	51	68	72	29	29%
DC	71	78	54	65	57	63	55	80	42	58	61	7	24%
DE	79	78	68	70	63	69	54	86	50	67	68	6	26%
FL	76	78	62	68	61	70	59	84	49	67	69	172	28%
GA	79	83	66	71	64	71	67	84	51	70	69	119	25%
HI	79	84	71	73	68	75	60	87	51	74	70	16	28%
IA	81	83	71	72	66	79	65	88	56	76	75	87	36%
ID	81	84	74	71	68	78	64	88	56	73	74	35	37%
IL	80	82	68	72	64	74	61	86	52	71	70	161	30%
IN	82	83	72	73	66	76	62	88	54	75	73	121	32%
KS	81	85	72	73	67	76	67	87	56	77	76	96	36%
KY	81	85	70	73	67	75	66	87	53	72	71	89	29%
LA	84	87	73	76	69	75	74	86	58	76	76	103	28%
MA	80	81	66	71	64	73	53	89	53	70	74	59	30%
MD	76	78	60	67	60	65	56	86	48	65	67	44	28%
ME	83	83	72	74	69	80	61	89	58	75	76	33	30%
MI	80	81	70	72	64	73	60	85	52	72	71	122	34%
MN	81	84	73	72	67	78	67	85	55	74	74	111	36%
MO	80	82	68	70	65	73	63	87	53	71	71	94	32%
MS	81	87	69	73	67	74	71	84	51	71	69	84	26%
MT	78	83	71	71	65	73	62	84	52	67	68	40	35%
NC	80	83	67	71	65	72	63	86	52	70	70	96	28%
ND	77	80	68	69	63	70	64	81	47	65	66	34	35%
NE	83	85	75	73	67	80	67	88	57	76	77	78	37%
NH	82	82	72	72	68	77	58	89	55	74	75	24	31%
NJ	77	78	61	68	60	69	53	83	47	64	66	64	25%
NM	76	79	67	70	64	72	62	83	48	66	63	40	26%
NV	73	75	61	66	61	69	54	84	47	67	67	27	29%
NY	76	78	62	67	61	70	52	85	48	64	66	163	27%

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OH	81	81	70	72	66	75	60	88	53	73	72	158	32%
OK	80	84	71	72	66	74	69	86	53	72	70	101	29%
OR	79	81	69	70	65	74	57	87	52	71	72	56	31%
PA	80	80	68	71	64	74	56	87	51	70	70	159	36%
RI	80	81	66	72	63	73	54	87	52	70	72	11	31%
SC	81	84	68	72	66	72	68	86	52	72	71	59	28%
SD	83	85	75	72	69	77	71	88	55	75	77	46	33%
TN	80	83	69	71	66	73	68	86	51	71	70	99	30%
TX	80	83	70	73	67	75	69	86	53	73	74	330	28%
UT	79	83	69	72	65	73	63	90	57	75	77	41	36%
VA	79	81	65	70	64	72	61	87	51	70	70	78	30%
VI	77	83	67	69	62	70	51	79	39	56	60	2	30%
VT	81	82	72	71	67	78	53	89	55	72	76	14	32%
WA	78	80	66	70	63	73	55	88	52	70	72	78	30%
WI	83	84	73	73	69	80	65	90	56	76	75	116	39%
WV	79	82	69	69	65	74	59	87	50	66	66	44	30%
WY	79	82	73	71	68	73	61	89	52	68	67	22	30%
US	79	82	68	71	65	74	62	86	52	71	71	4177	30%

October 2015

* Average "top box" score for participating, publicly reported hospitals in this state.

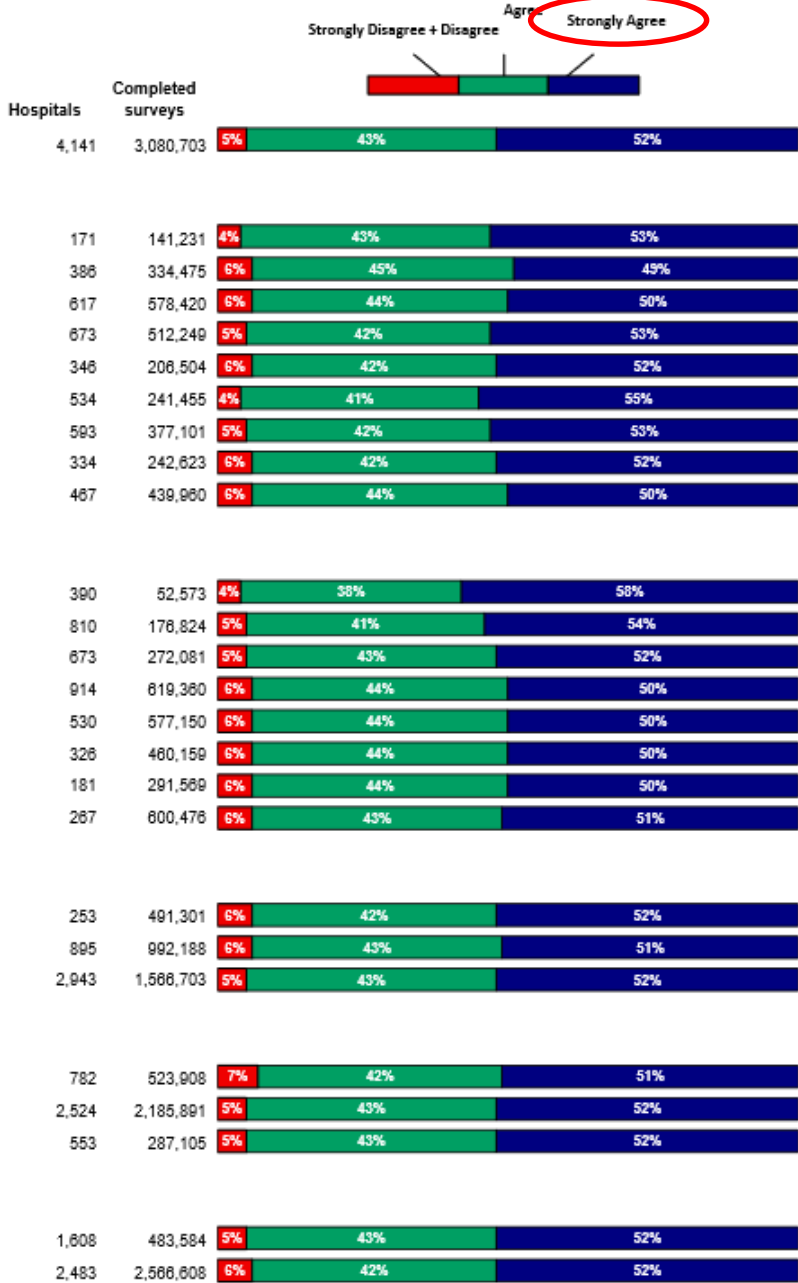
See HCAHPS results on www.Medicare.gov/hospitalcompare for full details.

** Response rate is calculated for hospitals in each state, and in the nation.

HCAHPS: Care Transition

(Represents patients discharged between July 2013 and June 2014)

HCAHPS Care Transitions



A national view by:

- Region
- Bed size
- Teaching status
- Ownership
- Location

' www.hcahpsonline.org~Originally Posted: 04-16-2015'

Composite 7 Care Transition

Section: Understanding your care when you left the hospital

- Question 23
 - The hospital staff took my **preferences** and those of my family or caregiver into account in deciding what my healthcare needs would be when I left the hospital.



Composite 7 Care Transition

Section: Understanding your care when you left the hospital

- Question 24
 - When I left the hospital, *I had a good understanding of the things I was responsible for in managing my health.*



Composite 7 Care Transition

Section: Understanding your care when you left the hospital

- Question 25
 - When I left the hospital, I clearly understood the purpose for taking each of my medications.



Composite 7 Care Transition

A 68-year old man is readmitted for heart failure only one week after being discharged following treatment for the same condition. He brought all of his pill bottles in a bag; all of the bottles were full, not one was opened. When questioned why he had not taken his medication, he began to cry, explaining he had never learned to read and couldn't read the instructions on the bottles.



10 Most Common Patient Complaints and Grievances with Hospitals



1. Sleep deprivation from clinicians coming to do tests and draw blood in the middle of the night.



2. Noisy nurses' stations that can interfere with sleep.



3. Personal belongings being lost.



4. Staff not knocking before entering the room, which can be interpreted as a sign of disrespect.



5. Not keeping whiteboards updated. Updated whiteboards allow patients to know who is caring for them. Patients would also appreciate a notebook where they can keep important information and take notes.



6. Lack of clear communication and not updating the patient or family members if the patient's condition changes.



7. Messy rooms where surfaces aren't wiped down, or the bathroom smells.



8. Feeling unengaged in their care or like they are not being listened to.



9. Lack of orientation to the room and hospital. Patients would like to know how to work the television and how to order food.



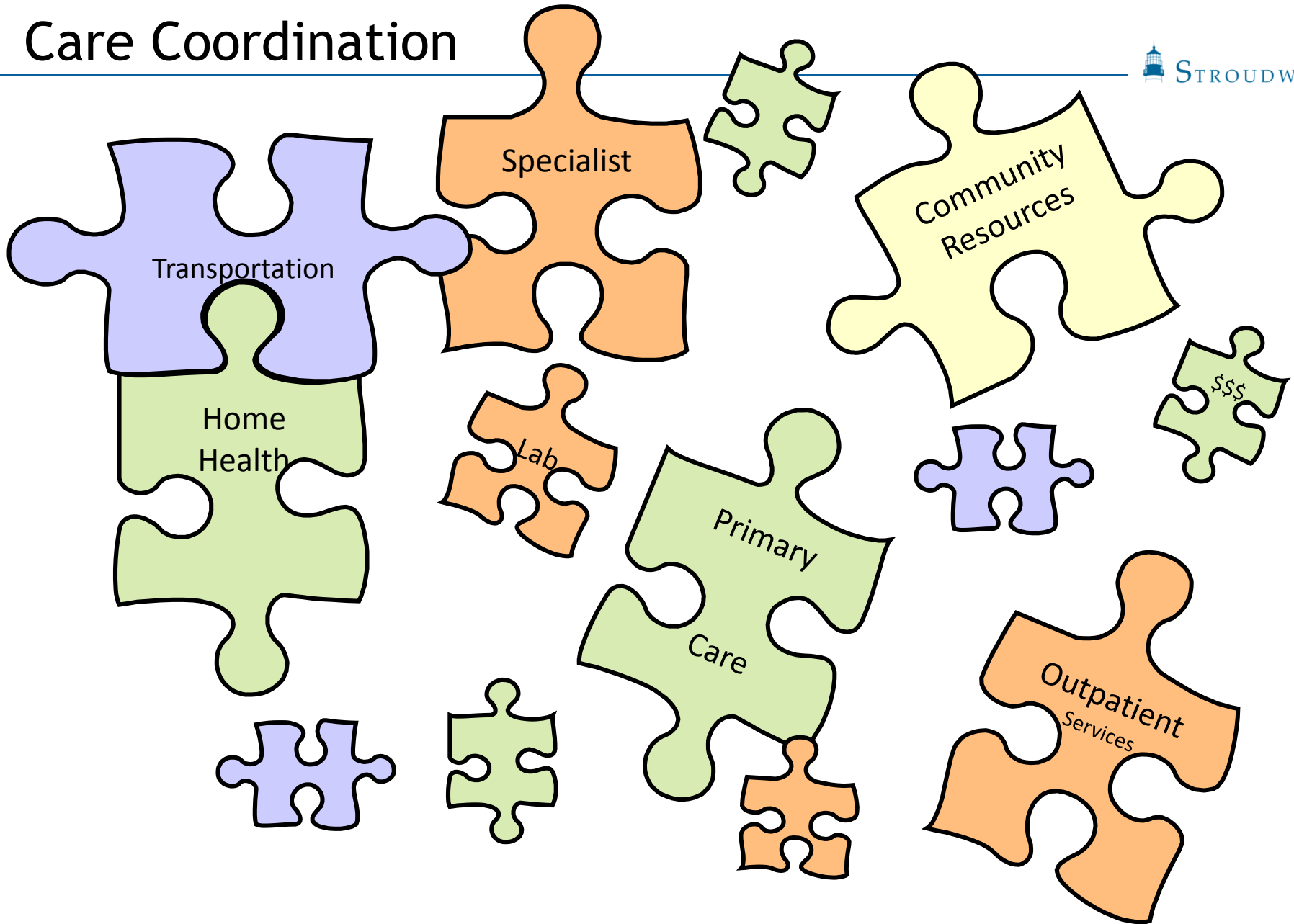
10. Lack of professionalism from hospital staff, especially when they are on break. "While you may be on your break, you are still a hospital employee and a reflection of the hospital," the article reads.

What Does *Transition of Care* Look Like?

- The Patient Journey
 - All movement “handoff” between settings/practitioners

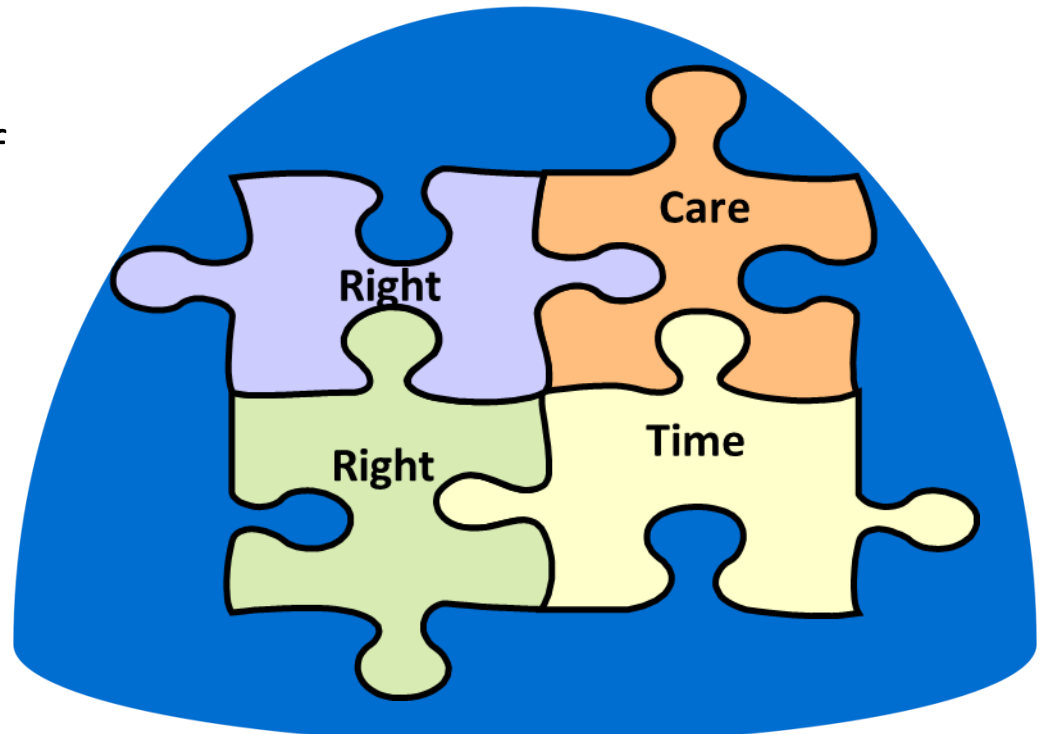


Care Coordination



Care Coordination

"Care coordination is the deliberate (conscious) organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services"



So.....Why are *seamless transitions* important?



- It's the right thing to do for our patients!
- Seamless transitions create better outcomes
- We can reduce unnecessary readmissions
- Reduce unnecessary Emergency Department visits
- Reduce risk of potential reimbursement impacts
- Improve or maintain positive relationship with our “consumers of care”
- Partners for ACOs/ Bundled payment contracting and referrals

*I've learned that people will
forget what you said, people
will forget what you did, but
people will never forget how
you made them feel.*

~ Maya Angelou

Learning and Action Objectives- Part 2

- Evaluate best practice *actions* for improving Care Transitions
- TUNE IN TOMORROW

