



Clinical Update



Winter 2012

Atrium University is funded by an educational grant from Atrium Medical Corporation. Visit us online at AtriumU.com

Satisfied Patients are Money in the Bank

Since this is such an important topic, we have doubled the length of our feature in this issue. **In the Literature** and **On the Web** are on page 3.

Clinicians often express frustration at the administrators' focus on patient satisfaction because their focus is on outcomes. Measures of satisfaction can be seen as simply evaluations of how nice people are, and most nurses know at least one gruff surgeon with no bedside manner that they would choose for themselves or a loved one who needed complicated surgery. However, satisfaction is big business. A report from Press Ganey noted that one standard deviation improvement in quality score resulted in a 2% increase in operating margin and that 30% of the variance in hospital profitability can be attributed to patients' perceptions of care.¹ And, beginning in October 2012, Medicare reimbursement to hospitals will be tied to patient satisfaction – an average of \$500,000 to \$850,000 at risk annually per hospital.² Since 2006, hospitals have been required to collect and submit data or lose 2% of reimbursement. In October, hospitals must meet certain thresholds of achievement or improvement to get full reimbursement. The amount at risk will increase in coming years.

HCAHPS

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) started as an assessment of health plans through the Agency for Healthcare Research and Quality (AHRQ). The name was changed in 2005 to reflect applications across care settings. HCAHPS is the hospital survey. It was implemented by CMS in October 2006, and public reports started in March 2008 (hcahponline.org). HCAHPS goes together with the quality indicators – also publicly reported – that currently focus on MI, heart failure, pneumonia, and surgical care (SCIP). These indicators will be modified; those for which hospitals are close to 100% will be refined and others updated as evidence evolves. A hospital's total performance score determining reimbursement will be 30% HCAHPS and 70% quality measures. (See **On the Web** for online resources for these tools and to see publicly reported data.)

While patient satisfaction is gaining attention now because of the direct link to payment, there are other key, measurable benefits of having satisfied patients. These include: improved volume related to reputation in the community, patient loyalty, reduced malpractice claims, more satisfied staff and physicians (and decreased turnover with related costs), and improved efficiency. One hospital linked satisfaction improvement to \$2.3 million in additional revenue.³

Many Things Affect Patient Perceptions

As clinicians, we can think about satisfaction as we have learned

Clinical Update is edited by Patricia Carroll, RN,BC, CEN, RRT, MS. and supported by an educational grant from Atrium Medical Corporation.

Quality Indicators Relating to Cardiac Surgery

- Preoperative antibiotic within one hour of surgery
- Postoperative antibiotic stopped within 24 hours
- Appropriate antibiotic chosen
- VTE prophylaxis ordered and implemented
- Glucose controlled postoperatively
- Hair removed with clippers
- Surgical patients who were on a beta blocker preop received postop
- Urinary catheter removed by POD 2
- Participate in data registry

to assess pain: it is what the patient says it is. Unlike quality indicators that are objectively evaluated through chart reviews, satisfaction is all about patient perception. And these perceptions are a result of their expectations. Some experts are concerned that these expectations result in bias on HCAHPS because hospitals in the South and Midwest have more satisfied patients than those in the Northeast. In addition, small hospitals that transfer complex patients score higher than hospitals with more than 500 beds, and hospitals with high patient ratings have higher mortality rates.³ Research has shown differences in the patient experience based on patient age, race/ethnicity, education, and health status. Self-ranked health status was most significant; one-third of hospitals ranked in the middle (50th percentile) by an average patient in "good" health would differ by at least 19 percentile points for patients who rank their health at the extremes as "excellent" or "poor." Differences between patients with post-baccalaureate education and those who didn't attend high school were similar to differences between patients aged 25 and aged 75.⁴

A study of satisfaction with surgery at 26 hospitals found that younger patients were less satisfied, as were those admitted through the emergency department. Patients who believed their stay was the right length were more satisfied than those who thought their stay was too long. Post-discharge complications resulted in significantly lower satisfaction scores, even if the questions did not relate directly to the complication. The strongest and most consistent predictors of dissatisfaction were treatment outcome, kindness of caregivers, and length of stay.⁵

Another consideration when exploring HCAHPS scores is what drives the patient's hospital choice. The best hospital for relatively healthy patients may not be the best for complex, ill patients.⁵ Keep in mind that all adult patients are surveyed for hospitals that receive Medicare payments – not just the Medicare patients. The expectations and experiences of healthy OB patients are going to be very different from those of a 70-year-old cardiac surgery patient. Also think about how well a hospital meets the needs of patients whose primary language is not English, and those with different cultural health practices. Patients' best experiences tend to come from hos-

pitals in which they are members of the hospital's typical population.⁵

The way the HCAHPS survey is conducted will also impact results in two ways: who responds and who doesn't, and the answers people provide. Hospitals typically hire companies to conduct surveys, and they have four options: mail, mail with telephone follow up, telephone interview, and voice response telephone. Telephone interviews provide more positive evaluations, but are significantly more expensive to conduct.⁶

The bottom line is that patients assume people in hospitals know what they are doing. They take the quality for granted unless there is a reason not to, and a poor surgical outcome is a significant indication of poor quality to the layman. Otherwise, patients don't feel qualified to judge the finer points of quality.⁵ Instead, food quality, cleanliness, and noise are surrogates of quality that patients feel comfortable evaluating along with whether clinicians cared about them.

Perceptions and Satisfaction After Cardiac Surgery

Studies have shown that patients' illness beliefs have a great impact on outcomes, and outcomes affect satisfaction. Beliefs are closely related to fear, anger, and distress. A study of cardiac surgery patients discovered that illness beliefs predicted disability, physical functioning, and depression post-op, even after controlling for cardiac variables; it was patient expectations that affected outcomes.⁷ (See **On the Web** for a link to the tool.)

A few studies have examined the patient experience to better prepare them and to set realistic discharge expectations.⁸⁻¹¹ One study interviewed patients contemporaneously.⁸ Key recovery issues were energy level; chest incision; sleeping; and shoulder, neck and back muscle discomfort. Researchers discovered these sensations changed between discharge, 2 days later, and 3 weeks later, and that the patients' descriptions were markedly different from those used by clinicians. A Hong Kong study¹¹ found depression and physical activity impairment peaked at one week, with recovery by three months and gradual improvement continued through six months.

An Australian study interviewed patients about their surgery and recovery experience six months after surgery.⁹ Again, patients described sensations they had not been prepared for: pain related to immobility (particularly stiffness and muscle pain), and inability to sleep. Patients also expressed the life-changing nature of the surgery – some said it made them realize what's important and what isn't, but others felt their age more and believed they were closer to death. Most recalled being sick, reaching a turning point, and then feeling better. The researchers stress the importance of realistic and consistent messages for patients.

Another study interviewed patients about their surgery experience one year later.¹⁰ The main theme was the quality of the contact with clinicians, but patients emphasized the positive relationships they had with other patients and those families during the hospitalization. In fact, male patients preferred sharing a room with other cardiac surgery patients; it provided not only camaraderie, but also a feeling of safety. In the program studied, there was no routine contact from the hospital department after discharge. Patients expressed a desire to be able to contact nurses who had cared for them in the hospital, perhaps with special call hours to minimize interruptions for the nurses. Patients found other patients could help them know what was "normal" during recovery, which reduced post

discharge anxiety and established realistic expectations.

You can see how not only the care provided in the hospital, but also the expectations of "normal" sensations and experiences during recovery that are set at discharge in addition to the timing of the HCAHPS survey completion can have a big impact on results. Backstrom and colleagues noted that patient satisfaction with care can be influenced by the person's health status at the time of the interview.⁹

Improving Cardiac Surgery Satisfaction

Nurses can have a big impact on satisfaction scores after cardiac surgery. The literature tells us the most important aspect is ensuring that patients have a thorough understanding of what to expect with regard to physical sensations, psychosocial responses, and the timeframe of recovery.^{5,7-11} Nurses have traditionally done a good job explaining what patients need to *do* – risk reduction, medications, and diet – but patients have expressed a need for more detailed information about what they are likely to *feel* – both physically and emotionally. There needs to be regular contact following discharge for at least the first three months postoperatively since physical, social and emotional recovery rates vary during that time. A study of CABG patients found that a comprehensive pre- and postoperative education program, including postdischarge telephone follow-up (averaging 133 minutes total per patient) significantly improved self-care scores and behaviors and reduced pain intensity, anorexia, respiratory difficulty, leg swelling, constipation, and number of ER visits than patients in the control group that received routine care.¹² That may seem like an extraordinary amount of time until you consider the cost of poor HCAHPS scores.

Before surgery, assessing beliefs related to heart disease provides the opportunity to correct misconceptions and reset expectations. This can provide significant dividends during recovery and when patients think about whether they were satisfied with their care and whether it met their expectations.⁷

Sources

1. Press Ganey: *Return on investment: increasing profitability by improving patient satisfaction*. South Bend, IN 2010.
2. Buhlman N, Matthes N: *The time to prepare for value-based purchasing is now*. Press Ganey; South Bend, IN 2011.
3. Daly R: Unsatisfactory marks. Hospitals question use of HCAHPS in scoring for value-based purchasing. *Modern Healthcare* 2011;41(33):30.
4. Elliott MN, Lehrman WG, Goldstein E, Hambarsoomian K, Beckett MK, Giordano LA: Do hospitals rank differently on HCAHPS for different patient subgroups? *Medical Care Research and Review* 2010;67(1):56-73.
5. Schoenfelder T, Klewer J, Kugler J: Factors associated with patient satisfaction in surgery: the role of patients' perceptions of received care, visit characteristics, and demographic variables. *The Journal of Surgical Research* 2010;164(1):e53-59.
6. Elliott MN, Zaslavsky AM, Goldstein E, et al.: Effects of survey mode, patient mix, and nonresponse on CAHPS hospital survey scores. *Health Services Research* 2009;44(2 Pt 1):501-518.
7. Juergens MC, Seekatz B, Moosdorf RG, Petrie KJ, Rief W: Illness beliefs before cardiac surgery predict disability, quality of life, and depression 3 months later. *Journal of Psychosomatic Research* 2010;68(6):553-560.
8. Moore SM: Development of discharge information for recovery after coronary artery bypass surgery. *Applied Nursing Research* 1994;7(4):170-177.
9. Backstrom S, Wynn R, Sorlie T: Coronary bypass surgery patients' experiences with treatment and perioperative care -- a qualitative interview-based study. *Journal of Nursing Management* 2006;14:140-147.
10. Gardner G, Elliott D, Gill J, Griffin M, Crawford M: Patient experiences following cardiothoracic surgery: an interview study. *European Journal of Cardiovascular Nursing* 2005;4(3):242-250.
11. Lopez V, Sek Ying C, Poon CY, Wai Y: Physical, psychological and social recovery patterns after coronary artery bypass graft surgery: a prospective repeated measures questionnaire survey. *International Journal of Nursing Studies* 2007;44(8):1304-1315.
12. Cebeci F, Celik SS: Discharge training and counselling increase self-care ability and reduce postdischarge problems in CABG patients. *Journal of Clinical Nursing* 2008;17(3):412-420.

In the Literature

Patient as Expert

The current issue of *Orthopaedic Nursing* has a terrific article about the lived experience of hip replacement, written by a nurse practitioner. Having done research in ethnography, she provides unique insight into the patient experience that HCAHPS focuses on. She identified two key areas – energy conservation and comfort – that were not addressed well by traditional resources. Then she offers her tips that can be shared with patients to prepare them for not only the surgery, but for the challenges of recovering at home.

Source: Camillo P: Practical preparation for hip replacement surgery. *Orthopaedic Nursing* 2011;30(6):367-372. [PubMed Citation](#)

Readmission Warning Signs

Researchers studied readmissions to 97 critical care units in 35 hospitals with 229,375 admissions over an eight year period to see if there are characteristics that predict a unit readmission. Ideally, the risk of readmission can then be factored into discharge decision-making. The top three surgical readmission diagnosis groups were CABG, GI malignancy, and thoracotomy for malignancy. Medically, congestive heart failure and “other respiratory” were the top two. The overall rate for readmission was 6.1% with a median interval of 3.14 days outside the unit. Researchers did not control for patients who were initially admitted to critical care, discharged, had surgery and were readmitted to critical care; e.g., the patient with AMI who is discharged from the CCU, has CABG and is then admitted to a postoperative ICU. They recommend tracking this variable, as these readmissions are not related to potential premature ICU discharge. Key factors increasing probability of readmission were: initial transfer from a different hospital; age; comorbidities; initial ICU length of stay; and low serum creatinine and albumin, potentially reflecting malnutrition. There was a 5.7 fold increase in mortality for readmitted patients.

Source: Kramer AA, Higgins TL, Zimmerman JE: Intensive care unit readmissions in U.S. hospitals: patient characteristics, risk factors and outcomes. *Critical Care Medicine* 2012;40(1):3-10. [PubMed Citation](#)

Purposeful Rounding

Researchers examined the effect of hourly rounds on a 36-bed medical-surgical unit over a three-month period and compared data from the same quarter the previous year. Nurses or aides checked on each patient every hour and followed a scripted assessment. Documentation was that needs were identified and met, no needs identified, patient was sleeping, or patient was off the unit. When patients were off the unit, a tent card was left to let the patient know someone was there to check on them, reinforcing the program. Sleeping patients were not disturbed. After the pilot program, while the number of falls did not change, the number with injuries were cut in half. Hospital acquired pressure ulcers were reduced, although the data was not significant, likely because of small sample size. Rounding reminded caregivers to regularly reposition patients. All scores on the HCAHPS for nursing care increased significantly (3.1 to 5.5 points), except for responsiveness to pain, which decreased by 0.6 for reasons not clear.

Source: Sherrod BC, Brown R, Vroom J, Sullivan DT: Round with purpose. *Nursing Management* 2012;43(1):33-38.

Check out Ask the Expert now available at AtriumU.com. You can submit a question about caring for patients with chest drainage and read questions from your colleagues with the evidence-based answers.



In this issue, these Web resources all relate to quality and HCAHPS.

The main Web site for all CAHPS programs is <https://www.cahps.ahrq.gov/> and the CMS site for HCAHPS is <http://www.hcahponline.org>

The Commonwealth Fund is a private foundation working toward a high performing health care system. They provide a wealth of tools and resources relating to improving all aspects of health care. <http://www.commonwealthfund.org/>

Why Not the Best at <http://www.whynotthebest.org/> (from the Commonwealth Fund) provides more robust comparison tools than Hospital Compare from CMS <http://www.hospitalcompare.hhs.gov> plus tools and resources to aid improvement activities. Users can develop their own reports and analyze benchmarks on the state and national level, as well as by hospital type. Why Not the Best integrates data from multiple sources in one easy-to-use location.

The Hospital Quality Alliance was the group that worked on indicators and items included in HCAHPS from 2002-2011 <http://www.hospitalqualityalliance.org>. While the group is no longer active, a number of resources remain on the Web site. Now, these activities have moved to the Measures Application Partnership <http://www.qualityforum.org/map/> established by the Affordable Care Act, where many quality initiatives have been established and funded.

The Illness Perception Questionnaire is used to evaluate a patient's beliefs about his or her illness. The site provides the tool in many languages, scoring instructions and links to articles about the tool's development, validation and use. <http://www.uib.no/ipq/index.html>

In the UK, a report published in 2001, the Bristol Inquiry and Kennedy Report, described the findings of an investigation of 35 deaths in a pediatric cardiac surgery program after an anesthesiologist whistleblower realized there were systemic problems in care of these children. This report is a model for an investigation, and virtually all the recommendations are now implemented in the NHS. http://www.bristol-inquiry.org.uk/final_report/report/Summary.htm