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Why The Emotional Engagement of Patients Will Trump HCAHPS®

A monster is lurking in the nooks and crannies of every hospital, and that monster is HCAHPS®. This somewhat straightforward attempt to bring transparency to healthcare is upon us, and is striking terror in the hearts and minds of hospital administration from Dover to Des Moines to Del Mar. For many good reasons, the alarm is very real and justified as the entire HCAHPS® approach was born out of fear and 100% "weakness prevention."

Don't misunderstand; weakness must be driven out at every level possible. But, to assume that the elimination or minimization of flaws will result in excellence is not only misguided, but it is potentially dangerous as well. Weakness fixing will indeed minimize risk, but without strengths promotion and engagement-based vision, excellence is impossible. Driving weakness out does not lead to excellence, nor vice versa. Rather, the two are exclusive of one another. The reality is we need both. Thus, separate strategies are required.

First, let me assuage the fears. This method of insuring that the "right steps" as measured by HCAHPS® are being followed will be found ineffective and will be ignored by boards, payors and healthcare leaders within 24-36 months. Why? Because of a statistical principle called "central tendency." Let me explain.

Throughout my 25 years of practice with healthcare institutions, variation in levels of service does not exist at the overall facility level. Discrepancies in patient satisfaction/engagement show strong differences across units and departments within the overall facility.[1] When HCAHPS® patient data is tabulated, a total score will be provided and this score will be nothing more than a homogenized average of the best and worst service compliance across the few departments within the facility (medical, surgical, and obstetrics patients only). See Graphic A which looks at hospitals by bed size and Graphic B displaying type of hospital, both showing responses to the question of "Would you recommend this hospital to your friends and family?"

At first glance, this response pattern is encouraging. But, if you look again, you will see that the response patterns are not different (little variance). When 92% of all 186,368 respondents rate this item as a "definitely yes and probably yes," the critical eye will ascertain that this item is not predictive of anything as virtually all are reporting top two box ratings. This is especially critical when observing that there are wide fluctuations across these test hospitals in:

1. ***Financial performance,***
2. ***Nurse and staff turnover,***
3. ***Physician engagement, and***
4. ***Employee engagement .***

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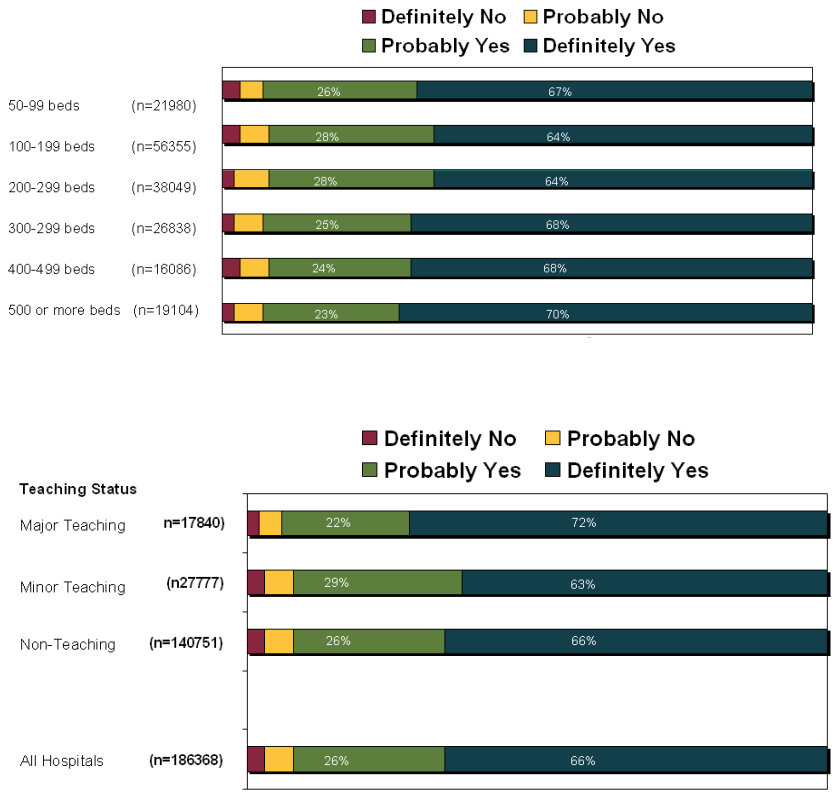
With the looming fear of lower reimbursement and lost contracts based upon these data, it simply will not play out as a reality. Virtually all hospitals will show almost no variance from one to another. The result: Confused payors and increased emphasis on hospital cost as the primary and possibly only differentiator.

That's the good news – now, here's the bad. The entire focus of HCAHPS® (weakness prevention) is on compliance to exact specifications, but not to those factors that really matter to the patient and their family. Of special concern is that the clarification around whom the outstanding units/departments are and, conversely, the troubled ones will remain unnoticed. Consequently, "spray and pray" interventions for improvement will be the order of business. It's comparable to testing 50 people collectively for a disease, finding occurrence and then treating all 50 for the disease.

THE REAL GOAL?

While the intention of HCAHPS® is absolutely correct, the method is severely flawed. In many ways, we are widening the gap on how patients/families define quality healthcare, and how those providing it are regulated to define it. In the end, isn't it our purpose to be the elite healthcare institution for the patients and communities we serve?

Research across hundreds of thousands of patients[2], now shows that it is the emotional perceptions they have to the service they receive that will dictate overall views. Neuroscience tells us that we are six times more driven by emotional retort than by rational thought[3]. Patients and their families are not walking computers taking in information, trading it off against all variables and thus responding in the most rational way. They are first and foremost, emotional[4].



GRAPHIC B – HCAHPS Scores by Hospital-Type

Data from 927 hospitals during the "pilot period" conducted by the Agency for Healthcare Research and Quality 2007.

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In my review of literally hundreds of patient survey questions, less than 2% address the emotional side of the patient experience. Maybe that is the reason we have not observed any movement in patient satisfaction scores representing the experiences of 2,230,606 patients treated at 1,576 hospitals nationwide between January 1, 2001 and December 31, 2005[5]. See graphic C.

This flat line would hold significance if the other critical outcomes like financial stability, employee turnover and mortality rates were also unwavering, but they are not. Could it suggest that we have been stalking an outcome using all the wrong tools?

How did we reach this point? One reason may lie in how we have been searching for "best practices" across healthcare organizations, both formally and informally. In search of the "right way," we have recognized excellence and studied it thoroughly from the most micro perspective to learn how the best "do it."

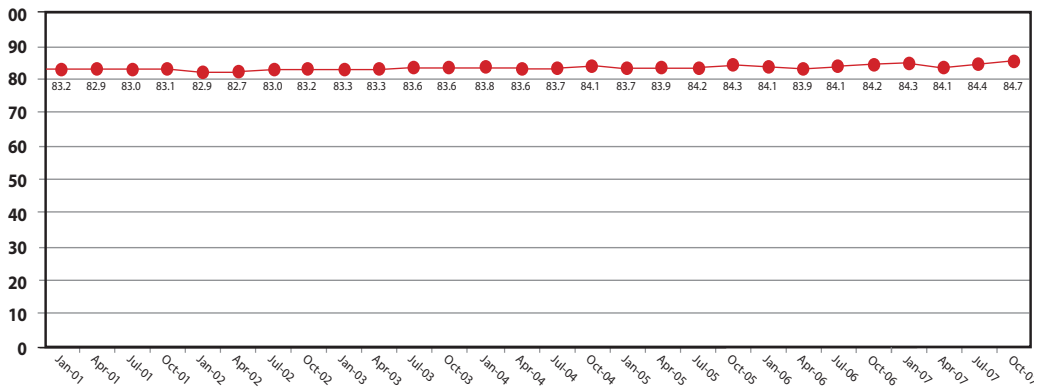
Once the steps can be identified, we can then require everyone to learn those steps and behaviors ensuring that we will then have great outcomes. Makes sense, right? Not exactly, because the research shows that:

1. **The best do not all do it the same way,**
2. **Actually the best achieve the same outcomes using very different means,**
3. **Some behaviors and steps can be learned, yet others prove very difficult to learn[6], thus**
4. **We need to legislate the outcomes not the steps.**

With this new view in mind, we must now embrace a new reality – steps can only be achieved by forcing different behaviors, but great outcomes can be created by the identification of "best systems" built around the achievement of the desired result. According to Donald M. Berwick, MD, CEO of The Institute for Healthcare Improvement (paraphrasing quality guru W. Edwards Deming), in a healthcare organization "The problems come from poor systems … not bad people." For all healthcare leaders, we must now embrace the best systems approach – not best practices!

The patient satisfaction areas we have been measuring and thus valuing have focused upon those variables most easy to measure (steps) – and then do something about. An example of this would be the staple questions around quality of food (which has been found to be the lowest predictor of overall satisfaction[7]), parking, frequency of bathroom cleaning, time in which the call button was answered, etc.

GRAPHIC C – National Patient Satisfaction Scores



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While some may view these as somewhat important, upon second look, they are all variables that are easy to point to but only get noticed by the patient/family when they are absent, do not occur or are poorly delivered.

The emotional world of the patient is not addressed by the HCAHPS® items. Yes, they (emotions) are harder to measure and, yes, they do not always hold an immediate or definitive "fix." But the research is clear that the "emotional well-being" dimension of patient care is the strongest driver of overall satisfaction. The reason is simple; they are the outcomes of a highly personalized "touch" and interaction with a nurse or staff member.

Most healthcare professionals entered this field because of a deep-felt mission and passion to make a difference. Through this ardor, they are able to make great decisions and respond fluently to patient needs. Sadly, HCAHPS® sends a message that it is not the passion that matters, but instead, ensuring that the prescribed steps are carried out and that the patient can recall them when the survey arrives. The scripting of nurses has already begun – not to create excellence, but to comply with standards built around the prevention of weakness.

There can be a short-term approach to this issue (as mentioned in previous paragraph), or a transformative approach which will create the desired, sustainable results. Enlightened leaders I talk with see this issue clearly. Through this process, those already strong in creating great outcomes will be weakened temporarily.

But, those already struggling to go just beyond mediocrity will be cast even further into turmoil. Hospitals have two options:

Short-Term Strategy (Weakness Prevention):

- **Strong scripts to be memorized by frontline staff**
- **A highly visible checklist for all staff**
- **Follow-up to ensure that the patient was fully aware of step occurrence**
- **In-house TV channels and/or communication instructing patients' on how to fill the survey out**
- **Team members encouraged to "catch" those not complying**
- **All energy directed toward "mechanical" compliance**

Enlightened Strategy (Excellence Promotion):

- **Strategy to attract and retain the best talent for each position**
- **Ensuring that every employee has a trust-based relationship with their manager**
- **Hiring and promoting managers that care**
- **Developing designed systems to ensure high employee engagement**
- **Create culture (pride, passion and commitment) that is a competitive advantage**
- **Leadership with compelling vision**

Bottom line is this – if you don't preemptively (or at least simultaneously) emotionally engage your patients, employees, and physicians, the HCAHPS® survey will become an opportunistic chance to let one's disengagement be heard and felt. C

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