



Rural Quality Improvement Technical Assistance

Best Practices in Patient Experience at Critical Access Hospitals: Incorporating Lessons from COVID-19

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

November 2022

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Introduction

Understanding and improving how patients experience care is an essential component of quality and reflects the leadership and culture of health care organizations. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey tool allows for a standard approach to assessing patient experience through a 29-item instrument and data collection methodology for measuring patients' perceptions of care.

The coronavirus pandemic dramatically changed health care delivery, disrupting the normal flow of daily clinical practices and how patients, their families and other loved ones, clinicians and other health care staff interact within the health care system.¹ Clinicians and health systems have been required to adapt to new care models and workflows and modify existing policies and procedures to support infection prevention strategies and to keep staff, patients, and families safe.² Many hospitals across the country made the difficult decision to alter visiting policies by staunchly restricting – or altogether eliminating – visitation to reduce the further spread of the virus. Processes aimed at improving patients' experience of care, including staff education, patient and family advisory councils (PFACs), communication, and other patient-and-family-centered improvement initiatives, were sidelined in the interest of ongoing safety and with consideration for limited staff capacity, making it even more challenging for hospitals to meet or exceed patients' expectations for their care experiences.

Yet, amidst this disruption, critical access hospitals (CAHs) found innovative pathways to improve patient and clinician communication, mitigate the stress and anxiety suffered by patients and their families because of altered visiting policies, and meet the health care needs of their patients while safeguarding best practices for patient experience, during an unprecedented global health care crisis.

This report captures suggested strategies for improving patient experience and HCAHPS performance as gathered from high-performing CAHs across the country during a virtual CAH HCAHPS Best Practice Summit. Included within are:

- An overview of the HCAHPS survey.
- The methodology utilized for selecting and gathering input from high-performing CAHs.
- Summit findings, including:
 - Recommendations for overall HCAHPS success.
 - Innovative strategies to improve patient experience based on lessons learned from the Coronavirus disease 2019 (COVID-19) pandemic.
 - Best practices for improving performance by HCAHPS domain.

¹ The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots. <https://www.commonwealthfund.org/>. The Commonwealth Fund, New York, NY. August 11, 2022.

² Silvera GA, Wolf JA, Stanowski A, Studer Q. The influence of COVID-19 visitation restrictions on patient experience and safety outcomes: A critical role for subjective advocates. *Patient Experience Journal*. 2021; 8(1):30-39. doi: 10.35680/2372-0247.1596.

HCAHPS Overview

HCAHPS is a survey instrument originally developed by the Agency for Healthcare Research and Quality (AHRQ) in 2002 to measure hospital patient perceptions of care.³ The Centers for Medicare & Medicaid Services (CMS) has required the survey for all Prospective Payment System (PPS) hospitals since 2007, and results have been publicly reported on [Care Compare](#) (previously Hospital Compare) since 2008.

At the time of this report, the HCAHPS survey asks discharged patients 29 questions. The survey contains 19 core questions about critical aspects of patients' hospital experiences, including:

- Communication with nurses and doctors.
- Responsiveness of hospital staff.
- Cleanliness and quietness of the hospital environment.
- Communication about medicines.
- Discharge information.
- Overall rating of hospital.
- Likelihood to recommend the hospital.

Additionally, the survey includes three items related to patients' understanding of care when they left the hospital (care transitions) and seven questions related to patient demographics, including five items used to adjust scores for the differing mix of patients across hospitals. HCAHPS can be implemented in four different survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR). Hospitals can use the HCAHPS survey alone or include additional questions after the core HCAHPS items.⁴

HCAHPS participation is currently not required by CMS for CAHs; however, the Health Resources and Services 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 resulting data to drive performance improvement. For the Q3 2020 – Q1 2021 reporting period (the time period used for this study), 1,224 of the 1,335 CAHs nationwide reported HCAHPS data.

Low patient volumes are a barrier to the utility of HCAHPS for some CAHs. The HCAHPS survey focuses on inpatient care only (i.e., it does not cover emergency department care), and many CAHs have limited inpatient census. The survey process also excludes patients discharged to hospice, skilled nursing, or nursing home care, reducing the number of patients eligible to be surveyed each quarter. For hospitals with 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 Q3 2020 – Q1 2021 reporting period, 240 CAHs (17.9%) met the threshold to have an HCAHPS star rating calculated, and 71 achieved an impressive five-star rating.^{5,6} 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.

³ <https://www.hcahpsonline.org>. Centers for Medicare & Medicaid Services, Baltimore, MD. August 8, 2022.

⁴ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQuality/Inits/HospitalHCAHPS>. Centers for Medicare & Medicaid Services, Baltimore, MD. August 8, 2022.

⁵ [NationalAnnualReport2019-071321.pdf \(flexmonitoring.org\)](#). Flex Monitoring Team, February 2021.

⁶ In calendar year 2019, 33.6% of CAHs reported more than 100 completed surveys. CMS did not release data for Q1/Q2 2022, so this more recent period only includes three quarters of data.

Method

This report provides an update to [A Study of HCAHPS Best Practices in High Performing Critical Access Hospitals](#), originally published in May 2017 as part of the Rural Quality Improvement Technical Assistance (RQITA) program, sponsored by FORHP and led by Stratis Health. This update was created based on input collected from high-performing CAHs during a CAH HCAHPS Best Practice Summit (the Summit) convened in August 2022 and illustrates the strategies participating CAHs employed to maintain their commitment to ensuring patients had the best possible health care experience, despite the challenges posed by the coronavirus pandemic and changing health care landscape. Additionally, the report offers frequently cited best practice strategies for each HCAHPS domain. These strategies were collected in a pre-meeting questionnaire and discussed by participants during the Summit.

Participant Selection

For the original study in 2017, hospitals invited to participate had either achieved a CMS HCAHPS star rating of five stars or were determined to be high performers based on an estimated association between the performance of CAHs that earned a CMS HCAHPS five-star rating and the performance of CAHs with less than 100 completed surveys, calculated utilizing the average of 11 topic-specific HCAHPS measures. Thus, CAHs with less than 100 completed surveys but an average score greater than 77 percent were also included in the selection process.

Recent performance data of the 2017 participant hospitals was analyzed to determine which CAHs to invite to the 2022 Summit. The definition of “high performer” for this selection round involved comparing hospital performance on each HCAHPS domain to the national average and ensuring the selected CAHs were consistently performing better than the national average in most or all areas of the survey.

Hospital Participation

Hospitals that accepted the opportunity to participate in the Summit were sent a pre-Summit survey to help provide context and identify key areas for discussion. In the survey, respondents were asked to identify innovative strategies that were implemented during the pandemic to address challenges that arose based on changing visitation policies or other COVID-related adaptations and which, if any, specific strategies or tactics they use to influence their scores related to each HCAHPS topic or composite. The complete pre-Summit survey can be found on the Technical Assistance and Services Center (TASC) resource page.

The Summit was a three-hour structured discussion conducted by a facilitator using the Zoom meeting platform. Participant positions represented in the discussion included: director of quality, director of risk, chief clinical officer (CCO), CEO, president & CEO, physician (hospitalist), chief nursing officer, director of nursing, vice president of quality, transitional care nurse, and nurse and care coordinator.

The following is a summary of participation in both the pre-Summit survey and the Summit:

- 37 hospitals were invited to participate in the Summit.
- 15 of 37 hospitals accepted the invitation to participate and were sent the pre-Summit survey.
- 12 of 15 hospitals completed the pre-Summit survey. Roughly 50% of hospitals that completed the pre-Summit survey were part of a larger health care system. The other 50% were independently owned.
- 10 of 15 hospitals participated in the Summit.
- Five of the participating hospitals also participated in the original 2017 focus groups.

The CAHs listed below participated by completing the pre-Summit survey and/or attending the Summit meeting:

- Abbeville Area Medical Center, South Carolina
- Broaddus Hospital, West Virginia
- Community Medical Center, Nebraska
- Floyd Valley Healthcare, Iowa
- Landmann-Jungman Memorial Hospital, South Dakota
- Marshall County Hospital, Kentucky
- Medicine Lodge Memorial Hospital, Kansas
- North Canyon Medical Center, Idaho
- Northern Light CA Dean Hospital, Maine
- Sheridan Memorial Hospital, Montana
- SMP Health St. Kateri, North Dakota
- Union County Hospital, Illinois

In aggregate, hospitals participating in the HCAHPS Best Practice Summit performed above the national average in every HCAHPS topic (Q3 2020 – Q1 2021).

HCAHPS Topic or Composite*	Summit Group Average	National Average
Response Rate	30%	24%
Communication with Nurses	88.5%	80%
Communication with Doctors	88%	80%
Responsiveness of Hospital Staff	81.2%	67%
Communication about Medicines	70.5%	63%
Cleanliness of Hospital Environment	80.8%	73%
Quietness of Hospital Environment	74%	63%
Discharge Information	89.3%	86%
Care Transitions	63.1%	52%

*Overall Rating of Hospital and Willingness to Recommend Hospital not included due to missing data.

The CAHs represented in the Summit 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.

CAH HCAHPS Best Practice Summit Findings

Sharing HCAHPS success best practices is an excellent way to improve the performance and productivity of an organization, as this transfer of information can help organizations fill knowledge gaps, improve efficiency, and encourage leadership. The hospitals selected to participate in the Best Practice Summit have some of the best patient experience scores among CAHs across the country. To understand how these high performers consistently outrank other hospitals, we invited participants to share what has contributed to their overall HCAHPS success over time, independent of interventions utilized to respond to the COVID pandemic. Key themes that emerged are:

- **Organizational culture and leadership** support of service excellence.

- **Staff engagement**, including recruiting, hiring, onboarding, and ongoing training are essential to establishing a culture and practices which support patient-centeredness.
- **Clear and consistent communication** with patients, families, and across all levels of the hospital (administration, clinicians, support staff) is foundational to a good patient experience.
- **Data transparency** about patient experience scores drives continuous improvement.
- **Gathering patient input** by improving HCAHPS response rates and soliciting real-time patient experience feedback.

Organizational Culture and Leadership

Culture and leadership play a significant role in shaping the care and treatment of patients. High-performing CAHs characterized the culture of their organizations as follows: passionate, engaged, familial, well-rounded, grounded in communication, hospitable, patient-focused, fluid, and transformative, and powered by excellence in serving the community, patients, and families.

Passionate
Well-rounded Engaged
Hospitable Familial Patient-focused
Grounded in communication
Powered by excellence in serving the **Fluid and**
community, patients, and families. **transformative**

Another characteristic of a high-performing culture that was not explicitly referenced when participants were asked to share terms that described their organizational cultures but is threaded throughout the entirety of this discussion is transparency. And this notion of transparency is another crucial factor in achieving HCAHPS success. The following are the diverse ways Summit participants discuss their HCAHPS strategies with their boards of directors, leadership teams, staff, and communities.

- Display HCAHPS data on the organizational Intranet; post results on hallway and breakroom bulletin boards; and email results to all staff members.
- Review results at departmental staff meetings, section meetings, and medical staff executive committee meetings.
- Quality, including HCAHPS performance, is a standing item on board meeting agendas.
- Promote high-performing areas on social media, including Facebook.
- Recognize and congratulate high-performing departments; highlight comments and feedback that call out excellent service.
- Utilize a vendor-provided scorecard to identify areas of opportunity and implement improvement strategies.
- Make it an organizational priority to ensure staff members feel connected to the survey process, are familiar with the survey questions, connect it to staff, and understand how to interpret results.
- Share results with patient and family advisory councils (PFACs) and seek input on how to improve.

Staff Engagement

Staff engagement was recognized as a critical best practice. Involving staff at all levels in improvement efforts and decision-making around patient experience, staff recognition (e.g., sending a kudos email to the top two performing departments each quarter), and frequent rounding and staff huddles are vital to cultivating and maintaining an engaged staff.

Recruiting and hiring practices emerged as a common theme early in the discussion. According to one participant: “*It starts before we even hire a staff member – it starts with recruitment.*” To that end, Summit participants encouraged using behavioral-based questions and peer-to-peer interviewing. Organizations identify those candidates who demonstrate an aptitude for navigating difficult situations, including conflict with clinicians, and effectively communicating and interacting with patients and families. Thirty- and ninety-day reviews for new hires contribute to helping leaders ensure desirable behaviors are hardwired and provide an opportunity to assess whether the new hire is indeed the right fit for the organization and/or the organization is the right fit for the employee.

Training for all staff, starting at orientation and continuing through an employee’s tenure, was cited as another influential component to consistently achieving high patient experience scores. Examples of such training include [Studer Group’s AIDET⁷](#) and Standards of Behavior Training, and homegrown service excellence training. HCAHPS scripting, or using keywords, are cornerstones of some training programs. For instance, when clinicians discharge patients, they are coached to ask: “Do you have any questions regarding your medications that I can help answer for you?” Using this pointed language is beneficial on multiple levels, including promoting consistency in practice, hardwiring key strategies and best practices for providing excellent service, and introducing the language patients will later see on satisfaction surveys.

Clear and Consistent Communication

In addition to hiring and training, Summit participants noted the importance of communication – communication between clinicians and patients, between patients and ancillary staff members, such as registration and housekeeping, and between staff members – in their overall HCAHPS success over time.

Best practice tactics for communication included:

- Consistent data transparency and visual display of data.
- Utilizing lean daily management systems, huddles, and bulletin boards.
- Organizational Intranets and dashboards, newsletters, and email.
- Using a reliable cascade framework and plan, daily and weekly staff huddles.
- Leadership rounding.
- Real-time conversations with patients.
- Including patient experience data in meetings regularly.

Data Transparency

Sharing data at all employment levels, from the bedside to registration, to housekeeping, to billing, ensures that every staff member understands that they contribute to the patient experience regardless of role. One hospital, part of a larger health system, noted the value of internal benchmarking. The ability to collaborate and share best practices with colleagues at other facilities within the same system helps

⁷ AIDET (Acknowledge, Introduce, Duration, Explanation, Thank) is a communication framework used by health care professionals to communicate with patients and each other in a way that decreases patient anxiety, increases patient compliance, and improves clinical outcomes. <https://www.studergroup.com/aidet>. Studer Group, Pensacola, FL. August 12, 2022.

promote a culture of transparency. It keeps employees focused and engaged in continuous improvement around patient experience.

Gathering Patient Input

The HCAHPS survey (and its results) is important because it serves as the patient's voice and gives a view into the patient's perception of the care provided. The higher the response rates (see table on page 5), the more hospitals receive valuable feedback from a higher proportion of patients, creating a more representative sample of the total hospital patient population, thereby better informing improvement efforts around patient experience.

Because robust response rates are so important, Summit participants were asked to share any work they are doing that influences response rates. Strategies included:

- Integrating survey information in conjunction with discharge papers.
- Using scripting in interactions with patients.
- Educating and informing patients about the survey and what to expect, including during leadership rounding.
- Post-discharge or transition of care phone calls made within 72 hours, including a reminder to expect the survey.

Creating awareness about the survey for patients and staff was top of the list for some hospitals. One hospital provides a colorful flyer about the survey attached to discharge instructions, informing patients to be on the lookout for the mailing, which often comes in a plain white envelope that can be mistaken for junk mail, asking them to take the time to complete and return. Another, which recently changed survey vendors, spoke to the importance of providing vendors with patient lists on a weekly or biweekly cadence to avoid long periods of time between discharge and the time the patient is surveyed. Keeping staff apprised of the survey vendor, survey modes, and applicable contact information (e.g., phone numbers, etc.) is equally important. Other hospitals strategically placed posters reminding patients of the survey, including information on the hospital website, and running announcements on waiting room television sets.

Additional advice is to take a proactive rather than reactive approach to patient experience. For example, one participant uses an outside vendor to collect real-time patient feedback about satisfaction. At discharge, patients are given a card with a QR code that takes them directly to a website, where they are given a single prompt: "Let us know how we're doing." Patients are then invited to leave a review on Google or Facebook or prompted to fill out a form on the hospital's website (links to each platform are provided). When the hospital receives a negative review or comment, a change or service recovery can occur promptly and before the patient is asked to complete the HCAHPS survey. Positive reviews provide an opportunity to celebrate wins with staff.

Other Considerations

Benchmarking, internally and with other industries, and overall organizational strategy rounded out the Summit discussion. Taking a step back to look outside health care, specifically in the hospitality industry, for insight into delivering exceptional customer service was an effective strategy for one hospital. Understanding that patients, like any other customer in the marketplace, have choices, hospitals must work to deliver an exceptional customer/patient experience. Lessons learned from observing the hospitality industry included: acknowledging the guest right away, offering friendly and timely service, explaining things in a way that is easily understood, and delivering on promises made.

A question about overall HCAHPS success was also asked on the pre-Summit survey. All survey respondents indicated the following factors contribute to overall HCAHPS success

- Culture (e.g., standards of behavior, teamwork, accountability)
- Leadership practices (e.g., leader visibility, leadership development, leader rounding with staff)
- HCAHPS data feedback (e.g., sharing the data with staff and clinicians often, providing opportunities for discussion and suggestions, fostering friendly competition) contributes to overall HCAHPS success.

A vast majority indicated that staff engagement (e.g., consistent, intentional involvement in decision-making and problem-solving, celebrations of performance improvement progress, rewards, and recognition) also plays a crucial role.

COVID Adaptations and Lessons Learned

The coronavirus pandemic changed the landscape of health care in remarkable ways. It profoundly impacted infection prevention strategies and use of personal protective equipment (PPE), access to care across the continuum, visiting policies and practices, modes of health care delivery, and patient and staff interactions – all of which contribute to shaping the patient experience. The ensuing discussion highlights the changes or innovations Summit participants implemented during the pandemic to address how patients experience their care and/or how hospitals received feedback or measured patients' care experience focusing on technology, visiting policies, physical structure, clear and consistent communication, and cross-staff support.

Technology

Not surprisingly, using technology and relying heavily on technology to support communication was a common strategy across the board. Most hospitals provided patients with hospital-purchased iPads/tablets to facilitate virtual visiting hours via FaceTime and/or Facebook and other social media platforms. Care conferences, other meetings with the care team, and specialty follow-up visits were conducted using virtual meeting platforms to allow for family presence and engagement, eliminate unnecessary travel, and maintain social distancing practices. Facilities also leveraged virtual platforms to train family members to provide home-based support post-discharge. Hospitals also began using or increasing their use of telemedicine (the use of technology that enables remote health care, also referred to as telehealth) as a care delivery platform, expanding access to care while reducing staff and patient exposure to the virus and conserving scarce supplies of PPE.⁸ All participants who discussed increased use of technology to support patient visitation or to expand access to service delivery indicated these practices would continue indefinitely.

⁸ Koonin LM, Hoots B, Tsang CA, et al. Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1595–1599. DOI: <http://dx.doi.org/10.15585/mmwr.mm6943a3external> icon.

Visiting Policies

Throughout the pandemic, health care facilities have been called to manage visitors to reduce the risk of transmission of COVID-19. For many, this meant updating visiting policies to limit or halt visitation, especially during times of surge. The critical access hospitals participating in the Summit took varying approaches to accommodate visitation during this time. Strategies used to mitigate exposure risks included:

- Scheduled visits.
- Placing patients in single rooms to the extent possible.
- Aligning visitation thresholds with positivity rates in the area.
- Working with families to stagger visitors to allow for a two-week quarantine period once a visitor has been with a COVID-positive patient.

Several hospitals created a special “support person” or “support partner” program, allowing patients to identify one person who would be trained and educated to become part of the care team, differentiating this person from other visitors. When visitation was either restricted or eliminated, the support person, who had a very specific role, was invited to participate in rounds, meet with the physician(s), learn about the patient’s medications, and provide other members of the care team insight into the patient’s likes and dislikes. Because this support person was integrated as an actual care team member, they could provide support to the patient on various levels, including person-to-person support.

Physical Structure

Physical structure also came into play as hospitals adapted to social distancing requirements and the Center for Disease Control and Prevention (CDC) visiting guidelines. One-storied, or ground-level, hospitals created visiting spaces outside patient rooms by putting room numbers on the windows and providing canopies to protect visitors from the elements. Hospitals planted flowers, added artwork, and installed bird feeders to make the outdoor space (the “outside hallway” for the patient) more inviting for patients and visitors. This approach made it possible for hospitalized patients to visit with their families, friends, and even pets – an integral part of the healing process – with reduced risk of exposure. Here, too, hospitals indicated these creative visiting spaces would remain post-pandemic.

Clear and Consistent Communication

Regardless of how hospitals modified their visiting policies or changed visiting accommodations to remain compliant with CDC guidelines, one thing remained steadfast: hospitals’ commitment to clear and consistent communication. Using a variety of venues, including television, radio, and social media, hospitals made a concerted effort to inform patients, families, and the communities served of what to expect at regular intervals as the pandemic evolved and guidelines were updated or changed.

Cross-Staff Support

Other COVID-related interventions supporting patient experience focused on hospital culture and cultivating a spirit of teamwork. At one hospital, staff were cross-trained across all areas, making it easier to allocate staff to areas with the greatest need, even if the work was not the employee’s primary

For one very small hospital situated in a community of only 900 people, visitation was managed on a rigorous, regulated, case-by-case basis, dependent on the number of admitted COVID-positive patients and the patient’s needs (e.g., end-of-life status). At times, visitation was limited to a singular visitor throughout the patient’s stay, while restrictions were often lifted when a patient was at the end of life. Clergy, for this hospital and others, had unrestricted access to patients, regardless of COVID status. Hospital leaders were careful to be transparent with their patients and staff and provided education about the risks associated with exposure and transmission of the virus to all visitors.

job function. Several hospitals increased their housekeeping staff and cleaning schedules to enhance cleaning in high-patient areas; some purchased expensive ultraviolet (UV) cleaning machines to promote cleanliness and strengthen infection prevention practices. Hospitals indicated they would continue these strategies into the future.

More nurses were hired to provide one-to-one care for COVID patients. COVID screeners were hired and stationed at points of entry to help manage the flow of people into the hospitals. Multidisciplinary incident command teams were formed to make decisions and address challenges due to changing visitation policies and other COVID-related adaptations.

Other Lessons Learned and Ongoing Opportunities

The COVID-19 pandemic strained health care systems around the world in extraordinary ways, requiring all systems to contend with limitations related to staffing, supplies, and space and rapidly adapt to new modes of care and workflows. Though we cannot say we are post-pandemic, hospitals have had some time to reflect on the last two years and think about what they might have done differently if they could change their care for patients. One hospital recognized the need for single rooms and is in the process of rebuilding to accommodate that need. Improving transfer communication was a topic addressed by multiple hospitals participating in the Summit. Discrepancies in health information exchanges from location to location increase patient risk and compromise transfer efforts when the correct information is not communicated or available at the right time, especially when patients are transferred to facilities where there is no pre-existing relationship. In addition, more focus on the importance of outpatient scheduling and follow-up with patients, families, and primary care providers to enhance the transfer from hospital to home to improve patient outcomes and ensure access to care was mentioned.

Finally, managing drift in practice is something that hospitals must continually do. COVID has consumed health care workers for the last two-plus years. Now that we have learned how to better manage our “new normal,” hospital leadership have the opportunity to re-orient staff to the core reason many choose the profession: to serve the patient and ensure every patient has an excellent experience. According to one hospital, “Policies will change, the CDC and state governments will change laws and regulations, but patient care and priorities should never change.” Taking time to review survey results, assess and reassess workflows and standard work, and adjust as necessary will support organizations in their quest to stay patient-centered.

Best Practices by HCAHPS Domain

While the Best Practice Summit did not include conversation specific to each of the eleven HCHAPS domains, hospitals were given an opportunity to address each HCAHPS area, including survey response rates and overall performance, in the pre-Summit survey. The following is a summary of those best practices, ranked from the most frequently used to the least used, based on the information provided by the 12 hospitals that completed the survey. Specific tactics listed in this section are based on best practices identified by CAHs in the [2017 study](#).

Communication with Nurses

- Patient whiteboards as an active tool to share information.
- Data feedback and discussion.
- Daily Interdisciplinary Huddles.
- Scripting or Keywords.
- Nurse bedside shift report.

In 2017, patient whiteboards were also the most frequently cited impactful intervention related to nursing communication, followed by nurse bedside shift reports, hourly rounding, scripting or keywords, and daily huddles. Other interventions included nurses rounding with physicians, multidisciplinary rounding, and mandatory scrub colors. During the Summit, participants discussed data transparency, visual display, and review as significant driving forces of overall HCAHPS success. Hospitals in 2022 report that bedside shift report is strongly encouraged, but it does not occur consistently, and some hospitals have struggled to hardwire the practice.

Communication with Physicians

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

Engaged physician leaders as a key driver for influencing communication with physician scores was cited by all but one of the twelve hospitals that completed the pre-Summit survey. This is a significant change from 2017, where “nurses managing up” (i.e., nurses softening, compensating for, or preparing patients for the behavior of physicians that have not yet transcended the bedside manner learning curve⁹). While not the leading driver, it was still a topic included in the focus group discussion. Data feedback, friendly competition, and nurses accompanying physicians on rounds were similarly ranked in 2017.

Responsiveness of hospital staff

- Culture (e.g., standards of behavior).
- Technological devices (e.g., call light systems, two-way speakers, communication devices).
- Hourly rounding (may include alternating Registered Nurses with Certified Nursing Assistants, documenting, and addressing Four Ps – pain, potty, position, and personal effects).
- No Pass Zone (e.g., everyone answers call lights, non-clinical support is provided by anyone).

⁹ <https://www.ruralcenter.org/sites/default/files/study-hcahps-best-practices-high-performing-critical-access-hospitals.pdf>. Stratis Health, Bloomington, MN. August 13, 2022.

Hourly rounding was by far the most common practice offered as an essential driver of patient satisfaction related to hospital staff responsiveness in 2017. The second was the standard that everyone wearing a hospital badge is responsible for answering call lights or patient alarms, and the third was using technological devices. The prevalence of culture and use of technological devices in 2022 could result from the increased attention on culture and the use of technology because of the coronavirus pandemic.

Pain Management (no longer an HCAHPS domain, but an essential aspect of patient experience)

- Patient whiteboards as a communication strategy.
- Setting goals and expectations.
- Use of alternative therapies.
- Automated pain assessment reminders.

The use of the whiteboard to document pain-related information continues to be the leading strategy for pain management, followed by discussing expectations and goals with patients, alternative therapies, and automated pain reassessment reminders. Quality improvement work around pain assessment and reassessment was noted by one hospital to improve process failures related to pain management.

Communication about Medicines

- Patient education (easy to read, use teach-back).
- Culture (e.g., standards of behavior).
- Pharmacist visits.
- Keywords/scripting.

Engaging a pharmacist in patient education about medicines was a key attribute to success in this domain in 2017 and continues to be a strategy employed by high performers in 2022. Other practices thought to drive HCAHPS communication about medicine scores include discharge phone calls, medication reconciliation, and using keywords or scripting, such as “education on your medications” and “side effects of your medications.”

Cleanliness of hospital environment

- Cleanliness auditing.
- Cleaning schedules.
- Notices regarding cleaning services.

Rounding by the director of environmental services (EVS) was also mentioned to help improve cleanliness scores. After the director at this hospital rounds, he shares his findings with the team to recognize outstanding work and identify improvement opportunities.

There was quite a bit of variation among responses to this question in 2017, where most participants noted that the hospital environment’s cleanliness largely depends on the quality of the environmental services team. Two common ideas involved room cleanliness auditing or rounds with varying degrees of formality and notes left on carts/beds or written on whiteboards, drawing patient and family attention to cleaning services performed before or during their hospital stay.

Quietness of hospital environment

- Awareness/reminders.
- Environmental noise control.
- Structural changes.

Hospitals reported using designated “quiet time,” where lights are dimmed and noise interruptions are kept to a minimum, as one way to help improve quietness scores. Other hospitals limit overhead paging and send frequent reminders to staff to minimize noise considering the varying levels of patient complexity on the floors. Structural considerations included in the 2017 report but not discussed during the Summit or in the pre-Summit survey include: enclosures around nurses’ stations and dictation areas and padded or carpeted floors. Monitoring and eliminating noise from doors, carts, and other equipment whenever possible is another environmental intervention that has proven to be successful.

Discharge information

- Discharge planning (starts at admission, interdisciplinary involvement).
- Discharge education (discharge packet, written information, teach back).
- Discharge phone calls or home visits (calls in 2-3 days, visits as needed).

Discharge planning is a key focus for one pre-Summit survey respondent. This hospital provides each patient with a discharge/education folder that includes pertinent information about the patient from all disciplines. The hospital has also invested in modifying the electronic health record (EHR) to build specific discharge templates that include key discharge components that nurses can check off once complete.

Care transitions

- Care transition planning (starts at admission, involves patient and family, interdisciplinary and cross-setting involvement).
- Care transitions education (in writing, video, teach-back).
- Community collaborative with representatives from different care settings to develop working relationships, consistent care transition processes, and shared terminology.
- Pharmacist visits.
- Scripting: “We want to ensure you understand what will happen when you leave the hospital.”

However, one respondent noted that its readmissions team had been transformed and now addresses care transitions throughout the organization. Transparency around HCAHPS scores and stressing that patient experience is everyone’s responsibility were also noted as key factors related to this topic.

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