The University of San Francisco
USF Scholarship: a digital repository @ Gleeson Library | Geschke Center

Master's Projects and Capstones | Theses, Dissertations, Capstones and Projects

Summer 8-13-2021

Implementing Patient Satisfaction Phone Calls to Improve CAHPS Communication Scores in a Hospice Setting

Claudia C. Castillo
cccastillo@dons.usfca.edu

Follow this and additional works at: https://repository.usfca.edu/capstone

Recommended Citation

Castillo, Claudia C., "Implementing Patient Satisfaction Phone Calls to Improve CAHPS Communication Scores in a Hospice Setting" (2021). *Master's Projects and Capstones*. 1216.
https://repository.usfca.edu/capstone/1216

This Project/Capstone - Global access is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Master's Projects and Capstones by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

Implementing Patient Satisfaction Phone Calls to Improve CAHPS Communication Scores in a Hospice Setting

Claudia C. Castillo

School of Nursing and Health Professions, University of San Francisco

NURS 670: Internship

Robin Jackson, MSN, MA, RN, OCN, CNL

August 1, 2021

Abstract

Problem: A hospice in the San Francisco Bay Area is being advised by The Joint Commission to increase their CAHPS scores. The monthly compliance report states communication with family as of February 2021 is 79%, getting timely help is 67%, and treating the patient with respect is at 95%. Each of these metrics has a goal to be at or above 95% threshold. These Joint Commission findings require improvement for the next TJC audit.

Context: Priorities include identifying the root causes of low communication scores and implementing new strategies that leave patients and their families feeling that healthcare team members communicated with them effectively. A SWOT analysis was conducted to determine the strengths, weaknesses, opportunities, and threats of the implementation.

Interventions: The patient's primary caregiver will receive a call within one month of admission. The purpose of this initial call is to assess how have they been since admission, do they know their care team, and do they have all of the supplies needed. The caller will focus on patient satisfaction, do they feel included in decisions with the care team, if they have experienced any difficulties contacting the team, and if there is anything else we can do for them at the moment. Calls will be documented on a patient survey call log and a patient note will be written stating what was discussed during the call and if any issues should be addressed.

Measures: The outcome measure is the score of communication with family with a goal of 95%. The process measures include the percentage of phone calls made to recently admitted patients (Daily Census Report) and the percentage of patients completing the CAHPS survey after discharge (Monthly Compliance Report).

Results: Post-implementation, communication CAHPS scores dropped by 1%. The current CAHPS score from July 2021 is 78%, which ranks the hospice as 22% in the nation.

Conclusions: Post-implementation, volunteers will continue calling patients and educating them about the CAHPS survey to increase survey response rates. The team remains confident that patient satisfaction phone calls will be successful in increasing CAHPS communication scores, but the implementation needs more time to take effect. Implications for practice include continuing research on how to best increase CAHPS scores. Although surveys do not fully capture the patient's feedback, the CAHPS survey will continue being an integral benchmark for accreditation and improving quality of care.

Implementing Patient Satisfaction Phone Calls to Improve CAHPS Communication Scores in a Hospice Setting

Key organizations like The Joint Commission, are responsible for accrediting healthcare facilities and hold a common vision to improve quality of care for all populations (King et al., 2019). When considering an evidence-informed quality improvement project, specifically for hospice, it is important to monitor care patterns and care quality across patients. One of the primary goals of hospice care is to provide patient and family-centered care as this quality is assessed through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, given to the primary caregiver of the deceased patient. Team member ratings are to fulfill hospice team communication, getting timely help, treating family members with respect, getting emotional support, getting help for symptoms, and getting hospice care training (Anhang et al., 2018). Within this specific hospice microsystem, The Joint Commission is directly recommending that this hospice's communication with family must improve from 79% listed on the monthly compliance report.

Problem Description

The Institute for Healthcare Improvement (2020) indicates that the Dartmouth-Hitchcock Medical Center clinical microsystem assessment tool can identify what areas of the microsystem require improvement. Current performance metrics are based on the "5 Ps", purpose, patients, professionals, processes, patterns, and metrics that matter. This microsystem exists to provide personal and individualized palliative care for patients with life-limiting illnesses through a continuum of care. The patient population within this microsystem are 19 years and older with the largest percentage of patients being greater than 80 years-old. Hospice patients have terminal diagnoses of six months or less and wish to maintain their quality of life. Professionals involved

in impacting communication scores include MDs, RNs, LVNs, spiritual care staff, home health aides, and social workers. Within the microsystem, these professionals work to ensure patient needs are being met. This includes providers ensuring patients are comfortable with their plan of care, nurses making home visits, social workers supporting the family with resources, and spiritual care staff offering emotional and spiritual support. Lastly, the metrics that matter are communication with family, getting timely help, and treating the patient with respect.

Elaborating upon the metrics that matter (MTMs), the monthly compliance report states communication with family is currently 79%, getting timely help is 67%, and treating the patient with respect is at 95% (Appendix I). Each of these metrics has a goal to be at or above 95% threshold. These Joint Commission findings require improvement for the next TJC audit. Priorities include identifying the root causes of low communication scores and implementing new strategies that leave patients and their families feeling that healthcare team members communicated with them effectively. Collecting this data is important to benefit future patients and their families when going through the experience of losing a family member to a terminal illness.

Available Knowledge

The following PICOT question gives guidance to the research conducted toward improving CAHPS communication scores: Can implementing phone calls to patients newly admitted to hospice improve CAHPS communication scores within four months compared to not implementing phone calls? Although there is limited evidence on implementing phone calls in a similar microsystem to improve communication with patients measured through the CAHPS survey, the existing literature provides a blueprint for future quality improvement (Appendix A). Kincaid (2020) is a quasi-experimental study where the team improved CAHPS communication

scores from 85% to 87%. Anhang et al. (2018) is a meta-analysis that analyzed 141,412 survey responses for 2500 hospices. Two out of five survey respondents reported their family did not always get the help that they needed for anxiety or sadness. Reblin et al. (2017) is a longitudinal study that analyzed 537 home visits and found distinct patterns of visit communication defined by who interacts most with the nurse and the expression of distress during the visit. Jung and Matthews (2021) is a systematic review of eight articles that revealed mixed results and that there is a need for additional nursing research that increases quality and benefits of end of life communication interventions. Quigley et al. (2020) is a quasi-experimental study where primary caregivers reported the quality of hospice care across settings and found that communication, treating the family member with respect, and providing emotional and spiritual support were most strongly associated with overall rating of care. This evidence is used to help guide the following project implementation.

Rationale

The National Quality Forum provides a framework and preferred practices for palliative and hospice care quality to evaluate quality across all health settings and professions and achieve a set of preferred practices the palliative and hospice care microsystems. The framework provides a structure for care quality measurement and reporting (National Quality Forum, 2006).

There is an emphasis placed on identifying aspects for quality improvement which directly applies to the PICOT question mentioned before. Considering the patient populations, different care settings, and levels of healthcare professionals, this framework can be applied to any hospice. The framework contains eight domains that allow systematic appraisal for the different aspects of hospice care. Those domains include structures and processes of care, physical aspects of care, psychological and psychiatric aspects of care, social aspects of care,

spiritual/religious/existential aspects of care, care of the imminently dying patient, and ethical/legal aspects of care (National Quality Forum, 2006). This extensive framework will allow for accurate quality measurement and reporting.

Specific Project Aim

The purpose of this project is to use evidence-based practice to improve CAHPS scores related to patient communication with the care team at a Bay Area Hospice. Communication with the patient also includes their families and caregivers. After the implementation, the data will determine if improved communication techniques (making phone calls to patients admitted within one month) increases CAHPS scores at a nonprofit hospice within the next four months. It is pertinent that the hospice facility increase their CAHPS communication scores as the Joint Commission will be reassessing for improvement within the next year.

Context

The SWOT analysis can help identify strengths, weaknesses, opportunities, and threats relating to this implementation and will aid the action planning process (Appendix E). Strengths are considered factors that are likely to have a positive effect on to help achieve a purpose (Foundation of Nursing Studies, 2015). This hospice in the San Francisco Bay Area has the strength of having an overall positive reputation in the community, consistent leadership, receives generous donations, and is able to offer many services that cater to the Bay Area's diverse population. Weaknesses are factors that can have a negative effect on achieving the shared purpose. Some weaknesses to consider are providers handing off care to another provider without sufficient communication, not having enough staffing to make phone calls to patients to improve communication, and time constraints.

Opportunities are external factors that have not previously been considered, but can have a positive effect. The addition of a MSN Intern provides a different perspective outside of the microsystem and conducts the implementation as an opportunity that can help achieve the shared goal. Threats are external factors likely to act as a barrier to achieving the goal (FONS, 2015). Some threats include the care team not being able to physically meet patients and families due to COVID-19, which can impair a patient's perception of communication. The largest threat to the goal is low survey response from patient families. Families receive the CAHPS survey within a weeks to months after the patient has been discharged, or deceased. When optional surveys are sent to grieving families, they can easily decline completing the survey. It is a goal that through making phone calls to patients, we can educate them on how much this hospice values their feedback to improve for future patients and families.

Intervention

The change being implemented regarding improving communication with patients includes the use of a daily census report. The patient's primary caregiver will receive a call within one month of admission. This call is a *check-in* call to see how have they been since admission, do they know their care team, and do they have all of the supplies needed. Patient satisfaction calls to families with patients that are actively dying should be avoided and reserved only for the care team. The caller will follow a loose-script focusing on patient satisfaction, do they feel included in decisions with the care team, if they have experienced any difficulties contacting the team, and if there is anything else we can do for them at the moment (Appendix D). Calls should be brief and respectful of the caregiver's time unless they indicate they would like to continue talking. Depending on the conversation, the caller than gauge whether it is appropriate to mention the CAHPS survey the family will receive in the future. Calls will be

documented on a patient survey call log containing the patient name, date of admission, date of call, primary diagnosis, MD, case manager, primary caregiver name and phone number, and whether or not a call back is needed. Lastly, a note should be written describing what was discussed during the call and if there are any issues needed to be addressed. This detailed call log is accompanied by a separate excel spreadsheet summarizing all of the calls made, their general response, and whether or not the CAHPS survey was mentioned. Before starting the intervention, the CNL will review current CAHPS scores pertaining to family satisfaction: overall rating of patient care and family's willingness to recommend this hospice. The CAHPS metric goal is to be at or above 95% threshold.

Study of the Intervention

All disciplines share the responsibility to communicate effectively with patients and their families. The team consists of an MD, RN/LVN, spiritual care staff, home health aides, and a social worker. The Director of Quality and Education will oversee the Quality Intern implementing the phone calls. A weekly meeting will be held between the Director of Quality and Education and the Quality Intern to discuss any issues encountered during the phone calls. During the bi-weekly interdisciplinary group meetings, all team members have the opportunity to collaborate and ensure the team is meeting the patient's goals. All patients that have a primary caregiver and their phone number listed will be called within one month of admission. As more calls are made, CAHPS survey response rates will be monitored and survey results will be analyzed for improvement of communication scores.

Measures

The outcome measure for this project is to improve CAHPS communication scores. The CAHPS survey is administered by the Centers for Medicare and Medicaid Services (CMS) as

part of public reporting or reimbursement programs. The outcome measure is the score of communication with family with a goal of 95%. The process measures include the percentage of phone calls made to recently admitted patients (Daily Census Report) and the percentage of patients completing the CAHPS survey after discharge (Monthly Compliance Report). In order to balance these measures, consistent communication from the care team should continue.

Ethical Considerations

Ethical considerations include potential harms associated with efforts to improve quality of care. Keeping ethics in mind, all patient families have the option to accept the call and speak to the Quality Intern/Patient Advocate or to decline the conversation. All staff members support the implementation and participate voluntarily. There are no conflicts of interests present between staff and patients. This project has been approved by the University of San Francisco School of Nursing and Health Professions for the Master of Science in Nursing, Clinical Nurse Leadership program as an Evidence-based Change in Practice Project. This project meets the guidelines outlined in the project checklist (Appendix B). This project involves research with human subjects, but does not need to be submitted for IRB approval per university policy.

Results

Before the project implementation, the microsystem's communication CAHPS scores were 79% in February 2021. This score ranked the hospice as 29% in the nation. Patient satisfaction calls began in March 2021 and continued throughout July 2021. Post-implementation, communication CAHPS scores dropped by 1% (Appendix I). The current CAHPS score from July 2021 is 78%, which ranks the hospice as 22% in the nation. The 1% drop was an unexpected outcome, but there are three considerations to take into account before drawing a conclusion.

a. The implementation was limited by a time constraint of four months. There is a possibility that the patients called in March 2021 through July 2021 have not been discharged to complete the CAHPS survey. The updated CAHPS results from July 2021 include most survey responses of patients who were admitted before March 2021 and were not included on the call list.
b. The implementation took place during the COVID-19 pandemic where many patients were receiving hospice care via phone call and video call. This could have affected the perception patients had toward communication since not a lot of communication occurred in-person.
c. Low survey responses from patient families influence CAHPS scores.

An increasing problem for healthcare institutions is combatting low survey response rates. There is usually no incentive for completing the survey and it can be quite lengthy. For certain patient families, it is much easier to decline answering the survey especially if the family is grieving a loved one.

Discussion

Summary

This implementation is ongoing since the many patients that were called have not yet been discharged and emailed the CAHPS survey. In August 2021, volunteers will continue calling patients and educating them about the CAHPS survey to increase survey response rates. The team remains confident that patient satisfaction phone calls will be successful in increasing CAHPS communication scores, but the implementation needs more time to take effect. The main lesson learned is that although the majority of patients on the phone were very satisfied with the hospice's care, the CAHPS scores do not necessarily reflect that satisfaction. Many patient

families who are satisfied with the care team's communication opt-out of the survey, since they feel they have nothing negative to say. Through making the calls, it is the hope that families recognize the importance of sharing their negative and positive feedback through the CAHPS survey to continue being accredited by The Joint Commission.

Conclusions

After a patient's death at hospice, the CAHPS survey is sent to the primary caregiver to assess the quality of care the patient received during hospice care. Maintaining sufficient CAHPS scores are important since these scores are now available via Hospice Compare for public knowledge. Low scores influence patient decisions regarding choice of hospice and nonprofit donations (Kincaid, 2020). Although this microsystem is exceptional at providing quality end-of-life care, there is a lack of educating patients and caregivers on how to understand and handle the physical manifestations that occur at end-of-life. Low CAHPS survey scores manifests from a lack of education and clarification to families that should be improved.

As the project continues to be implemented, the callers should maintain the following qualities in their phone calls.

a. Demonstrating empathy to the primary caregiver for their loved one under hospice care.
b. Encouraging them to share their concerns and reassuring them that we can take action, if an issue were to arise.
c. Expressing gratitude to the primary caregiver for taking the time to pick up the phone and to share their concerns.
d. Providing CAHPS education to increase survey response rates and to continue improving upon care for future families using hospice care.

Implications for practice include continuing research on how to best increase CAHPS scores. Although surveys do not fully capture the patient's feedback, the CAHPS survey will continue being an integral part for accreditation. Improving upon given metrics not only gains The Joint Commission's approval, but it improves the patient and family experience during a difficult time in their lives.

References

Anhang Price, R., Stucky, B., Parast, L., Elliott, M. N., Haas, A., Bradley, M., & Teno, J. M. (2018). Development of valid and reliable measures of patient and family experiences of hospice care for public reporting. *Journal of Palliative Medicine*, *21*(7), 924–932. https://doi.org/10.1089/jpm.2017.0594

Foundation of Nursing Studies. (2015). SWOT analysis. *Foundation of Nursing Studies*. https://www.fons.org/resources/documents/Creating-Caring-Cultures/SWOT-.pdf.

Institute for Healthcare Improvement. (2020). Clinical microsystem assessment tool: IHI. Retrieved February 19, 2021, from http://www.ihi.org/resources/Pages/Tools/ClinicalMicrosystemAssessmentTool.aspx

Jung, M. Y., & Matthews, A. K. (2021). A systematic review of clinical interventions facilitating end-of-life communication between patients and family caregivers. *American Journal of Hospice & Palliative Medicine*, *38*(2), 180–190. https://doi.org/10.1177/1049909120929323

Kincaid, R. B. (2020). Improving consumer assessment of health care providers and systems communication scores in hospice care: A pilot project. *Journal of Hospice & Palliative Nursing*, *22*(5), 359–362. https://doi.org/10.1097/NJH.0000000000000676

King, C. R., Gerard, S. O., & Rapp, C. G. (2019). Essential knowledge for CNL and APRN nurse leaders. Springer Publishing Company.

National Quality Forum. (2006). A national framework and preferred practices for palliative and hospice care quality. Retrieved March 21, 2021, from http://www.qualityforum.org/Projects/n-

r/Palliative_and_Hospice_Care_Framework/Palliative_and_Hospice_Care__Framework_and_Practices.aspx

Quigley, D. D., Parast, L., Haas, A., Elliott, M. N., Teno, J. M., & Anhang Price, R. (2020). Differences in caregiver reports of the quality of hospice care across settings. *Journal of the American Geriatrics Society*, *68*(6), 1218–1225. https://doi.org/10.1111/jgs.16361

Reblin, M., Clayton, M. F., Xu, J., Hulett, J. M., Latimer, S., Donaldson, G. W., & Ellington, L. (2017). Caregiver, patient, and nurse visit communication patterns in cancer home hospice. *Psycho-Oncology*, *26*(12), 2285–2293. https://doi.org/10.1002/pon.4361

Appendix A

Evaluation Table

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
(Kincaid, 2020) Improving Consumer Assessment of Health Care Providers and Systems Communication Scores in Hospice Care: A Pilot Project.	A Pilot Project/ Quasi-experimental	The team carried an average census of 100 patients throughout the project	CAHPS communication score improved from of 85% to 87%. In addition, the CAHPS survey question on timeliness of service improved from 70% to 80% over the duration of the project.	II B
(Anhang et al., 2018) Development of Valid and Reliable Measures of Patient and Family Experiences of Hospice Care for Public Reporting	Meta-analysis	This study analyzed 141,412 survey responses for the 2500 hospices for which there were at least ten respondents in Q2–Q3.	Two out of five respondents reported that their family member did not always get help that they needed for anxiety or sadness. More than one in four respondents indicated that the hospice team did not always discuss side effects of pain medicine, and almost as many indicated that the hospice team did not always keep them informed about their family member's condition. Hospice Team Communication is the strongest predictor of overall rating of care.	III B
(Reblin et al., 2017) Caregiver, patient, and nurse visit communication patterns in cancer home hospice	Longitudinal study	The study analyzed 537 home visits made by 58 nurses to 101 spouse/partner cancer caregiver-patient dyads across the span of enrollment in home hospice to patient death.	This study found 6 distinct patterns of visit communication defined by 2 dimensions: (1) who interacts most with the nurse (patient, caregiver, or dyad) and (2) the relative high or low expression of distress during the visit.	II A
(Jung & Matthews, 2021) A Systematic Review of Clinical Interventions Facilitating End-of-Life Communication Between Patients and Family Caregivers	Systematic Review	8 articles were included in the final review.	Appraisal of the selected studies revealed that the quality of the included studies was mixed. The results of this review highlight the importance of additional nursing research aimed at increasing the number, quality, and benefits	III A

			of EOL communication interventions for patients and their family members.	
(Quigley et al., 2020) Differences in Caregiver Reports of the Quality of Hospice Care Across Settings	Quasi-experimental	A total of 311 635 primary caregivers of patients who died in hospice.	Consistently across all care settings, hospice team communication, treating family member with respect, and providing emotional and spiritual support were most strongly associated with overall rating of care.	II A

Appendix B

IRB Statement of Non-Research Determination Form

Student Name: Claudia Castillo

Title of Project:

Implementing Patient Satisfaction Phone Calls to Improve CAHPS Communication Scores in a Hospice Setting

Brief Description of Project:

A) Aim Statement: To improve CAHPS communication scores within four months (August 2021) by implementing phone calls to patient families newly admitted to hospice.

B) Description of Intervention: The purpose of this project is to use evidence-based practice to improve CAHPS scores related to patient communication with the care team. Communication with the patient also includes their families and caregivers. Phone calls will be made to patient families recently admitted to hospice. The phone calls will follow a loose script and leave room for questions and concerns. The phone calls will be no longer than five minutes, but the length of the call is dependent on if the family wants to continue the conversation.

C) How will this intervention change practice?

After the implementation, the project can determine if improved communication techniques increases CAHPS scores at a nonprofit hospice within the next four months. If successful, this hospice may continue implementing patient satisfaction calls to reach their CAHPS goals. It is pertinent that the hospice facility increase their CAHPS communication scores as the Joint Commission will be reassessing for improvement within the next year.

D) Outcome measurements:

- CAHPS Communication with Family Scores
- Percentage of phone calls made to recently admitted patients
- Percentage of patients completing the CAHPS survey after discharge

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

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

Project Title:	**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.	**YES**	
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.	**YES**	
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.	**YES**	
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.	**YES**	
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.	**YES**	
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.	**YES**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**YES**	

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.	**YES**	
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."*	**YES**	

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.

STUDENT NAME (Please print):

Claudia Castillo

____

Signature of Student:

____**DATE 04/18/2021**

SUPERVISING FACULTY MEMBER NAME (Please print):

____

Signature of Supervising Faculty Member

____**DATE**____________

Appendix C
Project Charter

Project Charter: Improving Communication in a Hospice Setting

Global Aim: To improve CAHPS communication scores within four months (July 2021) by implementing phone calls to patient families newly admitted to hospice.

Specific Aim: To improve the percentage of CAHPS communication scores from 79% listed on the quality report. The Joint Commission is directly recommending that this percentage increases by the end of the year.

Background:

Although there is limited evidence on implementing phone calls in a similar microsystem to improve communication with patients measured through the CAHPS survey, the existing literature provides a blueprint for future quality improvement. Kincaid (2020) is a quasi-experimental study where the team improved CAHPS communication scores from 85% to 87%. Anhang et al. (2018) is a meta-analysis that analyzed 141,412 survey responses for 2500 hospices. Two out of five survey respondents reported their family did not always get the help that they needed for anxiety or sadness. Reblin et al. (2017) is a longitudinal study that analyzed 537 home visits and found distinct patterns of visit communication defined by who interacts most with the nurse and the expression of distress during the visit. Jung and Matthews (2021) is a systematic review of eight articles that revealed mixed results and that there is a need for additional nursing research that increases quality and benefits of end of life communication interventions. Quigley et al. (2020) is a quasi-experimental study where primary caregivers reported the quality of hospice care across settings and found that communication, treating the

family member with respect, and providing emotional and spiritual support were most strongly associated with overall rating of care.

Sponsors

Chief Executive Officer	
Chief Compliance Officer	
Director of Quality & Education	

Goals

When considering an evidence-informed quality improvement project, specifically for hospice, it is important to monitor care patterns and care quality across patients. One of the primary goals of hospice care is to provide patient and family-centered care and this is assessed through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, given to the primary caregiver of the deceased patient. Team member ratings are to fulfill hospice team communication, getting timely care, treating family members with respect, getting emotional support, getting help for symptoms, and getting hospice care training (Anhang et al., 2018).

1. Formatting a call log to document questions asked and patient responses.
2. Standardized implementation of phone calls to recently admitted patients on a regular basis.

Measures

Measure	**Data Source**	**Target**
Outcome		
% of family satisfaction: Communication with family	Monthly Compliance Report- Netsmart	95%
Process		
% of phone calls made to recently admitted patients	Daily Census Report- Netsmart	70%
% patients completing the CAHPS survey after discharge	Monthly Compliance Report- Netsmart	50%
Balancing		

No decrease in communication from care team	Netsmart communication documentation	Continue with current practice

Team

Quality Intern
MD Co Lead
RNs/LVNs
Director of Quality and Education
Spiritual Care Staff
Home Health Aides
Social Work Team

Appendix D

Loose-Script for Patient Satisfaction Calls

- Hi, my name is ______. I'm a patient advocate calling from _______ Hospice. May I speak to the family member of [patient's name]?
- My role as a patient advocate is to check-in and ensure we are providing the best care possible for your loved one. Do you have a few minutes to talk? If not, may I call back at a more convenient time?
- The reason for my call is to assure we are meeting your needs and to help answer any questions or concerns that may have come up. You were admitted last month, how has it been so far?

Positive Response

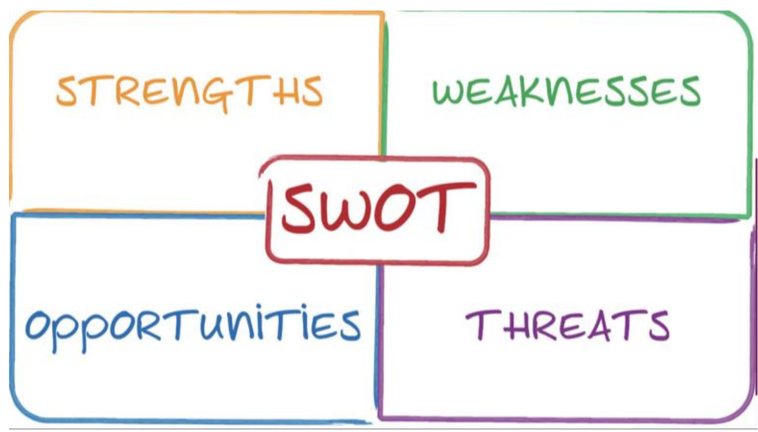
- That's great to hear. Have you met everyone from your care team like your doctors and case manager?
- Do you feel included as part of the care team?
- I just wanted to make sure you knew about our 24-hour help line. If you have any questions at all, you can call that number at any time and a nurse is always on the other side to pick up.
- Down the road, you'll be receiving a survey in the mail. We would really appreciate if you took the time to fill that out so we can continue improving upon our care for future families.

Negative Response

- Oh no, I'm so sorry to hear you had to experience that. That's unfortunate to hear.
- I really appreciate you sharing that with me.
- I will be sure to escalate this situation to my superior so we can make things right.
- Again, thank you for sharing this with me. We take feedback very seriously and will ensure that this does not continue to happen.

Appendix E

SWOT Analysis



Strengths:

This hospice has an overall positive reputation in the community, consistent leadership, receives generous donations, and is able to offer many services that cater to the San Francisco Bay Area's diverse population.

Weaknesses:

Providers hand off care to another provider without sufficient communication, they do not have enough staffing to make phone calls to patients to improve communication, and time constraints.

Opportunities:

The addition of a MSN Intern to provide a different perspective outside of the microsystem and conduct the implementation is an opportunity that can help achieve the shared purpose.

Threats:

Some threats include the care team not being able to physically meet patients and families due to COVID-19, which can impair a patient's perception of communication. The largest threat to the goal is low survey response from patient families. Families receive the CAHPS survey a few months after the patient has been discharged, at a hospice discharge usually means the patient is now deceased. When we send optional surveys to grieving families, they can easily decline completing the survey. It is a goal that through making phone calls to patients, we can educate them on how much the hospice values their feedback to improve for the future.

Appendix I

Monthly Compliance Reports

CAHPS Scores Before the Implementation

Report date 02/13/2021

Real-Time Satisfaction Survey Results: CAHPS Hospice

Data & Benchmark Summary (View Survey Administration report for selected period)

	You	State (CA)	National
CCNs:	1	196	1,488
Completed Surveys:	54	14,704	136K

Quality Measures - Top Box Scoring Methodology (Expand / Collapse All)

Top Box	You Actual	You 12M Trend	SHP State (CA)	SHP National	You % Ranking
1. Communication with Family Measure Details (view all response details)	79%	12 month trend high	80%	82%	29%
2. Getting Timely Help Measure Details (view all response details)	67%	point: 80.0% (Sep	73%	76%	17%
3. Treating Patient with Respect Measure Details (view all response details)	95%	2020); 12 month	89%	91%	78%
4. Emotional and Spiritual Support Measure Details (view all response details)	95%	trend low point: 92.2%	90%	92%	79%

Hide Document Map

CAHPS Scores After the Implementation

Report date: 07/09/2021

Real-Time Satisfaction Survey Results: CAHPS Hospice

Data & Benchmark Summary

	You	State (CA)	National
CCNs:	1	197	1,532
Completed Surveys:	125	12,693	113K

Quality Measures - Top Box Scoring Methodology

Top Box	You Actual	You 12M Trend	SHP State (CA)	SHP National	You % Ranking
1. Communication with Family Measure Details	78%		79%	83%	22%
2. Getting Timely Help Measure Details	72%		71%	76%	31%
3. Treating Patient with Respect Measure Details	92%		89%	91%	46%
4. Emotional and Spiritual Support Measure Details	95%		90%	92%	75%