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A Formal HCAHPS Teaching Program Targeting Communication Improves HCAHPS Scores

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Abstract

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey given to patients after discharge from an inpatient unit is a validate tool used to determine the level of patient experience. Organizations across the country, including the Northern California Academic Medical Center, have implemented many initiatives aimed at improving these scores. HCAHPS scores for the hematology/oncology unit at this medical center remain low even after previous education efforts. The aim of this quality improvement project was to improve the patient experience, as evidenced by HCAHPS scores, with the implementation of an HCAHPS teaching program for nursing staff, focusing on understanding what HCAHPS are, how patients absorb information, and key phrases and practices that can positively affect patient perceptions. Over a three-week period, staff received education on HCAHPS, top box scores, and communication intervention and tools that can be used for each of the three domains being focused on by the organization, care transitions, education about medication, and staff responsiveness. HCAHPS scores and the rate staff integrated interventions into their practice were the main measurement modalities. Knowledge of HCAHPS and attitude towards importance improved among staff, unfortunately HCAHPS scores for staff responsiveness, the domain requiring the most improvement, did not meet the benchmark but did improve by 13 points (49% to 62%). This HCAHPS teaching program has potential to improve HCAHPS scores significantly, however due to the project lead having an unforeseen absence education was not reinforced as planned.

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Introduction

Problem Description

With the inception of the Affordable Care Act (ACA) hospitals are no longer rated solely on quality, outcomes and cost. Now the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey plays an important part in rating systems as well as accounting for up to 30% of value-based purchasing (VBP) scores and incentive payments (Dempsey, Reilly, & Buhlman, 2014). Many have questioned the idea of focusing on patient experience as a means of measuring healthcare organizations, however, over the years data has proven that how patients perceive care directly correlates with patient outcomes (Papanicolas, Figueroa, Orav, & Jha, 2017). HCAHPS has been extensively studied to ensure the measurement of patient experience, on all levels, is accurate and useful for broadening organizations process improvement programs. When organization's HCAHPS scores meet benchmarks, it boosts the reputation of the organization and indicates to consumers that hospital staff focus on delivering patient centered care and that there is a commitment to improving quality measures (Mehta, 2015).

Like many hospitals, this Northern California Academic Medical Center's hematology/oncology unit struggles to meet the target for three of the nine HCAHPS domains; care transitions, education about medication side effects, and staff responsiveness. Traditional methods of increasing patient satisfaction have not been successful, especially for the domain of staff responsiveness. It is apparent that new techniques and interventions are needed to improve patient satisfaction and staff's understanding of HCAHPS.

HCAHPS scores for the domain of staff responsiveness currently require the most improvement, however there is room for improvement for the remaining two domains as well, communication about medications and care transitions. Staff responsiveness must increase by almost twenty points to meet the benchmark, whereas communication about medications requires only a two-point increase. An informal survey confirmed that further education is needed regarding what HCAHPS are, why they are important, and how they are measured as only ten percent of surveyed staff were able to answer these questions. Furthermore, a microsystem assessment, patient and staff interviews indicate that improvements to communication among staff and patients as well as improved workflows for meeting patients' needs has been a missing, key element of HCAHPS improvement strategies.

After an informal learning needs assessment, which consisted of a five-question survey, of the Shared Leadership Unit Council for hematology/oncology, it was determined that there was a lack of understanding of HCAHPS. The six members of the unit council were aware that HCAHPS are measured and reported on a weekly basis and that improvement is needed. However, their knowledge of what questions are asked, what top box scores mean, and the role HCAHPS scores play in Medicare reimbursement was low. This small assessment can be applied to the unit, considering the staff responsiveness scores for this unit have decreased from approximately 60% in June 2018 to 49% in February 2019

HCAHPS scores for the unit level were trended for eight months to determine if there was a correlation between changes on the unit and decreasing scores. Although the data showed a potential correlation, it is difficult to make a finite determination do to the six to eight-week delay in receiving HCAHPS scores post discharge. Daily reports of call light response times were also collected from the call light response system. Patient interviews were conducted five

days a week by the unit's management team. During these interviews' patients would report that

nursing staff are wonderful but at times they felt they had to wait too long for responsiveness to

an identified area of concern. Additionally, patients commented, "I don't want to complain, but

sometimes it takes too long for my nurse to come see me.", "I know the floor/staff are really

busy, but I wait too long sometimes.", "My nurse must have been really busy today because I

didn't see him/her often."

Available Knowledge

Measuring and improving patient experience has become a corner stone of quality

measures for healthcare organizations across the country. HCAHPS has been the survey of

choice since 2013, for measuring patient experience, after the Affordable Care Act (ACA) linked

HCAHPS scores to the Center for Medicare and Medicaid Services (CMS) Value-Based

Purchasing (VBP) reimbursement program (Merlino et al., 2014).   Paid Medicare benefits in

fiscal year 2018 totaled $704.6 billion, and the penalty for not meeting the VBP quality measures

was one to two percent (CMS, 2018; Medicare Payment Advisory Commission, 2018).

The review of literature supported the following PICO question: On an inpatient

hematology/oncology unit, will a formal HCAHPS teaching program, that includes key

words and interventions, for staff versus no teaching program increase the HCAHPS

domain of staff responsiveness from 47.7% to 57% by August 1, 2019?

Effective communication skills can be learned and improved when an effective

training program is used. Studies have shown that effective communication can be linked

to improved patient outcomes, safety and patient satisfaction, as well as staff satisfaction

(Boissy & March, 2016). Three such studies were reviewed by this CNL student. Each

study aimed to determine the impact of formal education programs targeting improved

communication between hospital staff and patients and the relation to HCAHPS scores.

Additionally, Boisy & March (2016) showed statistically significant improvement in

HCAHPS scores related to communication with staff being highly satisfied with the

course with significantly higher empathy levels. Allenbaugh, Corbelli, Rack, Rubio, &

Spagneoletti (2019), did not find their program to be as effective as there was only a

moderate change in HCAHPS scores after the education was implemented. However,

staff were open to the education and felt their communication had improved. The study

conducted by Keith, Doucette, Zimbro, & Woolwine (2015), unfortunately, did not warrant

improvement in HCAHPS scores. The authors predict that since staff and unit leaders were not

involved in the decision-making process for how the education would be implemented and

evaluated, staff did not buy into the change resulting in little to no improvement.

     The review of literature continues to be directed towards clear, consistent and concise

communication with patients with a positive impact on how they perceive staff listening to their

preferences (Alaloul, Williams, Myers, Jones, & Logsdon, 2015). Improving staff's ability to

communicate well is a priority, however, if the information and message being presented to the

patients is not consistent organizations may not see an increase in HCAHPS. Three studies

observed significant improvements in many of the HCAHPS domains after the implementation

of script-based, concise and consistent communication tools. The uniqueness of these studies

was that staff were included in the development of scripts and communication tools. All three

discovered that continued communication with staff during the implementation phase allowed

for feedback, reinforcement and encouragement (Alaloul, 2015; Annonio, 2016; Horton, 2017).

Hourly nurse rounding has been shown to increase patient satisfaction and decrease falls, pressure ulcers and call light usage (Brosey & March, 2015). Two studies were reviewed to determine the effect of hourly rounding by staff and leaders on HCAHPS scores. Brosey and March (2015) discovered that by using a change management strategy the intervention influenced a culture change in nursing practice. Although the study did not find a significant change in HCAHPS scores, overall patient satisfaction improved. Winter and Tjiong (2015) attempted to determine a correlation between nurse leader rounding and improved HCAHPS scores. There was not a statistically significant increase in HCAHPS, however there was an increase in the level of trust between patients and staff because patients could see leaders had a vested interest in the day to day operations of the organization.

Education, scripts and communication tools, and rounding may all have an impact on patient satisfaction and outcomes, however organizations must have an environment in which change is embraced to see positive results. Kutney-Lee et al. (2016) found that hospitals with engaged staff and robust shared governance had some of the highest HCAHPS scores. Dempsey, Reilly and Buhlman, (2014) found that when staff have a clear understanding of the benefits of an intervention and are key collaborators patient satisfaction and staff satisfaction increases. Their study also revealed that staff were more engaged when accomplishments were rewarded, recognized and linked to quality instead of a score. Indovia et al (2016) confirmed a correlation between real-time staff feedback with increased HCAHPS scores.

Evidence suggests that the implementation of a formal HCAHPS teaching program aimed at improving staff communication skills by utilizing a script-based, concise and consistent communication tool can have a positive effect on HCAHPS scores. Furthermore, daily nurse leader rounding with real-time feedback to the staff will increase trust between nursing staff and

patients. Lastly, involving the unit's shared leadership unit council in the development, implementation and evaluation of the teaching program will increase staff participation thereby improving safety, quality and outcomes.

Rationale

Everett Rogers' diffusion of innovation theory is an ideal change model process for a fast-paced hematology/oncology unit that experiences frequent changes. Rogers argued that in most cases, if there are initially a few team members open to a new idea who are willing to adopt and use it and encourage others, more team members will adopt leading to a critical mass. Eventually the number of team members who have adopted the new idea reaches a saturation point leading to sustainable change (Kaminski, 2011).

Five stages of adoption create a blueprint for Rogers' theory; knowledge, persuasion, decision, implementation, and confirmation stage. In the knowledge stage team members are made aware of the new idea and what affects implementation would have for the microsystem. For Rogers' the persuasion stage refers to how the team member processes the information provided to them whether it be positive or negative. During this process a team member often will seek more information regarding the new idea and think about how the new idea would affect his or her practice. Knowledge and persuasion stages would be addressed with the formal HCAHPS teaching program. In the decision stage team members choose to adopt or reject the new idea. At times members of the team must participate in small tests of change before committing fully to the new idea. With each week's teaching point staff are encouraged to do a small test of change for themselves. Once the mental decision to adopt a new idea has been made, team members move to the implementation stage where the idea is put into practice. Implementation may last for an extended period of time until the new idea has become standard

practice. Finally, team members engage in the confirmation stage where members look for validation of the decision to adopt and implement the new idea (Rogers, 1983).

The interventions taught in the HCAHPS teaching program need to be adopted into each staff members practice to create sustainable change. Rogers theory believes that when champions are utilized in implementation of the innovation peers can be influenced. This is in part because champions have shared values, purpose and understanding of issues with their peers. With this shared purpose they can balance the multiple needs of the unit and lead their peers to the adoption of the shared vision.

Rogers theory also details how organizations with certain characteristics are more likely to succeed with implementation of innovations. The characteristics this Northern California Academic Medical Center possesses include; being a larger organization, being well interconnected, as well as having sufficient organizational slack. Rogers found that large organizations are more innovative. He also determined that high degrees of network interconnectedness allow for new ideas to flow more easily. Lastly, having ample available resources to assist with an implementation can positively impact the process (Batras, Duff, & Smith, 2014).

In addition to the adoption process, Rogers separated adopters into five categories, innovators, early adopters, early majority, late majority and laggards. Innovators and early adopters are integral members of the change process team as they are quick to decide to adopt a new idea and can persuade others to follow, this group represents the HCAHPS champions and unit council members. However, laggards can also be integral if involved early in the process as they often have years of experience and knowledge that can be useful when attempting to implement a new idea.

Since the hematology/oncology unit is a large, interconnected unit with many resources, Rogers change theory worked well for the group. Staff were very eager to provide evidence-based interventions; however, they were not easily persuaded to adopt a new behavior until they have worked through Rogers decision phases. It was also important to remember that adoption of new ideas is a process and not a discrete event, which is why the teaching program allowed time to digest information and trial interventions before full adoption was expected (Hornik, 2010).

Specific Project Aim

The aim of this project is to improve the patient experience, as evidenced by HCAHPS scores, with the implementation of an HCAHPS teaching program for nursing staff, focusing on understanding what HCAHPS are, how patients absorb information, and key phrases and practices that can positively affect patient perceptions.

The project begins with understanding where staff are in their knowledge of HCAHPS, how their verbal and non-verbal communication affects patient's perception of care and staff responsiveness. The project ends with implementation and evaluation of a HCAHPS teaching program for staff. The objective was to reach the following goals during the project; (1) staff will be able to verbalize what constitutes a HCAHPS "top box" score, (2) staff will be able to identify three ways they can change their practice to incorporate the standard workflow and scripting into their daily practice, and (3) staff will be able to demonstrate proficiency in the standard workflow and scripting by utilizing these interventions 90% of the time.

The Press Ganey improvement model tool was utilized to identify the cause of the low HCAHPS scores and potential solutions. When identifying the causes, it was important to put

ourselves in the patients' shoes to discover how our verbal and nonverbal communication made them feel. We may not be able to change how patients feel, but we can create positive experiences (Press Ganey, 2011). The tool then assisted with determining solutions that were focused on the patient experience but addressed the deficiencies in the care that was being provided. Once this work was completed, Rogers change theory was used to implement the teaching program.

Methods

Context

The hematology/oncology unit is a 38-bed unit with private and semi-private rooms. The patient population consists of newly diagnosed acute leukemia patients requiring induction or consolidation chemotherapy; lymphoma and sarcoma patients who necessitate multiple cycles of chemotherapy, as well as solid tumor patients who need supportive care for side effects of treatment and/or chemotherapy. Pain management and end of life care accounts for many of the solid tumor admissions. There are 100-110 team members, including nurses, permanent staff and travelers, nursing assistants, and unit secretaries. Nurses and nursing assistants work well together to provide individualized care to each patient. Therapeutic relationships are formed with these chronically ill patients due to their prolonged lengths of stay and frequent admissions which deepens staff's commitment to working in a collaborative environment.

Although patient and staff form trusting therapeutic relationships, patients still feel there is room for improvement. This is evident from the HCAHPS scores over the last ten months which show a decline in the three domains being focused on by this academic medical center. In the past HCAHPS scores have been higher, but with staff turnover and patient acuity levels

increasing, traditional means of sharing HCAHPS score with staff have not worked. One benefit

of the increase in new staff is there is an increase in staff engagement. With staff engagement

spreading there is an opportunity to educate and include the staff in process improvements aimed

at increased HCAHPS scores and ultimately change the culture of the unit.

In addition to a microsystem assessment, an Institute for Healthcare Improvement

cultural assessment was completed for this hematology/oncology unit. The unit scored between

a 15 and 30, which is in the 'strong start' category. Per the culture assessment the unit values

trust, respect, inclusion and a just culture. Teamwork, maintaining competencies, and

understanding why close calls happen are priorities for staff (IHI, 2019). Frontline staff are not

aware of serious safety events and action plans being shared with the full board of the

organization, indicating this as an area for improvement. Pulling on the unit's strong desire to

maintain teamwork, a just culture, and practice with evidence-based protocols, the HCAHPS

teaching plan can be successfully implemented to improve the patient experience.

To ensure that all potential downfalls to this quality improvement project were explored a

strengths, weakness, opportunities, and threats (SWOT) assessment was completed (Appendix

A). Strengths for this unit were found to be the sustained culture and priority of providing the

best possible patient centered care, high engagement of the unit council, and a supportive

management team and assistance from a patient experience project manager. These strengths

indicate that frontline staff want to improve the patient experience, and with the guidance and

support of management they can be the drivers of the change. Building on the unit strengths are

the opportunities of engaging new staff who want to be involved, nursing assistants and unit

clerks eagerness to participate in the change process, and a patient population that is thankful for

their care, but who would like better communication with frontline staff. Inclusiveness of ideas

during the intervention creation phase has been a crucial step as it encourages everyone to be

involved in the change. Weaknesses revolve around the issues of communicating to a large staff,

new staff who are focused on learning policy and procedures, and the need for improvement in

collaboration between nurses, nursing assistants and unit clerks. Although new staff members

are eager to be involved in change, their time is still consumed with learning how to practice

within their new organization. The management team utilizes several forms of communication

to reach over 100 staff, however reaching all staff may take three to four weeks delaying full

implementation of any new initiative. The unit takes pride in their teamwork nevertheless

communication and teamwork between nurses and nursing assistants and nurses and unit clerks

requires improvement for this project to be effective. Threats for this unit included; drawn out

union contact negotiations and the threat of a nursing strike, a group of laggards who did not see

the need for change, staff turnover, and most importantly the six to eight-week delay in receiving

HCAHPs results. Most institutions do not receive HCAHPs data until several weeks after a

patient has been discharged. With this delay, staff can become discouraged with the lack of

improvement in scores even though they have implemented the desired changes. It is important

that any team attempting to institute change, aimed at improving HCAHPS scores, acknowledge

and communicate the expected delay in results to staff (Indovina et al., 2016).

A cost benefit analysis and proposed budget for the HCAHPS teaching program revealed

a potential CMS reimbursement gain of $20,000 per year (Appendix B). Costs for the proposed

project are minimal and are in the form of printed materials and incentives for reaching

milestones of the project. As discussed before the use of the unit council during work hours and

the management team negates the need for financial resources for the project. Since HCAHPS

surveys require six to eight weeks for results to be reported, a minimum of six months to a year

should be set for assessment of the financial impact of the program. Lost CMS revenue from

VBP program penalties can equal $20,000 per year, it is projected that twelve months post

teaching program implementation this will no longer be lost revenue:

Reclaimed CMS revenue	$20,659.66
Cost of HCAHPS Teaching Program	$250
Estimated net gain	$20,409.66

　　　　With a large staff, a communication plan that reaches everyone and addresses all learning

styles was developed. Education began with addressing what HCAHPS are and how they are

measured. This was done by discussing one teaching point each week and presenting at shift

huddles five days a week. Presentations were done by HCAHPS champions and the

management team. With each teaching point an intervention was introduced, and staff were

encouraged to try one intervention. To ensure all staff received the teaching, weekly

presentation information was added to the unit newsletter, a power point was displayed on the

unit's electronic board, and an interactive learning board was created. Patient comments from

recent surveys were shared with staff. Finally, the complete teaching plan was reviewed at staff

meetings. Six to eight weeks post HCAHPS teaching plan implementation HCAHPS scores

were compared to pre-program implementation and were shared with the staff.

Intervention

　　　　The implementation of this HCAHPS teaching program occurred in two phases,

education and implementation of interventions. The education was broken down into three

sections to prevent information overload and to allow staff time to do their own small tests of

change with the proposed interventions. To keep the teaching program on track each section

occurred over a one-week period. By creating a three-section program the team was able to

utilize the daily shift huddle time for education thereby decreasing the cost of implementation.

The first section included education on why the HCAHPS survey is important to the organization

and therefore why frontline staff need to be educated. An explanation of top box scores and the

three HCAHPS domains the organization is focusing on was a main teaching point. With that a

deeper dive into the questions asked for each domain, was reviewed to increase transparency.

The second section educated staff on the HCAHPS domain of staff responsiveness. The unit's

current score was discussed as well as patient comments that have been shared with the

management team. Examples of how current communication to patients is perceived and can

affect how patients answer the questions was also included. Changes to the language used to

communicate with patients and simple actions that can be utilized was given to staff with the

expectation that staff would trial one intervention that week. Section three addressed the other

two HCAHPS domains, communication about medications and care transitions. Current scores,

current practice and possible interventions for each domain was covered in this phase as well.

Although staff were encouraged to test different interventions and adopt them into their

daily practice there was a need for a GO-live date for full implementation. The GO-live date was

set for one-week post completion of the HCAHPS teaching program. Champions as well as the

management team rounded on staff to assess their level of engagement with the interventions.

The management team continued to complete their active daily management rounds with patients

assessing for changes in how staff are communicating to patients. Lastly the teaching program

was reinforced at staff meetings, daily huddles, weekly newsletters and the unit visibility walls.

Measures

Outcome and process measures were utilized as measures to evaluate the improvement

project (IHI, 2019). The main outcome measure was the actual HCAHPS scores for the unit

receiving the staff HCAHPS teaching program. The HCAHPS survey is a measure that is valid

and reliable as it is a widely implemented survey across the nation and utilized by the Centers for

Medicare and Medicaid Services. Additionally, a pre and post survey (Appendix C) was an

outcome measure of staff's HCAHPS knowledge, specific to the domains focused on by the

organization, importance of the HCAHPS scores to the organization, and finally what a top box

score is. This outcome measure is also valid and reliable, as proven by the independent testing

of the questions.

The process measure determined how well the staff had integrated the proposed

interventions into their daily practice. This process was less reliable as it was not possible to

monitor each staff member's practice on a weekly basis. Each staff member had different ways

of implementing the interventions leading to variability in the outcomes. In addition, there was

variability in how each staff member was observed based on the differences of the champions

and management team. With the limited time frame, it was expected that significant changes in

HCAHPS scores would be limited due to the lengthy turn around time of survey results. With

this limited time comes the possibility of a small sample size which would affect the significance

of any change.

Ethical Considerations

Implementing a HCAHPS teaching program is ethically the correct thing to do.

Interventions were not aimed at the patients, but instead the interventions benefited the patients.

Therefore, institutional review board approval was not warranted, and the project met evidence-

based change or practice project criteria (Appendix D). As nurses our practice is guided by the

American Nurses Association (ANA) Code of Ethics as well as the ANA Scope of Practice.

Both documents provide the foundation for patient centered care, emphasizing communication

and shared decision making (Epstein, 2015 and Marion, 2017). There are times in our practice

that nurses feel ethical and moral distress due to the situations we see and tasks we are asked to

do. If, during these times, nurses review the code of ethics and scope of practice one can re-

center their practice to align it with the elements of these documents, decreasing their distress.

As the HCAHPS teaching program was initiated there was a level of distress among the

staff regarding being asked to do, what they felt was, one more thing. One way the clinical nurse

leader (CNL) student was able to address the staff's concerns was to draw on specific aspects of

the code of ethics and scope of practice. Utilizing the code of ethics staff were able to

understand how improving communication with patients regarding their preferences for care

planning, side effects of medications, and expectations for responsiveness of staff essentially

fulfilled many of the provisions. Commitment to the patient and contribution to healthcare

environments are the two that resonated most with staff. When staff understood that applying

effective communication techniques not only would potentially increase HCAHPS scores but

was also in alignment with their primary commitment to the patient and role in maintaining an

ethical environment, per the code of ethics, they were open to trialing the change.

The same understanding held true when the staff were presented with standards seven

through sixteen of the ANA Nursing Scope and Standards. With a wide range of knowledge of

the standards of professional nursing practice, it is not surprising that staff did not understand

how the HCAHPS teaching program could help them practice to the standard. Staff appreciated

being able to connect the interventions they were being asked to implement, to what was

expected of them, at all times, according to the ANA. Change will always be met with

uncertainty, however, when staff are able to connect the benefit of the change to evidence, better

outcomes and patient satisfaction, the intervention has an increase chance of being successfully

implemented and sustained.

Results

This project began with this CNL student noticing the decreased HCAHPS scores and the

possible correlation with the timing of several roll outs for new equipment and assessments

within the organization. After completing a preliminary analysis of data from a six-month

period, an informational meeting was held with a project manager for patient experience with the

intention of gaining further understanding of the knowledge gap. With the assistance from the

project manager, HCAHPS data was reviewed and dissected uncovering several reasons for the

low scores for staff responsiveness (Appendix E). Subsequently it was hypothesized that formal

HCAHPS education with helpful phrases and interventions would be most effective at positively

affecting HCAHPS scores.

Improving HCAHPS scores is a top priority for this organization therefore gaining

support from leadership was not difficult. The most influential stakeholders were the unit

council members, making gaining their buy in imperative. The unit council was unclear as to the

importance of HCAHPS scores and how changing the daily practices of frontline staff could

make a difference in the scores. However, after viewing a presentation by the patient experience

project manager the council began to understand not only the importance of HCAHPS for the

organization, but more importantly what HCAHPS mean to patients. With this newfound

understanding there was excitement, which lead to an open dialogue related to how a teaching

plan should be structured, rolled out and the role of the unit council members as champions.

In hopes of not only seeing an increase in HCAHPS scores but also staff's knowledge of HCAHPS, a three-question pre-survey was completed. Of those surveyed, less than ten percent knew what constituted a "top box" score, why HCAHPS are important for the organization, nor could list the three HCAHPS domains being focused on by the organization. Additionally, active daily rounding was conducted with patients to elicit their comments on the care being provided. Overwhelmingly the comments were positive, however many would comment that they had to wait too long for staff to respond to their needs. Pre-survey data and patient comments confirmed the CNL student had formulated an accurate hypothesis.

An initial literature review had been completed after the initial meeting with patient experience, but after speaking with stakeholders a further literature review was completed. The additional review was completed to ensure the HCAHPS teaching program was an evidence-based design. Being able to show this evidence to staff while rolling out the program would strengthen the likelihood staff would absorb the information and then adopt the change. It also served to prove that formal teaching programs can have positive results, concise consistent messaging is key and most of all having an engaged staff can make the program a success (Alaloul, 2015; Boissy, 2016; Kutney-Lee, 2016).

A large amount of information was necessary for the teaching program to be effective, however it was evident that presenting the program in its entirety would impede the staff's learning. As to not overwhelm the staff the teaching program was divided into three sections (Appendix F), with the initial section focusing on the what and why of HCAHPS scores as well as the current state of HCAHPs scores for the unit. The remaining two topics built on the initial information, however the information focused on the three priority HCAHPS domains chosen by the organization; staff responsiveness, communication about medications, and care transitions.

For each domain the current state was reviewed using patient comments making it more real and

impactful for staff. Additionally, common practices seen on the unit were reviewed with staff,

specifically related to how patients perceive these practices. Modifications to how staff

communicate with patients and their families was warranted based on evidence and patient

comments. To address this need, staff were given examples of small changes to the phrases

currently used that would have a positive impact on how the patient perceived interactions with

staff. Small changes, such as sitting at the bedside while speaking with patients or writing out

the patient's daily schedule on the white board, were also shared with staff to foster open

communication and self-advocacy. With each topic staff were encouraged to trial as many of the

recommendations as they were comfortable with. The goal of this step was to give staff time to

work through their decision to adopt or reject the intervention (Rogers, 1983).

Initially the teaching program was to be presented at daily shift huddles and staff

meetings by this CNL student and HCAHPS champions. Unfortunately, there were unforeseen

circumstances that prohibited the student from being present for much of the rollout and post

implementation observation. The responsibility of educating staff fell to the HCAHPS

champions, who although eager to participate, did not have the passion for the project that the

student had. The result of this unplanned pause to the project was twofold; champions were able

to communicate feedback from staff to the CNL resulting in a new teaching tool, and staff had

additional time to digest the education solidifying their choice to adopt the intervention. After

listening to champion and staff feedback, the CNL student created a one-page teaching tool

(Appendix G) aimed at providing a quick and concise reminder of the what and why of

HCAHPS and key interventions for each of the three HCAHPS domains. Staff response to the

HCAHPS teaching tool was overwhelmingly positive and was shared with other nursing units throughout the organization.

Discussion

The goal of the improvement project was to increase staff's HCAHPS knowledge thereby allowing staff to make changes to their daily practice which would then improve patient satisfaction and increase the HCAHPS staff responsiveness score for the hematology/oncology unit. Staff knowledge of HCAHPS did not improve as significantly as hoped, with only an increase of 30% of staff answering the post survey correctly. However, with the unplanned absence of the CNL student, a lower improvement of staff knowledge was expected. Conversely, the goal of improving HCAHPS staff responsiveness score to 57% from 47.7% was met and exceeded, increasing to 62% (Appendix H). Per Press Ganey this improvement is especially significant considering survey results take six to eight weeks to process and be reported to the organization. With this information the working hypothesis for this project is supported by the timeline of twelve weeks between the beginning of education and return of survey results.

Much of the success of the project was due in part to the passion and commitment of the unit council members (HCAHPS champions). Once the council understood the evidence and need for improving HCAHPS scores they were quick to adopt the project. Learning their cherished hematology/oncology patients were reporting their gratitude for the care they received but also voiced their displeasure with long wait times, their drive to improve communication and responsiveness was ignited. Investing in this project allowed them to then be the voice for their peers when they felt the amount of information was too overwhelming. Taking the feedback and

recommendations, the CNL student was able to simplify the education into a one-page teaching

tool which was positively received by staff.

Even though the project resulted in an increased HCAHPS staff responsiveness score the

design of the implementation phase could have been improved. Further work could have been

done to ensure the amount of information included in each teaching point was appropriate for a

five-minute huddle. One-page teaching tools for each topic could have been useful resources for

the staff as they trialed the interventions. Reviewing how to deliver each teaching point with the

HCAHPS champions could have prevented the pause in the project experienced by the

unexpected absence of the CNL student. Lastly, larger hospital projects and goals should have

been considered when establishing the implementation timeframe in order to counteract the

burnout being felt by staff.

Conclusions

Developing a formal HCAHPS teaching program that was easy to understand with

interventions that were easily integrated into daily practice, was successful as indicated by staff

response and HCAHPS scores. Understanding that previous methods of educating staff on the

need to improve HCAHPS and staff's need for concrete ways to change their daily practice was a

strength of this improvement project as this had not been done prior. Show casing patient

comments and how current practices affected patient perception of staff responsiveness, provided

a sense of urgency for staff, increasing the rate of adoption. With a few revisions to how the

teaching program is implemented the program can be sustained and spread throughout the

organization. Utilization of the PowerPoint presentation and one-page teaching tools during new

hire orientation would ensure new staff are educated about the priorities and culture of the

organization. In addition, each nursing unit could edit the presentation to include their respective

HCAHPS scores and patient comments to ensure current staff are also educated.

The work of improving HCAHPS scores can be propelled when CNLs are involved. A

master's prepared CNL has the necessary skills and competencies to complete a systems

analysis, create an education program and implement an improvement project by managing the

information and a team (AACN, 2013). CNLs are acutely aware that successful projects are not

the result of work from one person, instead they are the result of a team who has the evidence

and knowledge to be change agents. CNLs understand that focusing on improving

communication in turn improves HCAHPS and patient outcomes.

Patient perception of care will continue to play an important role in how hospitals are

evaluated and graded on performance. Hospitals must focus on practices, behaviors and

communications that drive HCAHPS scores. Staff that are educated on the importance of the

needed changes and are included in the decision-making process are more likely to be engaged in

the culture change. This hematology/oncology unit could have continued to utilize common

practices such as hourly rounding, white boards, and bedside report, which would not have

resulted in improved HCAHPS scores. Instead a formal HCAHPS teaching program with a

strong emphasis on clear consistent communication was utilized to refocus improvements to

interventions that will have a lasting effect on patient satisfaction.

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Appendix A

Strengths, Weaknesses, Opportunities, and Threats Analysis

STRENGTHS

- Unit culture of wanting to provide the best possible patient centered care.
- Unit council who have an interest in improving HCAHPS
- Supportive management team
- Assistance of patient experience project manager

WEAKNESSES

- New staff that are still learning policies and procedures
- 110 staff need education on HCAHPS
- Collaboration between nurses, nursing assistants and unit clerks needs improvement

SWOT

OPPORTUNITIES

- New staff want leadership opportunities
- Nursing assistants and unit clerks want a voice
- Addition of more communication with patients would increase patient satisfaction as reported by patients

THREATS

- Contract negotiations and possible strike
- Laggers who don't see the need for change
- Delay in receiving HCAHPS results may discourage staff
- Staff leaving for new opportunities

Appendix B

Cost Benefit Analysis for HCAHPS Teaching Program

Description	Value
2018 Medicare Revenue	$1,032,983.00
2018 CMS Penalty	2%
2018 Lost Revenue	$20,659.66
Cost of Education Program x1yr	$250
Potential Increased Revenue	$20,409.66

Appendix C

Pre and Post HCAHPS Knowledge Survey

Questions were weighted based on what was being asked. Question 1 accounted for 3 points, as

staff were required to list all 3 domains. Question 2 accounted for 4 points, as all 4 options were

correct. Question 3 accounted for 1 point as only one answer was correct.

1. List the 3 HCAHPS domains our organization chose to focus on this fiscal year?

2. HCAHPS are important because? (circle all that apply)
    a. HCAHPS is a standard survey instrument used to measure a patient's hospital
        experience.
    b. Performance on HCAHPS is tied to Medicare reimbursement
    c. HCAHPS Star Rating are available online as part of Hospital Compare
    d. HCAHPS align with Stanford's goal of delivering the best possible care for every
        patient every time.

3. A "Top Box" score means
    a. Patients rank hospitals by which one they like best and the hospital at the top is
        the "top box"
    b. The percentage of patients giving a rating of "5" (Very Good)
    c. The percentage of patients giving a rating of "1" (Very Poor)
    d. The received a large number of survey responses or a large "n size".

Appendix D

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

STUDENT NAME: Bobbie Davis

DATE: 5/6/19

SUPERVISING FACULTY: Mary Lou De Natale   .

Instructions: Answer YES or NO to each of the following statements:

Project Title: HCAHPS Teaching Program	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	x	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence- based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	x	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files. If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

Appendix E

Process Improvement Tools: Fishbone and Gantt Chart

Fishbone Diagram: HCAHPS Need Improvement

People

RN has a heavy assignment and is stuck in one room

Staff are in other rooms when patients call.

Lack of willingness to hold each other accountable for not answering call lights

RNs will leave room & not go into the room if they see the NA coming.

Staff using personal cellphones in patient care areas and on break

Procedures

No standard procedure for triaging patient calls

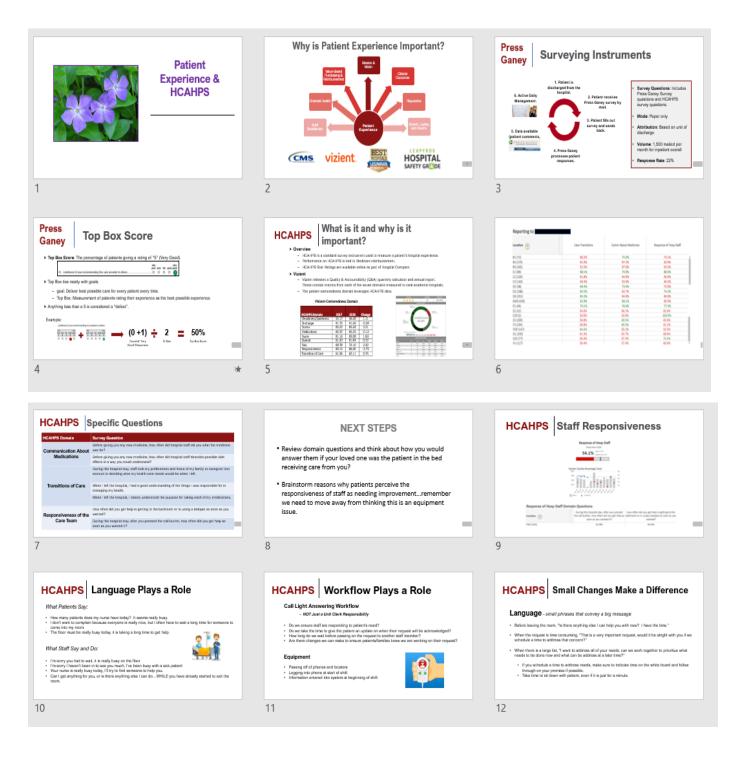NA is pulled from floor to sit with patient needing 1:1

Lack of algorithm for disseminating calls to staff.

Pt call light requests are not relayed to appropriate staff

Staff don't complete patient care tasks while in the room

HCAHPS scores are below the benchmark for staff responsiveness

Acuity has increased, resulting in more time spent with each patient.

Patient needs are not urgent

Patients do not participate in ADLs without encouragement from staff.

Patients are high risk for falls

Until controlled, nausea, diarrhea, pain can hit unexpectedly

Call lights not working

Locators not working

Staff not utilizing phones appropriately

Staff not utilizing call light system appropriately

Lack of education to patients regarding the technology used to communicate

Population

Equipment

HCAHPS Teaching Program Gantt Chart

Task	Nov-18	Dec-18	1/6/19	1/13/19	1/20/19	1/27/19	2/3/19	2/10/19	2/17/19	2/24/19	3/3/19	3/10/19	3/17/19	3/24/29	3/31/19	4/7/19	4/14/19	4/21/19	4/28/19	5/5/19	5/12/19	5/19/19	5/26/19	6/2/19	6/9/2019	6/16/2019	6/23/2019	6/30/2019	7/7/2019	7/14/2019	7/21/2019	7/28/2019
Microsystem Analysis	█	█																														
Prioritize Gaps in Practice		█	█																													
Analyze NSI, HCAHPS & Call Light			█	█	█	█																										
Present Raw Data at Staff Meetings					█	█																										
Collaborate with Patient Experience							█	█	█	█																						
Patient Rounding							█	█	█	█	█	█	█	█	█	█	█	█	█	█												
Review of Literature				█	█	█	█	█	█	█	█																					
Meet with Manager to Finalize Focus of Project														█		█																
Present Project to Unit Council													█	█	█	█																
Pre-Evaluation of Staff																	█															
Create/Present Teaching Plan Week 1																	█	█														
Create/Present Teaching Plan Week 2																		█	█													
Create/Present Teaching Plan Week 3																			█	█												
Present Teaching Plan at Staff Meetings																						█	█									
Implement Teaching Plan																	█	█	█	█	█	█	█									
Observe Staff																						█	█	█	█	█	█	█	█	█	█	█
Post-Evaluation of Staff																													█	█	█	█

Appendix F

HCAHPS Teaching Program PowerPoint Presentation

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Appendix G

HCAHPS One Page Teaching Tool

HCAHPS: WORDS MATTER
SMALL PHRASES CONVEY A BIG MESSAGE

WHAT ARE TOP BOX SCORES?

Top Box Score: The percentage of patients giving a rating of "5" (Very Good).

Top Box ties neatly with SHC's goals.

-*SHC's goal:* Deliver best possible care for every patient every time.

-*Top Box:* Measurement of patients rating their experience with SHC as the best possible experience.

Anything *less* than a 5 is considered a "defect".

STATISTICS ABOUT LISTENING

- **50%** of what we hear we immediately forget
- Within **2 months**, we have forgotten **75%** of what was heard
- Of the **25%** we do remember, only about **60%** is correct
- Research shows saying a key word or phrase **3 times** in conversation increases retention.

COMMUNICATION ABOUT MEDICATIONS

- We often say, *"This medication could cause..."* Unfortunately patients don't associate these words with side effects.
- Try saying, *"A side effect of this medication is..."* or *"For your safety, I want to review your side effects."*
- After reviewing, ask them to share their understanding of what you taught them.

STAFF RESPONSIVENESS

- **Before** leaving the room, *"Is there anything else I can help you with now?" I have the time."*
- When request are **time consuming**, *"That is a very important request, would it be alright with you if we schedule a time to address that concern?"*
- When the list is **long**, *"I want to address all of your needs, can we work together to prioritize what needs to be done now and what can be addressed at a later time?"*
- When admitting patients *educate* them about **hourly rounding.** Also include that it may take *2-5 minutes* to have their call light answered so grouping requests is helpful.

CARE TRANSITIONS

- The **key word** in the care transitions questions is *"PREFERENCES."* Repeating this word *as often as possible* will likely encourage the patient to respond more **positively** to this question.
- Staff should **actively** ask about the preferences of patients, family members, and caregivers.
- Staff should regularly *offer options* to patients by asking which option they prefer to **individualize** care and consider preferences.

Created by: Bobbie Davis 6/19

Appendix H

HCAHPS Score: Staff Responsiveness