Improving your HCAHPS scores

A Collection of Articles from Today’s Hospitalist Magazine’s Coding Section

By David Frenz, MD
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Doctor-patient communication for (physician) dummies
Strategies to improve your HCAHPS performance

Chairs and whiteboards
Promising solutions for flagging communication scores

DOO, POO and you
Getting on the same page as your patients

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REIMBURSEMENT USED TO BE SO EASY. We got paid for what we did, even if we didn’t do it very well. But payment, to a large degree, now hinges on how well we do our jobs.

Hospitalists are pretty quality-oriented, so we can generally live with reimbursement pegged to clinical metrics for conditions like pneumonia and heart failure. But even the biggest quality mavens get twitchy when dollars are put into play for subjective measures. And perhaps nothing is more subjective than interpersonal communication.

HCAHPS

The current survey consists of 32 questions, three of which target physicians specifically: During this hospital stay, how often did doctors treat you with courtesy and respect; during this hospital stay, how often did doctors listen carefully to you; and during this hospital stay, how often did doctors explain things in a way you could understand?

In each case, patients are given four choices: never, sometimes, usually and always.

Survey says!
HCAHPS data are aggregated and then posted on Medicare’s "Hospital Compare"Web site.

The current data for my hospital were collected during calendar year 2012. Patients reported that our physicians “always” communicated well 77% of the time, which puts us below both the national and Minnesota averages (81% and 83%, respectively). Our doctors tied a competitor down the street but lagged another by 3%.

A few percentage points doesn’t seem like a big deal until you consider that the CMS transforms these data into percentiles. My hospital’s 77% puts us at about the 25th percentile nationally. In other words, 75% of hospitals in the country are doing better in this department. Ouch!

I don’t know about you, but we clearly need a little help. Accordingly, I’ve pulled together some of my favorite resources for everyone’s benefit.

What else?
Doctors often fail to establish the patient’s full agenda. We might start with an open-ended question—“How are you feeling today?”—but we quickly switch gears to specific queries like, “Are you short of breath?” Once that occurs, the patient will never voice everything on his or her mind.

One of my favorite techniques involves wearing patients out. I picked this up from an article published in the February 2003 Mayo Clinic Proceedings. You still start with an open-ended question but follow every patient answer with this mantra: “What else?”

Hospitalist: How are you feeling today?
Patient: I’ve been having heartburn.
Hospitalist: What else?
Patient: My back hurts.
Hospitalist: What else?
Patient: The food here is really bad.
Hospitalist: What else?

Most physicians fear that this will go on forever, but patients generally run out of things to say pretty quickly. At that point, you can take stock of what you have and start parsing through everything.

BATHE your patients
Another arrow in my quiver comes from Marian Stuart, PhD, a psychologist, and Joseph Lieberman, MD, MPH, a family physician. It is an approach known as BATHE, an acronym that stands for Background, Affect, Trouble, Handling and Empathy. The physician side of the conversation involves four scripted questions and a concluding statement.

Hospitalist: How are you feeling today? (B)
Patient: To help my mood. I have bad mood swings and fight with people.
Frenz: Does quetiapine have any side effects?
Patient: Yeah, it could give me sugar diabetes.
Frenz: And why is diabetes bad?
Patient: It could give me a heart attack.
Frenz: And what is a heart attack?
Patient: It's when part of my heart dies. If too much heart dies, then I could die.
Frenz: And what am I going to do about this?
Patient: You're going to check the sugar in my blood now and then.

This guy did OK but you'd be surprised how little patients understand. Fortunately, the teachback method allows you to identify gaps and immediately fix them.

Dollars at risk
Our hospitalists are currently eligible for an annual quality bonus of up to 11.5% of their base salary. Of this, 12% is tied directly to HCAHPS physician-communication scores. It is a relatively small percentage of the overall package, but it can still amount to several thousand dollars.

The big problem is that HCAHPS data reflect the patient experience with all doctors: There is no drilldown by specialty or to individual providers. Hospitalists get lumped together with rogue surgeons, specialists who talk over patients' heads and frazzled emergency physicians.

Any solution for low HCAHPS scores thus needs to encompass all credentialed providers, not just hospitalists. An initiative now being discussed at my hospital would produce specific strategies and tactics to follow later this year. I will circle back with an update.

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THINGS WEREN’T GOING SO WELL for my hospital when I last left you in my February column. There was lots of handwringing over our dismal HCAHPS scores for physician communication.

Unfortunately, new data still have us on the wrong side of the bell curve. Apparently, a tincture of time doesn’t heal, at least for this illness.

The HCAHPS survey, as you recall, contains three questions specific to physicians: During this hospital stay, how often did doctors treat you with courtesy and respect, listen carefully to you, and explain things in a way you could understand?

The latest publicly reported data come from patients discharged between April 2012 and March 2013, which in hospital medicine time is several partners ago. Our doctor communication score this time was 78%. We still lag the Minnesota average (83%) and remain at the 25th percentile nationally.

Still, 79% of patients indicated they would “definitely recommend” our hospital to others. This exceeds our competitors’ scores and falls somewhere between the 75th and 90th percentile for that category.

Countermeasures
Our administration put together a small work group to discuss ways to improve physician communication. Any countermeasure had to be simple, inexpensive and evidence-based.

If you’ve ever done quality improvement work, you’ll recognize that these are remarkable constraints. Evidence-based is a given, but what occurs in hospitals is never simple or inexpensive.

After relatively little deliberation, we staked our future on two countermeasures: chairs and whiteboards.

Take a seat
We have all heard that we should sit down for patient encounters. But is there any evidence that patients see us differently when we sit instead of stand?

Investigators at the University of Kansas put that conventional wisdom to the test. They had two a priori hypotheses, which were outlined in the February 2012 issue of Patient Education & Counseling. The first was that patients would perceive that physicians spent more time with them than they actually did if doctors sat during rounds instead of standing. The second was that physicians sitting down would actually spend more time at the bedside.

For the study, a research nurse randomly directed physicians to either sit or stand before they entered the patient’s room. The nurse stayed in the hallway and timed the duration of the encounter with a stopwatch. After the physician exited, the nurse interviewed patients using a standardized protocol, asking them to estimate how much time the physician had spent with them. Nurses also asked, “What did you think about the interaction with Dr. X?”

Patient encounters, which were performed by surgeons, were crazy quick: Sitting encounters averaged 1 minute and 4 seconds, while standing visits lasted 1 minute and 28 seconds, with no statistical difference between the two. Patients, however, perceived things much differently. They felt that sitting encounters lasted 5 minutes and 14 seconds and that standing visits were 3 minutes and 44 seconds. That difference was statistically significant.

P values count for something, but effect size—whether the difference is clinically meaningful—is the name of the game. Ninety-five percent of patients in the sitting group gave positive feedback about their physician, with comments like, “The doctor took the time to sit and listen.”

On the flip side, only 61% of patients in the standing group offered positive feedback. Negative comments
Patient perceptions, at least from an HCAHPS standpoint, are reality.

Patient satisfaction scores increased across the board (pun intended) on the medicine wards. Doctor communication, nurse communication and shared decision-making scores increased by 4, 6.4 and 6.3 points respectively on a 0-to-100 point scale: statistically significant results. Those upward ticks reversed the hospital’s 18-month slide in all three categories. Scores from the surgical wards without whiteboards remained flat. Ditto for food quality and room temperature.

Changes ranging from 4% to 6% seem pretty small. But remember: Data are transformed into percentiles. My hospital’s HCAHPS doctor communication score lags the national average by only 3%. But this amounts to an entire quartile on a percentile basis.

Implementation

With these data in hand, our hospital is going to give these measures a whirl. Most rooms already have chairs, which are often in use by family. The trick will be getting providers to sit on the end of the bed or finding some portable seating solution. I’m half-seriously considering a seat cane, which would also come in handy at my kids’ baseball and soccer games. Whiteboards run about $45 for the three-by-two foot version the investigators in Wisconsin used. That’s just a single 99231 in Medicare money, plus the continuing cost for dry-erase markers.

Like everything else in hospital medicine, the key will be relentless messaging and hardwiring. I’ll let you know how we do.

David Frenz, MD, is a hospitalist for HealthEast Care System in St. Paul, Minn., and is board certified in both family and addiction medicine. You can learn more about him and his work at www.davidfrenz.com or via LinkedIn.
DOO, POO and you

Getting on the same page as your patients

THIS YEAR, I’VE BEEN ON A WRITING JAG about doctor-patient communication. As I mentioned in my February and April columns, my hospital’s HCAHPS scores in this department have been lackluster—so much so that we’re implementing countermeasures to improve them.

I’m taking up my proverbial pen again this month to address “Your Care From Doctors,” those three HCAHPS survey questions dealing with our interactions with patients. Jim Beattie, MLIS, my longtime partner in crime, is pitching in. We’ve developed a lot of these ideas together for an evidence-based medicine class that we teach at the University of Minnesota.

DOE and DOO

Doctors spend a lot of time chasing data. Fever spike? Look for a source of infection. Pulmonary infiltrate? Make sure antibiotic coverage is appropriate. Persistent hyperglycemia? Better fiddle with insulin. Continue ad nauseam until your shift is over.

But does any of this really matter to patients? Think twice before laughing or turning the page.

Way back in 1994, Allen Shaughnessy, PharmD, and David Slawson, MD, began writing about disease-oriented evidence (DOE): information in textbooks and journal articles dealing with “etiology, prevalence, pharmacology, prognosis, and so on.” They pointed out that this stuff is “absolutely crucial to medicine” but often falls far short of the things that patients actually care about.

DOE is closely related to disease-oriented outcomes (DOOs), to which hospitalists devote slavish attention. Examples include length of stay, unplanned readmissions and health care-associated infections. And who can blame us? The Centers for Medicare and Medicaid Services follow these data closely, publicly shame us on Medicare.gov and tie hospital reimbursement to performance on key metrics. Heck, if your hospital is like mine, part of your paycheck is probably riding on your DOOs.

But, again, do any of those really matter to patients?

POEMS and POO

Drs. Shaughnessy and Slawson developed a brilliant remedy for DOE, something they called patient-oriented evidence that matters, or POEMS. The essence of a POEM is medical literature that focuses on “outcomes that matter to your patients.” Those include, for example, mortality, morbidity and quality of life. If we’re going to be effective for our patients, they argued, this is where we should be spending our time.

This idea caught on quickly. The British Medical Journal rolled out a weekly feature in 2002 dedicated to POEMS. As a kick-off editorial noted, “most research does not provide information that matters to patients,” and the journal was hoping to fix this. Many years have since passed, but the POEMS keep coming, now delivered daily via e-mail and a companion podcast.

American Family Physician (AFP) was an early adopter. It introduced an evidence-grading rubric for its authors in 2004 that is still in use. The taxonomy gives precedence to patient-oriented outcomes (POOs) and drops DOOs to the very bottom of the pile (an apt metaphor). AFP describes DOOs as “intermediate, histopathologic, physiologic, or surrogate results (e.g., blood sugar, blood pressure, flow rate, coronary plaque thickness) that may or may not reflect improvement in patient outcomes.”

The nine Ds

Medical students are pretty concrete, so we’ve come...
Keep patient-oriented outcomes very much in the foreground during all discussions with patients.

up with a POO list (wink, wink) that spells things out. Students are also into mnemonics, so every POO starts with D. We present the list here—drumroll, please!—for the first time in print. Shoot us an e-mail if you can think of other items that we should add.

The nine Ds: patient-oriented outcomes (POOs)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>What patients are thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>What’s wrong with me?</td>
</tr>
<tr>
<td>Death</td>
<td>Will this kill me?</td>
</tr>
<tr>
<td>Disability</td>
<td>Will I regain function?</td>
</tr>
<tr>
<td>Discomfort</td>
<td>Can you relieve my pain?</td>
</tr>
<tr>
<td>Distress</td>
<td>How will I cope?</td>
</tr>
<tr>
<td>Disfigurement</td>
<td>Will I ever look normal again?</td>
</tr>
<tr>
<td>Drugs</td>
<td>Will I need to take medications?</td>
</tr>
<tr>
<td>Dollars</td>
<td>How much will treatment cost?</td>
</tr>
<tr>
<td>Discommode*</td>
<td>Will this disrupt my life?</td>
</tr>
</tbody>
</table>

*A synonym for inconvenience

Back to you

Does that mean you should ignore bandemia? Nope. How about that metabolic acidosis or ugly-looking telemetry strip? Of course not. Disease-oriented data always matter, but they aren’t the only things that matter. As radiologists are wont to say in their dictations, “Clinical correlation is recommended.”

With that in mind, we suggest the following approach to direct patient care: very consciously keeping POO in the foreground during all discussions with patients and putting DOO on the backburner.

Take Ms. Jones, for example, who was admitted to your service with a hip fracture. Make sure she knows what’s wrong with her, that she’s unlikely to die from her illness and will probably regain full function. Assure her that you have medications to address her pain, and provide her with some support for her emotional distress. Tell her that the medications aren’t too expensive and that follow-up care after hospital discharge won’t disrupt her life. Thank her for picking your hospital and inform her what time you plan to round again tomorrow.

Later, after you exit her room, you can turn your attention to the DOOs. Perform due diligence, and put all of that stuff in your daily note. And if you’re feeling particularly mischievous, you could toss in, “All of the patient’s questions were answered”—a small but sly indication that you delivered care that really mattered.

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