A Study of HCAHPS Best Practices in High Performing Critical Access Hospitals

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Overview

This resource shares HCAHPS best practices of high performing critical access hospitals (CAHs) identified through focus group discussions with 38 hospitals from across 17 states. The report includes:

- An overview of the HCAHPS survey
- Methodology for selection of high-performing CAHs and the focus group process
- Best practices summarized by HCAHPS topic
- A list of resources utilized by participating CAHs to improve HCAHPS performance
- Wish list of high performing CAHs for further improvement
- Information on use of the Small Hospital Improvement Program (SHIP) to support HCAHPs among focus group hospitals.

Key strategies for each HCAHPS topic reflect the best practices cited most frequently by focus group participants. Additional strategies are those that were discussed, but were identified by smaller numbers of participants.

Hospitals that participated in the focus groups ranged in average daily census from one to around 20. The selection process for hospitals, and focus group discussions were segmented by higher and lower volume CAHs to facilitate the identification of differences in best practices according to volume, and ensure inclusion of strategies across facilities with varying resources. Few differences in best practices between lower and higher volume CAHs were found, but the variations that were recognized are called out in the findings below.

Background

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a survey instrument developed by the Agency for Healthcare Research and Quality (AHRQ) in 2002 to measure hospital patient perceptions of care[1]. The survey has been required by the Centers for Medicare & Medicaid Services (CMS) for all Prospective Payment System (PPS) hospitals since 2007, and results have been publicly reported on Hospital Compare since 2008.

The HCAHPS survey has 32 questions. There are 25 questions divided into 11 topics that track and compare performance (the other seven questions relate to demographics and patient information). Of the 11 topics, seven are composites of two or three questions, including nurse communication, doctor communication, responsiveness of hospital staff, pain management, communication about medicines, discharge information, and care transition. Two of the topics are individual questions related to cleanliness and quietness of the hospital environment, and two of the topics are global questions related to overall rating of the hospital and willingness to recommend the hospital.

HCAHPS participation is currently not required by CMS for the 1,340 critical access hospitals (CAHs) in the United States[2]. However, 1,029 CAHs reported HCAHPS data for the Q1 – Q4 2015 reporting period (the time period used for this study). The Health Services Resources and Administration (HRSA) Federal Office of Rural Health Policy (FORHP) has included HCAHPS in the Medicare Beneficiary Quality Improvement Project (MBQIP), a quality improvement activity launched in 2011 under the Medicare Rural Hospital Flexibility (Flex) grant program. The goal of MBQIP is to expand the capacity of CAHs to participate in national quality improvement reporting programs and ultimately improve the quality of care by using the data to drive performance improvement. FORHP has established gradually increasing MBQIP reporting criteria for CAHs to be eligible to participate in

Flex funded activities, such as education, training, and support. Public reporting of HCAHPS data is also a requirement for participation in the FORHP funded Small Rural Hospital Improvement Project (SHIP) program, which provides small grants, administered by State Offices of Rural Health, to support rural hospitals with 49 beds or fewer in activities related to improving quality and value.

One barrier for the utility of HCAHPS for some CAHs is low patient volumes. The HCAHPS survey focuses on inpatient care and many CAHs have limited inpatient census. The survey process also excludes patients that are discharged to hospice, skilled nursing, or nursing home care which further reduces the number of patients who are surveyed each quarter. For hospitals that have at least 100 completed HCAHPs surveys in the most recent four quarters, CMS calculates and publishes an HCAHPS star rating composite on a five point scale, with five stars as the highest rating, and one star as the lowest. For the Q1 – Q4 2015 reporting period, 452 US critical access hospitals were eligible for star ratings, and 81 of them achieved the impressive five-star rating. All CAHs are strongly encouraged to participate in HCAHPS regardless of patient volume because the ability to compare performance with other hospitals based on a national reporting program is an important driver of performance improvement related to patient perception of care.

Method

Hospital Selection

Hospital selection for the study was based on achievement of a CMS star rating of five stars, however, hospitals with less than 100 completed surveys in one year are not assigned a star rating. An estimated association between the performance of CAHs with over 100 completed surveys that achieved a CMS five star rating and the performance of CAHs with less than 100 completed surveys was calculated utilizing the average of 11 topic-specific HCAHPS measures. CAHs with an average score greater than 77 percent were included in the selection process. A more detailed description of the hospital selection process is included in Appendix C.

The first two focus groups were conducted with 15 Minnesota CAHs (7 higher volume and 8 lower volume) as a pilot for the subsequent national focus group calls due to the familiarity of MN CAHs with the study team increasing the likeliness of response, and comfort with providing feedback for improvement. After the Minnesota focus group calls were completed, a random sample was drawn from the higher volume and lower volume CAH lists which were weighted increase the possibility of varied geographic representation. Invitations to participate in two-hour HCAHPS focus group conference calls were extended to 26 CAHs that achieved an HCAHPS five-star rating, and to 26 similarly-performing CAHs with less than 100 completed surveys. Ten lower volume and 13 higher volume CAHs from 17 states responded. Hospitals that participated in the focus groups ranged in average daily census from one to around 20.

Focus Group Process

Hospital representatives that responded to the invitation were given several options to choose from in terms of focus group times, and five additional focus group calls were conducted, two calls including 13 higher volume CAHs, and three calls involving 10 lower volume CAHs. The focus group questions followed the flow of HCAHPS questions and composites, starting with overall drivers of success and resources utilized, and ending with an HCAHPS wish list question and an inquiry into the use of Small Hospital Improvement Project funding to support HCAHPS. The list of questions is included in Appendix A. Questions were sent out beforehand to participants so they would have an opportunity to review and prepare their responses. Participants on the focus group conference calls were primarily

hospital quality staff, but several CEOs, CNOs, and nursing managers also participated. Focus groups were conducted in round robin format.

Higher and lower volume CAHs were invited to separate focus groups to enhance the comfort level and camaraderie of participants and to facilitate the identification of differences in best practices according to volume. However, few differences in best practices between the two groups were found, those few items that did stand out as a variance between higher and lower volume CAHs are called out in the findings below.

Data Notes:

- HCAHPS performance by topic is often communicated using the percentage of patients choosing the "top box", which is the most positive response to HCAHPS survey items, and this is the interpretation for HCAHPS scores reported in this document.
- The time period for HCAHPS comparisons below is quarter three of 2015 through quarter two of 2016 (Q3 2015 – Q2 2016) to reflect the most recently available performance. However, hospitals were chosen to participate based on data from calendar year 2015.

The following CAHs participated in the HCAHPS Focus Groups:

Lower volume CAHs

Alliance Health Madill, Madill, OK
Appleton Area Health Services, Appleton, MN
Beartooth Billings Clinic, Red Lodge, MT
Charles A. Dean Memorial Hospital, Greenville Junction, ME
Horn Memorial Hospital, Ida Grove, IA
Johnson Memorial Health Services, Dawson, MN
Mayo Clinic Health System St. James, St James, MN
Mercy Hospital Waldron, Waldron, AR
Munising Memorial Hospital, Munising, MI
North Shore Hospital, Grand Marais, MN
Power County Hospital District, American Falls, ID
Renville County Hospital & Clinics, Olivia, MN
Sanford Westbrook Medical Center, Westbrook, MN
Sanford Wheaton Medical Center, Wheaton, MN
Sheridan Memorial Hospital, Plentywood, MT
Shoshone Medical Center, Kellogg, ID
Sleepy Eye Medical Center, Sleepy Eye, MN
Spectrum Health Kelsey Hospital, Lakeview, MI

Higher volume CAHs

Abbeville Area Medical Center, Abbeville, SC
Avera Holy Family Hospital, Estherville, IA
Bigfork Valley Hospital, Bigfork, MN
Bronson LakeView Hospital, Paw Paw, MI
CentraCare Health Melrose, Melrose, MN
Central Valley Medical Center, Nephi, UT
Community Memorial Hospital, Hamilton, NY
CrossRidge Community Hospital, Wynne, AR
Glacial Ridge Health System, Glenwood, MN
Grant Regional Health Center, Lancaster, WI
Gunnison Valley Hospital, Gunnison, UT
H.B. Magruder Hospital, Port Clinton, OH
Lakewood Health System, Staples, MN
Marshall County Hospital, Benton, KY
Meeker Memorial Hospital, Litchfield, MN
Perry County Memorial Hospital, Tell City, IN
River's Edge Hospital and Clinic, St Peter, MN
Riverwood Healthcare Center, Aitkin, MN
UHHS Conneaut Medical Center, Conneaut, OH
Yoakum Community Hospital, Yoakum, TX

In aggregate, hospitals participating in the HCAHPS Best Practices Focus Groups performed above the national average in every HCAHPS topic.

HCAHPS Topic or Composite	Focus Group Average	National Average
Response Rate	38%	29%
Overall Rating of Hospital	82%	72%
Willingness to Recommend this Hospital	81%	72%
Communication with Nurses	88%	80%
Communication with Doctors	88%	82%
Responsiveness of Hospital Staff	82%	69%
Pain Management	88%	71%
Communication about Medicines	72%	65%
Cleanliness of Hospital Environment	84%	74%
Quietness of Hospital Environment	72%	63%
Discharge Information	89%	87%
Care Transition	61%	52%

Focus Group Findings

HCAHPS Response Rates

HCAHPS surveys can be administered in four ways, or modes: mail only, telephone only, mixed (mail followed by telephone), and interactive voice response (IVR)[3]. Studies have indicated that the highest HCAHPS response rates are generated with mixed mode, followed by mail only and telephone only[4]. The national HCAHPS response rate average is 29 percent[5]. Survey response rates of the participating hospitals varied from 18 to 76 percent. Most of the participating hospitals administer mailed surveys only (68%), followed by telephone only (18%), with no appreciable differences between the lower volume and higher volume hospital groups. These numbers are not far from a representation of national mode data, which reflects 60 percent mailed surveys and 40 percent telephone surveys[6]. The average response rate for the focus group hospitals is 38 percent, with a median of 37 percent. Only two hospitals in the upper half of the median utilize phone surveys compared to six hospitals in the lower half, aligning with studies suggesting mailed HCAHPS surveys render a higher response rate. Only one participating CAH utilizes mixed mode, generating a 39 percent response rate.

The HCAHPS Quality Assurance Guidelines[6] provide guidance as to what hospitals can and cannot do to prevent bias when they are notifying patients of the HCAHPS survey and it is important that hospitals be familiar with them, especially when using any forms of scripting that might sway patient responses or incentives to complete surveys. Participants of the HCAHPS focus groups described interventions employed to enhance response rates. The most common intervention was to simply notify patients to expect the survey. This was most often done verbally at the time of discharge. Nine of the participants also provided a flyer or brochure to announce the survey at the time of discharge and six described more broad HCAHPS awareness promotions

such as posters, the hospital website, or announcements on waiting room television screens. Two of the hospitals suggested specific scripts for notification of the survey.

Another frequently described intervention is to ask patients about their satisfaction with their hospital stay during some type of patient rounding, such as leader rounds, discharge planning rounds, or interdisciplinary team (IDT) rounding and remind patients to complete and return the survey, assuring patients that the information would be acted on to improve hospital care. Ten of the participants follow up by reminding patients to complete the survey during discharge phone calls. Other, less common interventions described were providing vendors with patient lists on a weekly or biweekly basis, quarterly response rate reviews, and nothing at all is done to enhance response rates in two of the focus group hospitals.

The hospitals with the top five response rates utilize a vendor that mails HCAHPS surveys. All but one of them notify patients of the surveys verbally and with posters or brochures, and the hospitals with the top two highest response rates specify that they provide a list of patients to their HCAHPS vendor twice a month to improve the timeliness of the surveys.

Improving Response Rate Strategies:

- Tell patients about the survey
  - Often at discharge
  - Flyer or brochure
  - Posters, hospital website, announcements on waiting room television screens
- Remind patients during discharge phone calls
- Leader rounding – assess patient satisfaction during stay and/or remind of survey
- Weekly or biweekly patient lists to vendors

Overall HCAHPS Success

Focus group participants were asked "What are the one or two most important practices or behaviors you think drive your overall HCAHPS success?" in order to capture interventions likely to influence patient perceptions of overall hospital ratings and willingness to recommend the hospital to others. The top three responses involved practices specifically related to 1) behavior of hospital leaders, 2) HCAHPS data awareness, and 3) intentional efforts to improve the culture of the hospital. Staff engagement followed, at times with a rather blurred margin when differentiating between culture and staff engagement. For example, the term "ownership" was categorized in the context of culture, but is also related to staff engagement.

Participants from hospitals with lower volumes were more likely to attribute HCAHPS success to their "small town, family atmosphere" (9:1), without being able to readily articulate global HCAHPS improvement practices. The lower volume CAHs do score a little higher on overall rating than the higher volume CAHs at 83 percent compared to 81 percent, while the national average overall hospital rating is 72 percent. Connections were made with leader behaviors or attributes of the hospital culture in the lower volume CAHs, however, during subsequent topic specific discussions such as responsiveness or communication. Staff education on HCAHPS surveys, performance tied to evaluations or compensation, hiring staff to fit behavioral expectations, teamwork, and adequate staffing ratios were also given as contributing factors to overall HCAHPS performance.

Some practices described in response to this global question were also a common response to a specific HCAHPS question or composite. For example, hourly rounding was mentioned five times as a driver of

overall HCAHPS success, but was the most frequent response during the discussion on responsiveness of hospital staff and is included in that section of this document.

Culture

Culture is defined as the norms, attitudes and beliefs held among a group of people[7]. Exactly half of the focus group participants attributed their hospital's HCAHPS success to the culture of the organization, using words such as "embedded" or "unified" and "pride" to indicate an intentional and global expectation for positive attitudes and behavior toward patients and toward each other. Phrases to capture the cultural expectations, such as "This matters to us" or "Everything in our power" were adopted by several of the participating hospitals to serve as a true north, or guiding behavioral principle. Others described the adoption of formal behavioral standards with varying degrees of hardwiring into the hiring and evaluation process. Hiring to fit is one method to sustain culture change, where the attitudes and personalities of potential employees are evaluated for alignment with the behavioral expectations upheld in the organization. Woven into descriptions of organizational culture shifts were the ideas of teamwork, accountability, and consistency of expectations for leaders, providers, and employees.

Leadership Practices

It is well established that leaders shape the culture of an organization, and focus group participants confirmed this notion with 58 percent of participants attributing their HCAHPS success to leadership behaviors. Several narrowed focus specifically to behaviors of the CEO. Tangible culture shaping leader behaviors were offered, including leader rounding with staff and patients, leadership development opportunities, and CEO visibility and engagement.

Leader rounding with staff can take many forms, but the key concept is an intentional, predictable and ongoing connection of leaders at all levels with providers, staff or supervisors to establish relationships, affirm good work, allow an opportunity for requests, suggestions and concerns to be shared, and to harvest opportunities to recognize and reward employees. Specific quality topics such as HCAHPS may be included in these conversations. Some participating hospital leaders accomplish leader rounding through administrative huddles on units, some through individual meetings with staff and providers, and others with regularly scheduled walk-rounds. Leader rounding in some of the hospitals is incorporated into evaluations to promote consistency. Participants often connected leader rounding with staff satisfaction.

Leader rounding with patients also looks a little different from hospital to hospital, but the idea is for a person of authority, such as the CEO, or a leader in nursing, environmental, dietary, customer experience, or others to visit patients to assess their satisfaction and correct any points of concern while they are still in the hospital. Specific questions might be asked to align with a pertinent quality improvement topic such as hand hygiene, or an HCAHPS question such as quietness of the hospital environment. Some of the leaders also ask patients if there are any hospital staff or providers they would like to recognize, and then send hand written thank you notes to the individuals and may recognize them at a meeting or event. Forty percent of the hospitals represented in the focus groups have leaders that round on patients regularly.

Leadership development opportunities are an integral foundation of the leadership behaviors in critical access hospitals with outstanding HCAHPS performance. Education is provided to new leaders initially and regularly thereafter to equip them in areas such as behavioral intelligence, teambuilding, and justice and accountability. Suggested resources for leadership development will be provided in the next section of this document.

CEO visibility was also described as an important leadership behavior by several of the focus group participants. This visibility involved being on patient care units often, at all hours, talking to staff, patients,

families. One such CEO presented the hospital's behavioral standards to new employees, stamping a note of authority and expectation to the standards. Another CEO visibility idea involves breaking down barriers to excellence, supporting quality improvement efforts 100 percent and making sure resources are available to accomplish quality and patient satisfaction goals.

On leadership:

"Our CEO is 100 percent involved in everything. She is out on the floor, at all hours, in all areas, asking questions, talking to employees, patients and families"

HCAHPS Data Feedback

Over half of the participants across both the higher volume and lower volume groups of CAHs emphasized the importance of sharing HCAHPS data with staff and providers often and in many ways. Data feedback was also brought up as a near-top improvement strategy for almost every HCAHPS question or composite, a confirmation to the crucial nature of scorekeeping in building momentum around performance improvement efforts. Sharing the data and talking about it generates enthusiasm around improvement and lets staff and providers know that leaders are paying attention to progress and that it is important. HCAHPS data is shared in dashboards, at department, provider, leadership and board meetings, on bulletin boards in hallways, in physician dictation areas, cafeterias and nurses stations. It was emphasized often that the data sharing was most effective when presented with opportunities for discussion and brainstorming. This might occur at meetings, during daily huddles in patient care units, or during leader rounding with groups of staff.

On HCAHPS data feedback:

"Everyone knows what areas we are trending up and down in, and that we are paying attention to the results"

Staff Engagement

"Happy staff make happy patients" is the prevailing message when it comes to staff engagement as a driver of HCAHPS success. Based on focus group comments, it appears that although staff appreciate celebrations of performance improvement progress, rewards and recognition, a more important component of staff engagement and satisfaction cited by almost 40 percent of participants, is to be consistently and intentionally included in decision making, action planning and problem solving for their departments. Asking staff to solve problems or improve care and removing barriers to implementation of their ideas is perceived as evidence of being valued. This strategy is a double win in that participants indicated it often creates more effective solutions than when the people closest to the problem are not consulted. HCAHPS results tied to evaluations and compensation, however, were described as drivers of success in several of the lower volume CAHs. Staffing ratios were also mentioned by three of the higher volume focus group participants, which likely contributes to both staff and patient satisfaction.

On staff engagement potential:

"We have strong front line staff investment. They own it. HCAHPS is on every meeting agenda. Performance is reviewed frequently with discussion around what can be done to improve. This matters to us. This matters to all of us."

Overall HCAHPS Success Key Strategies

- Culture
  - Standards of behavior
  - Teamwork
  - Accountability
- Leadership practices
  - Leader visibility
  - Leadership development
  - Leader rounding with staff
- HCAHPS Data Feedback
  - Share the data with staff and providers often
  - Provide opportunities for discussion and suggestions
  - Foster friendly competition
- Staff Engagement
  - Consistent, intentional involvement in decision making and problem solving
  - Celebrations of performance improvement progress, rewards and recognition

Additional Strategies

- Evaluations or pay for performance tied to HCAHPs
- Hire for fit
- Dedicated staff or committee
- Staffing ratios

Communication with Nurses

Patient whiteboards are the most frequently cited impactful intervention related to nursing communication, followed by nurse bedside shift report, hourly rounding (discussed under "responsiveness of hospital staff"), scripting, and daily huddles. Other interventions not already addressed during overall HCAHPS performance are nurses rounding with physicians, multidisciplinary rounding, and mandatory scrub colors.

Patient Whiteboards

Patient whiteboards, a tool utilized primarily by nurses to share information with patients and other members of the health care team, are thought to improve nursing communication in nearly three quarters of the participating critical access hospitals. Information included on whiteboards varies from hospital to hospital, but typically includes names of the nurse and physician on duty, treatment goals, activity restrictions, and diet. More detailed versions might add time a patient's next pain medication is due, possible discharge date, services needed at home, and a place for patients to write questions for the health care team. Some participants noted that whiteboards must be used faithfully to improve nursing communication performance, and observational audits are done to make sure whiteboards are being utilized. Nurses are more likely to use whiteboards when they consider them a way to communicate with patients rather than another task that must be completed. As one participant phrased it "You have to teach to the why". Asking nurses to design the layout and content of whiteboards also increases the likelihood they will be an effective communication tool.

Nurse Bedside Shift Report

In AHRQ's Guide to Patient and Family Engagement in Hospital Quality and Safety[8], nurse bedside shift report is included as a key strategy to "help ensure the safe handoff of care between nurses by involving the

patient and family". This strategy is also described as a driver of nursing communication success in well over half of the HCAHPS focus group hospitals, overcoming varying degrees of initial resistance to transform the longstanding tradition of a more informal nurse to nurse shift report. In one hospital, the successful change was suggested and initiated by natural nurse leaders, reinforcing the effectiveness of staff engagement and empowerment. That hospital indicated nursing communication HCAHPS score improvements within one quarter. Some hospital leaders bolstered the initial change with observational audits, and some utilize forms built into their electronic health record (EHR) to add structure to the handoff. One participant said that patients are asked if they would like family members or visitors to leave the room during bedside shift report to avoid privacy concerns. Many of the CAHs surveyed said patients appreciate the opportunity to hear and participate in the handoff of their care from one nurse to another.

On bedside shift report:

"Bedside report is getting better as time goes by. Our nurses didn't like it in the beginning, but our patients like it and our scores have improved"

Scripting

Five of the participating CAHs referenced types of scripting in relation to nursing communication, but the concept came up as an overall HCAHPS driver of success as well as in response to other HCAHPS composites and questions. Scripting provides structure to help nurses and other hospital personnel to communicate effectively and consistently with patients. AIDET, a popular Studer Group tool, was referenced most often, and stands for "Acknowledge, Introduce, Duration, Explanation, Thank you". AIDET is said to help guide staff in all conversations with patients, and in some hospitals is taught to all staff and new employees.

Daily Huddles

Daily huddles are another HCAHPS strategy that came up as an overall HCAHPS success strategy as well as in more than one topic of the HCAHPS survey discussion. Huddles typically take place at the same time every day on patient care units, aka, "the floor", and involve multiple disciplines, such as a charge nurse, staff nurses and/or a utilization review nurse, social services, physician, pharmacist, infection preventionist, physical therapist and others. They might also be called daily briefings or multidisciplinary meetings, and vary in terms of structure. A patient by patient approach might be taken to talk about safety concerns, a 24 hour look-back to talk about any patient incidents or situations and how care might be improved, or a conversation that includes present patient census, patient safety issues, and staffing. Patient satisfaction might be woven into the structure of the daily huddles, and in some hospitals, the huddles are immediately followed by patient rounds involving two or more disciplines, such as nursing and pharmacy. Whatever the structure, huddles allow staff an opportunity to verbalize safety concerns and suggest remedies, and foster heightened staff engagement and ownership of patient safety issues. The connection to nursing communication is the consistent messaging to patients provided by the entire healthcare team as a result of an intentional opportunity for all disciplines to connect and discuss patient care.

Communication with Nurses Key Strategies

- Patient whiteboards
- Nurse bedside shift report
- Data feedback and discussion
- Scripting
- Daily Huddles

Additional Strategies
- Hourly rounding
- Leader rounding with patients
- Nurse engagement/ownership
- Mandatory scrub colors

Communication with Physicians

Not all of the participating HCAHPS Focus Group CAH representatives were able to differentiate between nursing and physician communication practices. Many of the strategies mentioned are echoed nursing communication practices, such as patient whiteboards and daily huddles. The most common driver associated with HCAHPS physician communication success is frequent data feedback on the measure and the friendly competition that ensues between providers and between physicians and nurses.

A practice that came up in both nursing and physician communication, but more frequently related to physician communication, is that of nurses accompanying physicians on rounds, which supports the consistent messaging idea described in daily huddles. Several hospitals provide chairs or stools in patient rooms to encourage physicians to sit down during patient rounds and convey a less rushed and more attentive feel to physician communication. Note pads and pens at the patient bedside provide a consistent place for patients to write questions down between physician visits for review during rounds. Enhanced hospital/physician rapport, an engaged and energetic CMO, and increased physician accessibility associated with hospitalist programs are other attributes associated with physician communication. Finally, the practice of nurses "managing up" physicians came up, which essentially translates to nurses softening, compensating for, or preparing patients for the behavior of physicians that have not yet transcended the bedside manner learning curve.

Communication with Physicians Strategies
- Data feedback, friendly competition
- Nurses accompany physicians on rounds
- Sit down during patient visits
- Note pads and pens at bedside for patient questions
- Engaged physician leaders
- Hospitalist programs

Responsiveness of Hospital Staff

Responsiveness of hospital staff essentially captures how satisfied patients are with the amount of time it takes hospital staff to respond to requests for help. Among focus group participants, lower volume CAHs outperformed higher volume CAHs in the by couple of percentage points at 81 and 83 percent respectively, aligning with lower volume participant suggestions that lower volume CAHs might do better on HCAHPS based simply on more staff time per patient.

Hourly rounding is by far the most common practice offered as an important driver of patient satisfaction related to hospital staff responsiveness in both lower and higher volume critical access hospitals. Second is standard that everyone wearing a hospital badge is responsible to answer call lights or patient alarms, often

referred to as the "no pass zone." Use of technological devices is third, particularly identified in higher volume CAHs. Other practices tied to hospital staff responsiveness are staff engagement, escorting patients, family members, and visitors to their destinations rather than verbally directing them, consistently asking patients if there is anything else they need before leaving the room, and increasing the presence of certified nursing assistants (CNAs) or patient care technicians (PCTs). Responses in this category more than others also hint at the culture of the organization in terms of patient centeredness and customer service staff education.

Hourly Rounding

Hourly rounding refers to purposeful patient visits conducted by licensed or unlicensed nursing staff to check on the status of patients and take care of personal needs, in effect, before the patient has to push a call light. Almost 65 percent of the participating critical access hospitals attribute hourly rounding to patient satisfaction related to responsiveness of hospital staff. Several participants add that hourly rounding ultimately contributes to staff satisfaction as well due to a subsequent decrease in patient call light use by patients. The most frequently described hourly rounding model involves licensed nurses alternating with CNAs or PCTs, which helps alleviate nursing resource burden, and several participants stated that rounding is decreased to every two hours during the night shift. Hourly rounds are often structured around what is commonly known as the "4 P's – pain, potty, position, and personal effects or possessions", and usually end with staff asking patients "Is there anything I can get you before I go?" Documentation of hourly rounds may be accomplished using EHR templates, on paper forms posted on patient room doors, or on patient whiteboards.

No Pass Zone

No Pass Zone is a concept that originated with the Hospital Quality Institute where all hospital employees are expected to stop and respond to call lights and patient alarms rather than to pass by. Almost half of the focus group participants indicate that similar expectations are promoted in their hospitals to improve HCAHPS performance related to responsiveness, although not all of them used the "No Pass Zone" terminology. In one hospital the expectation is known as "Everyone's a Caregiver". Patient care requests for non-clinical support such as a beverage or tissue are taken care of immediately by any employee, including the CEO, while requests of a clinical nature are handed off to nursing personnel. Overall, comments related to No Pass Zone are positive with an added quipped perk of less traffic in patient care areas due to avoidance by staff afraid to enter patient rooms.

On No Pass Zone:

"We implemented No Pass Zone, for call lights and also alarms to tackle alarm fatigue. If you're on the floor, no matter what you do, when a call light goes off, no one walks by. At first some staff were nervous, but it's getting better with practice"

Technological Devices

Technological devices thought to improve response times by hospital staff involve call light system characteristics and nursing communication devices, some of which were connected. Call light systems described include those allowing a patient to specify whether a nurse or CNA is being requested, or to specify the reason the call light is being activated, such as for a beverage, toileting assistance, or a medication. Bed alarms can be integrated into call light systems, flashing different colors outside the room and sounding different alarms. Other systems trigger an alarm at a desk manned by a secretary or a CNA and requests can be forwarded to nursing staff using a portable phone. Two way speakers are installed in

patient bathrooms so patients can be reminded not to get up alone, but to wait for someone to help. Some call light systems also accommodate response timeliness auditing. Nursing communication devices ranged from old school pagers to handheld phones integrated with the call light system to hands-free ear pieces that allow nurses to communication with patients and with other nurses on different channels.

Responsiveness of Hospital Staff Key Strategies

- Culture
  - Standards of behavior
- Hourly Rounding
  - May alternate RNs with CNAs
  - Four Ps (pain, potty, position, and personal effects)
  - Documented
- No Pass Zone
  - Everyone answers call lights
  - Non-clinical support can be provided by anyone
- Technological devices
  - Call light systems
  - Two way speakers
  - Nurse communication devices

Additional Strategies

- Staff engagement
- Escorting patients, family members, and visitors
- Scripting: "Can I get you anything before I go?"
- Certified nursing assistants (CNAs) or patient care technicians (PCTs)
- Patient centeredness and customer service staff education

Pain Management

Amidst the complexity of pain medication prescribing during an ongoing opioid abuse epidemic, patients are given an opportunity to evaluate how well hospitals do in managing their pain on HCAHPS surveys. Several of the participants admitted that pain management is a difficult topic due to opioid abuse, but the overall atmosphere of the discussions were positive and proactive.

CMS has acknowledged the complexity of this issue by removing the pain management dimension from the scoring formula used in the Hospital Value-Based Purchasing Program (Hospital VBP) for Prospective Payment System (PPS) hospitals. Changes to the pain management questions on the survey are being explored, but in the meantime, the pain management questions remain on the HCAHPS Survey and the pain management measure will continue to be publicly reported on Hospital Compare.

The most frequent pain management interventions described by focus group participants are the use of patient whiteboards to document pain related information, discussing expectations and goals with patients, alternative therapies, and automated pain re-assessment reminders. Specific pain management quality improvement work involving chart audits on pain assessments and reassessments after pain treatments with feedback to nursing staff is boosting HCAHPS performance in six of the participating CAHs. Other promising strategies include intravenous cannula insertion skill development, specific surgical practices

including locally administered pain medication during surgery, and staffing adjustments based on surgical volume to facilitate an expected ten minute pain medication response time.

Patient Whiteboards

Half of the focus group participants state that using white boards to help caregivers to remember to talk about and address pain, and to remind patients what is being done about their pain is a winning strategy in boosting patient satisfaction regarding pain management. There is some variation between hospitals as to exactly what is documented on the boards, but the general principle is the same. Pain scales, pain goals, time of "last given" or "next due" medication dose, and medication and alternative treatments prescribed are some of the pain-related points included on patient white boards.

Setting Expectations and Goals

Another common strategy identified as a driver of patient satisfaction regarding pain management is that of expectation setting. Patient education is provided by a physician or nurse, and at times in a prehospital setting for scheduled hospitalizations, regarding the type of and severity of pain patients might expect in relation to the hospitalization procedure or event, and available treatment options. Clarification that "pain management is not always pain free" helps prepare patients for some pain, and reduce dissatisfaction. Thorough assessments of baseline pain and establishing the level of pain that is acceptable to patients is also important. In one hospital, pain is discussed with each patient during multidisciplinary rounds, including pain goals and treatment options. In another, a pain plan is established with each patient at the beginning of every shift including the pain goal, and whether the patient would like the nurse to check in regarding pain regularly or wait for the patient to call.

Alternative Therapies

Alternative pain therapies are more frequently related as drivers of pain satisfaction regarding pain in lower volume critical access hospital focus groups. Therapies suggested include those involving heat or cold such as warm compresses, towels, blankets, and ice packs, as well as positioning, relaxing music, aroma therapy, distraction activities, pet therapy and back rubs or massage. One hospital provides a comfort menu with several alternative therapy options for patients to choose from. Several participants specified that nurses use the phrase "this is to help with your pain" when administering alternative therapies to make sure patients understand the connection between the therapy and pain management.

On pain management and alternative therapies:

"Nurses are taught to use the words 'Let's see if this will help your pain'"

Automated Pain Reassessment Reminders

Electronic reminders to check on patients for effectiveness of pain treatments are available in some call light systems and in versions of electronic health record (EHR) systems. In one hospital, a button can be pushed outside of a patient room that sets an alarm in one hour to remind nurses to go back and check on the patient. Most of the automated reminders described, however, are built into the EHR system. In one system, an initial pain scale value has to be entered and the administering nurse's badge scanned when pain medications are scanned for administration. Fifty minutes after the medication is given, an alarm reminds the nurse to reassess the patient, enter a follow up pain scale value and rescan his or her badge. The alarm can be delayed for up to five minutes one time, followed by a hard stop that prevents further documentation until the follow up assessment is completed. Other EHR system reminders are softer, simply providing alerts when reassessments are due, a screen color change, or "a task fires and continues to fire until addressed".

Pain Management Key Strategies

- Patient whiteboards
- Setting goals and expectations
- Alternative therapies
- Automated pain assessment reminders

Additional Strategies

- EHR or call system reminders
- Pain management as a nursing quality improvement priority
- Frequent pain assessments
- Hourly rounding
- IV insertion skill development
- Locally administered pain medication during surgery
- Ten minute turnaround time for pain medications

Communication about Medications

Focus group participants most commonly attribute success in this dimension to patient education provided by a pharmacist, closely followed by variations of written patient education on medications. Discharge phone calls, in some hospitals conducted by a pharmacist, medication reconciliation, and using key words such as "education on your medications" and "side effects of your medications" are other practices that are thought to drive HCAHPS communication about medication scores. One hospital offers medication organizers to patients when they are discharged.

Pharmacist Visits

Not surprisingly, the majority of the focus group CAHs with patient education being provided by pharmacists are from the higher volume hospital group. Different approaches to pharmacist visits are taken. Some pharmacists visit every patient at least one time while they are hospitalized to essentially conduct a medication reconciliation review on all of the patient's medications, while others round on all patients every day to talk about any new medications and answer questions. Some pharmacists visit patients to provide education only when new medications are ordered and may return to review all medications on discharge, and some routinely visit all patients at the time of discharge. Another model involves pharmacy visits only for certain medications such as insulin or Coumadin. Pharmacist involvement in medication reconciliation in partnership with nurses and physicians is an important medication safety practice. Additionally, pharmacist involvement in interdisciplinary rounding and quality improvement, medical staff and other committees and projects supports medication safety. CAH leaders without the resources to accommodate medication teaching by pharmacists should not lose heart, however, because there is only a very small (<1%) difference in average scores of the two groups, suggesting that other disciplines can also do a fine job of communicating about medications.

On pharmacist visits:

"We recently instituted having our pharmacist visit patients about medications and side effects. Nurses used to do this, but the fresh face has helped scores immensely"

Patient Education

Providing patient education is identified as an important practice related to HCAHPS medication communication scores by over half of the focus group participants, with several important details. Most of the time written information is provided on new medications and reviewed right before the new medication is given for the first time, so that patients can hear and read about it before they take it. Medication handouts typically include at the very least, what the medication is for and common side effects. In some of the participating CAHs, EHR hard stops are in place that do not allow further documentation after a new medication is scanned until patient handouts are printed and the nurse documents that patient education is completed. Several participants specified that patient education on medications provided at their hospital is easy to read, common language, very simple, or written at a second grade level, and the Teach-Back method for providing patient education in conjunction with written materials was specified by three participants. Teach back involves requesting that patients repeat back to the health care professional what has been taught. In one hospital, an evening nurse visits all inpatients to provide or reinforce medication teaching, and in several others, medication education is reviewed by a nurse, pharmacist, or discharge planner at the time of discharge. Another helpful practice identified is for nurses to specify in simple terms what medications are for every time they are given, such as "for your heart" or "for your stomach".

On communication about medications:

"For new medications, nurses have to bring up education to read to the patient when she is giving the med. It's a hard stop. She can't go on until she does that"

Communication about Medications Key Strategies

- Culture
  - Standards of behavior
- Pharmacist Visits
- Patient Education
  - Easy to read
  - Teach back
- Key Words

Additional Strategies

- Discharge phone calls
- Medication reconciliation
- Bar code scanning
- Medication organizers

Cleanliness of Hospital Environment

There was not as much synergy around any particular interventions for this HCAHPS topic, and many of the focus group comments were directed at the merits of the environmental services department. Two common ideas involved room cleanliness auditing or rounds with varying degrees of formality, and notes on cards or whiteboards drawing patient and family attention to cleaning services performed before or during their hospital stay.

Several of the hospitals established clear expectations that everyone is responsible for environmental cleanliness, and five participants described patient room cleaning schedules that include a thorough cleaning in the morning and a brief evening check in to empty trash cans and "tidy up", which may be performed by a nurse, a CNA, a volunteer or environmental services staff. Global strategies offered in the context of environmental cleanliness that have already been touched on are staff engagement as an integral part of the health care team, staff education, and sharing HCAHPS data regularly with staff. Customer service oriented interventions include encouraging environmental services staff to take time to visit with patients and to check with patients to see if there is anything they need before they leave the room. Facilitating access to environmental services staff using electronic request forms or two way radios is also attributed to cleanliness success.

Cleanliness Auditing or Rounding

There is considerable variation across the focus group hospitals when it comes to the "how and who" of monitoring room cleanliness. Beginning with the most sophisticated method, three of the critical access hospital infection preventionists utilize adenosine triphosphate (ATP) monitoring systems on patient rooms that have been cleaned. ATP monitoring detects organic material on surfaces. Glow gel monitoring is a less expensive and therefore more frequently utilized method to monitor the cleanliness of surfaces. Infection preventionists or environmental services managers apply the gel to designated high touch surfaces before rooms are cleaned, and return afterwards with a glow light to monitor surfaces for the removal of glow gel during cleaning. In some hospitals environmental services managers or infection prevention perform visual cleanliness monitoring. The frequency of the various types of monitoring ranges from 100 percent of rooms audited to monthly random audits to spot checks every six months or annually, and individual and/or aggregate feedback is provided to environmental services staff to guide performance improvement efforts.

Another approach to cleanliness monitoring utilized in several of the participating hospitals is to incorporate cleanliness and environmental appearance into some type of existing rounding process, such as environmental safety rounds, hourly rounds by nursing staff or leader rounds to patients. In one hospital the employees performing monthly environmental rounds are alternated to give a fresh perspective and "avoid missing the forest for the trees". Another hospital is proactively soliciting patient input into environmental care by taking the Patient and Family Advisory Council (PFAC) to different areas of the hospital every month to offer improvement suggestions, which have led to positive changes.

Notices of Cleaning Services

HCAHPS is about patient perception, and around half of the focus group hospital participants describe efforts to heighten patient and family awareness to the cleaning that is being done in their rooms before and during their stay. Tent cards are left in newly prepared rooms, whiteboard notes written by environmental services staff, and calling cards are left on bedside tables. Names of staff, the date and time of cleaning and a way to contact environmental services might be included. In one hospital, a creative touch is added by leaving a card tucked in a towel animal on the patient's bedside table.

On cleanliness of hospital environment:

"All staff members are responsible to scan a patients room and make sure things are picked up and the garbage is empty before they leave"

Cleanliness of Hospital Environment Key Strategies

- Cleanliness auditing
- Notices of cleaning services
- Cleaning schedules

Additional Strategies

- Everyone is responsible for cleanliness
- Environmental services staff engagement as an integral part of the health care team
- Environmental services staff education on cleaning
- Environmental services staff education on customer service
- Access to environmental services staff via two-way radios or electronic requests
- Patient and Family Advisory Council (PFAC) environmental assessments

Quietness of Hospital Environment

The need for rest in order to heal is a paradoxical idea given the bustling activity found in most hospitals. The HCAHPS question on quietness of the hospital environment challenges hospital leaders to find solutions to relieve that paradoxical tension, and many of the critical access hospitals participating in the focus groups have risen admiringly to the challenge. However, among focus group participants, lower volume CAHs do a little better on this measure at 73 percent compared to 71 percent in the CAHs with higher patient volumes. Heightened awareness through ongoing and frequent reminders was most regularly cited as a strategy. Staff reminders are provided in meetings, newsletters, e-mails, and in real time when voices are carrying or groups of people are congregating in hallways near patient rooms. Technological devices utilized to monitor and draw staff attention to noise levels have been used in seven of the focus group hospitals with mixed results. Most participants agreed that the usefulness of these devices is, at best, short term to heighten awareness to noise levels.

An array of additional quietness interventions have been implemented in the participating hospitals. Structural changes such as enclosures around nurse's stations and dictation areas, and padded or carpeted floors were made in several of the hospitals with positive results. Nurse's stations are decentralized in a couple of the hospitals, and participants cautioned that new noise problems might arise as nurses have to raise their voices to communicate with each other. Communication devices were suggested as interventions to decrease hospital noise by two of the focus group participants. Other environmental interventions include monitoring and eliminating noise from doors, carts and equipment whenever possible. Several of the hospitals have designated quiet times and cleaning or maintenance activities are avoided during these times. Lights are dimmed in the evenings in many of the hospitals, and four of the participants mentioned "hush" or "shhhh" campaigns that involve posters and cards to remind staff and visitors to be quiet. White noise machines and soothing music on a television "care channel" have been found to be helpful, and comfort items such as ear plugs and pillows are offered in several of the hospitals.

On quietness of hospital environment:

"We instituted a "Shhhh" campaign. Staff took pictures in groups, and with their families and put the pictures all around hospital. It was a fun campaign and patients enjoyed it"

Quietness of Hospital Environment Strategies

- Awareness/Reminders
- Structural Changes
- Environmental Noise Control

Additional Strategies

- Quiet times
- Keep patient doors closed
- White noise
- Soothing music on care channels
- Earplugs or pillows

Discharge Information

Generally, hospitals receive fairly high patient ratings on the HCAHPS topic of discharge information. The composite is based on two survey instrument questions with yes or no responses, rather than the "top box" scoring method utilized for other topics:

- "During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?"
- "During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?"

Additional survey detail on this topic is provided in an attempt to shed light on the considerable disparity in hospital performance between the topics of discharge information and care transitions, which, by nature of the titles, might be expected to be similar. Also, the interventions provided by the focus group hospitals are similar for both topics. For discharge information, the most common interventions are categorized broadly into three areas – discharge planning, discharge education, and discharge follow up, summarized in order of flow rather than by number of responses. There were no appreciable differences in the nature of discharge information strategies between the lower and higher volume focus groups.

Discharge Planning

During the HCAHPS focus group discussions on discharge information, the point was made several times that successful discharge planning for each patient must start at the time of admission. This is accomplished in a variety of ways in the participating hospitals. Discharge planning may be led by a social worker, discharge planning nurse, case manager, or a combination of all three, often in conjunction with a charge nurse and physician. Ten of the participants specified that dedicated time is allocated for this role, which fosters continuity and consistency of discharge planning activities. In at least one hospital, the EHR contains an automated discharge planning referral. The discharge planning leader begins rounding with patients early in their stay, in some hospitals accompanied by an interdisciplinary team. Planning begins with a baseline assessment of home needs and services, with the general goal of making sure patient needs will be met when they are discharged. An alternative model is for the discharge planning leader to round individually with patients and to conduct an interdisciplinary huddle daily to discuss patient discharge needs. A whiteboard in a "nursing care room" with a listing of all patients, their provider, complaint, discharge date and patient needs is maintained in one hospital to provide readily available discharge planning information to nurses when discharge planning services are not available. In some hospitals, discharge planners also are

assigned the task of providing discharge planning education to nursing staff, and in one hospital, a nurse obtaining her Master's degree took on this role and developed a new discharge packet as a Capstone project.

Discharge Education

Around half of the participating CAH representatives point to some type of discharge education as a strong driver of high HCAHPS survey discharge information scores. Most commonly, a discharge packet, folder, or binder is given to patients early in the admission. One hospital realized a dramatic increase in HCAHPS scores after beginning to give patients one inch binders with separator tabs for different types of education, such as diagnosis, medications, treatments, equipment, and after care. The front cover has a reminder to bring the binder to all follow up appointments. Hospital staff add information to it and refer to it often during their stay.

Contents of discharge packets, binders, or folders are often reviewed at discharge along with written discharge instructions, a discharge care plan, or an after visit summary (AVS), which are typically generated from the EHR. Some participants specified that discharge educators utilize the Teach-Back method for delivering exit care instructions, that all written discharge information is designed to be easy to read, and that plenty of time is allowed for discharge education to help ensure that patients understand what they are being taught.

Discharge Phone Calls or Home Visits

Post discharge follow up, whether by phone or in person, is the most frequently referenced strategy connected to HCAHPS discharge information success. Strategies for implementation vary widely. Discharge phone calls might be conducted by a utilization review nurse, discharge coordinator or planner, or pharmacist, most often two to three days after discharge. Patients are asked about their pain, if they have questions about their medications, and discharge information might be reviewed. Some hospitals follow up only with certain types of patients, such as obstetric or surgical patients or those deemed to be at a high risk of readmission. Several of the hospitals provide follow up home visits, most often based on criteria such as qualifying for home or community-based social services, high risk of readmission, or lack of access to home care services. However, at least one very low volume CAH offers discharge home visits to every patient.

Discharge Information Key Strategies

- Discharge Planning
- Discharge Education
- Discharge Phone Calls or Home Visits

Additional Strategies

- Whiteboard in nursing care room with names of all patients, discharge plans
- Dedicated staff
- Staff education on discharge planning
- EHR triggers for discharge visits

Care Transitions

As mentioned earlier, HCAHPS care transitions scores for all hospitals are much lower than HCAHPS discharge information scores, and this disparity also holds true for the focus group CAHs. Transitions of care is a composite of three four-point Likert-type scale questions on the HCAHPS survey:

- "During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left."
- "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health."
- "When I left the hospital, I clearly understood the purpose for taking each of my medications".

A review of the HCAHPS survey questions can help clarify the difference in hospital performance between Care Transitions and Discharge Information, but also reveals a disconnect between the composite name – Care Transitions - and the content of the questions it represents. Although the questions address patient perception and understanding of care needs when they leave the hospital, the majority of the focus group responses in this topic are better aligned with processes for effective transitions of care with strategies such as community care collaboration meetings, readmission committees, and formal care transition programs. Medication reconciliation was offered several times as a strategy, however, and "giving patients control of their care", and "explaining patient responsibilities" also was mentioned. Addressing expectations in patient materials can also be a strategy, for example, first page of a discharge folder given to patients in one hospital states "Discharge planning starts with admission. We want to have a good understanding of your preferences related to discharge needs". Finally, one participant stated that educating case management on the HCAHPS survey questions was helpful in improving performance on this topic, which may also be great place to start for this topic.

Care Transitions Strategies (not including duplicate discharge Information strategies)

- Community care collaboration
- Readmission committee
- Care transition programs
- Giving patients control of their care
- Explaining patient responsibilities
- "We want to have a good understanding of your preferences related to discharge needs"
- Staff education on the HCAHPS survey questions

Resources Utilized by Participating CAHs to Improve HCAHPS Performance

Participants were asked what culture of patient safety or customer service resources they found to be helpful related to HCAHPS performance improvement. By a large margin, Studer Group resources or consulting services were the most frequently referenced, with half of the participants having benefitted from the work. The AHRQ Patient Safety Culture Survey was also found to be helpful in 12 of the hospitals. Seven participants referred to programs or resources provided by their HCAHPS vendors. A complete listing of the available resources recommended by the focus group participants is located in Appendix B.

Critical Access Hospital HCAHPS Wish Lists

After covering all of the HCAHPS topics, focus group participants were asked "Given no resource limitations, what strategies would you implement to improve HCAHPS performance?" Staffing resources was the most common answer, including dedicated patient experience positions, pharmacists, dedicated discharge positions, and transition coaches or programs. Employee and physician engagement programs, equipment such as computers and hands free communication systems and patient experience amenities such

as care channels, a blanket warmer in every room, and a big hospitality basket for little things that patients may have forgotten.

Small Rural Hospital Improvement Grant Program (SHIP)

The Small Rural Hospital Improvement Grant Program (SHIP) is supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP). SHIP grants can help small, rural hospitals to participate in improvement programs such as HCAHPS. The final question of the HCAHPS focus groups was intended to gauge the use of SHIP grants for HCAHPS improvement. Ten of the responding CAHs utilize SHIP grants for HCAHPS participation or improvement. Information about the SHIP program can be found here: https://www.ruralcenter.org/ship.

Conclusion

Thanks to the generous sharing of HCAHPS learning experiences and strategies by the 38 successful critical access hospital participants from across the country, the purpose of this study has been accomplished - to learn about and share high performing CAHs HCAHPS best practices. The critical access hospitals represented in this study range in average daily census from around one to over twenty, demonstrating the ability of even the smallest hospitals to not only participate in national quality improvement programs, but to stand out as leaders and make lasting contributions that will impact the hospital care provided to rural residents across the country.

Appendix A: HCAHPS Best Practices Focus Group Questions

- What is the approximate average daily census of your CAH, including swing bed patients?
- What strategies do you utilize to enhance HCAHPS response rate?
- Does your vendor use telephone surveys, mailed surveys or both?
- What are the one or two most important practices or behaviors that you think drive your overall HCAHPS success?
- What culture of patient safety or customer service resources have you utilized/implemented in your hospital and what have you found to be most helpful (prompts if needed)?
    - HSOPS survey
    - TeamSTEPPS
    - Justice and Accountability
    - Studer Group
    - If Disney Ran Your Hospital (Lee)
    - Why Hospitals Should Fly, Charting the Course (John Nance)
    - Others?
- What specific practices have you implemented that improved your performance related to the following HCAHPS composites?
    - Communication with nurses
    - Communication with doctors
    - Responsiveness of Hospital Staff
    - Pain Management
    - Communication about Medicines
    - Cleanliness of Hospital Environment
    - Quietness of Hospital Environment
    - Discharge Information
    - Care Transition
- Given no resource limitations, what strategies would you implement to improve HCAHPS performance?
- What successful resources have you developed internally that you might share with CAHs nationally?
- Are you using Small Hospital Improvement Program (SHIP) funding to support your HCAHPS work?

Appendix B: Tools, Resources, and Suggested Reading

Tools and Resources

AHRQ's Guide to Patient and Family Engagement in Hospital Quality and Safety includes a section on Nurse Bedside Shift Report, which is said to improve nursing communication by involving the patient and family in the change of shift report for nurses.

AHRQ Health Literacy Universal Precautions Toolkit provides tools that support the HCAHPS topics of nursing and physician communication, communication about medications, discharge information and transitions of care by helping to simplify communication with and confirm comprehension for all patients.

AIDET a Studer Group communication framework for healthcare professionals to communicate with patients and each other.

Baird Group offer consulting services and resources that support HCAHPS performance through culture transformation guidance.

Baldridge Performance Excellence Program offers a wide array of products to help organizations improve.

The Beryl Institute - Improving the Patient Experience is a global community of practice dedicated to improving the patient experience through collaboration and shared knowledge.

Brian Lee - Custom Learning Systems provides a series of HCAHPS educational programs for leadership and frontline staff.

Cleveland Clinic Office of Patient Experience consult with community hospitals to identify, implement and promote HCAHPS best practices.

GiANT Worldwide is a global company dedicated to leadership transformation through intentional apprenticeship

Just Culture - The Center for Patient Safety offers resources to help establish a culture that encourages open reporting of adverse events and risky situations, yet hold people and organizations accountable in a just manner.

Larry McEvoy is a seasoned health care executive and experienced emergency physician consultant particularly focused on the shared work between executives, clinicians, and clinical leaders to facilitate dynamic shifts in mindset, method, and performance.

No Pass Zone A Hospital Quality Institute initiative to provide quick and effective responses to patient's needs

Pat McGill | Motivational Speaker | Customer Service Pat delivers workshops, keynotes and training seminars on topics pertinent to personal and professional development.

Senn Delaney - The Culture Shaping Firm consultation services that inspire leaders to create thriving organizational cultures.

Studer Group partners with organizations to build a sustainable culture that promotes accountability, fosters innovation, and consistently delivers a great patient experience and the best quality outcomes over time.

Surveys on Patient Safety Culture | Agency for Healthcare Research & Quality The AHRQ Surveys on Patient Safety Culture (SOPS) program enables health care organizations to assess how their staff perceive various aspects of patient safety culture.

Teach-Back Toolkit combines health literacy principles of plain language and using teach-back to confirm understanding.

TeamStepps an evidence-based set of teamwork tools, aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals.

Transforming Care at the Bedside a framework for change on medical-surgical units built around improvements in safe and reliable care, vitality and teamwork, patient-centered care, and value-added care processes.

Suggested Reading

Charting the course: Launching patient-centric healthcare, Nance, J. J., & Bartholomew, K., Second River (2012)

Going Lean in Health Care. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2005. (Available on www.IHI.org)

HCAHPS handbook: Hardwire your hospital for pay-for-performance success, Studer, Q., Robinson, B. C., & Cook, K., The Fire Starter Pub. (2010)

If Disney ran your hospital: 9 1/2 things you would do differently, Lee, F., Bozeman, MT: Second River healthcare press. (2004)

Inspired nurse, Bluni, R., Fire Starter Pub. (2009)

Why hospitals should fly: the ultimate flight plan to patient safety and quality care, Nance, J. J., Second River Healthcare Press (2008)

Appendix C: Hospital Selection Methodology

Detailed Method

Steps:

1) Select all CAHs in the MBQIP HCAHPS file for CY 2015 reporting
2) Divide into "low" and "high" volume CAHs. Cutoffs were determined by exploring distributions of the # of discharges (# of discharges were approximated by using the response rate and # of surveys completed). "Low volume" was ultimately defined as 300 or fewer discharges in a year. "High volume" was over 300 discharges in a year. (This is essentially the same thing as less than 100 surveys – average of ~33% response rate x 300 discharges = 100 surveys)
3) Create an average score for each CAHs to estimate performance. This was calculated by adding up all HCAHPS elements in the MBQIP HCAHPS files for each hospital (composite 1, 2, 3, 4, 5, 6, and 7, plus Q8, Q9, Q21, and Q22), and dividing by the number of elements (11).
4) For hospitals that had a Star Rating calculated (those with at least 100 surveys returned), compare the Star Rating to the average score. Estimate association between Star Rating and average score to determine a cutoff point (77) above which all 5 star hospitals fall.
5) Apply this high-performer cutoff point as inclusion criteria for all hospitals. After limiting, there were 146 high volume and 247 low volume hospitals remaining.
6) To encourage geographically representative participation, randomly sample hospitals by National Organization of State Offices of Rural Health (NOSORH) region. Draw a weighted sample from the low volume list and the high volume list. Ultimately 26 hospitals were sampled from each of the two groups.

Limitations: Only one data point was used (CY 2015), so it is not possible to know if this high performance continues over time. Association between average score and Star Rating is an approximation.

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