HCAHPS: How Can you Always Help Patients (and Providers) Succeed?

Florida Hospital Association
Orlando, FL

August 19, 2013
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AHRQ/HRET Patient Safety Learning Network (PSLN) Project

- This program is supported by the U.S. Agency for Healthcare Research and Quality (AHRQ) through a contract with the Health Research and Educational Trust (HRET).
- HRET is a charitable and educational organization affiliated with the American Hospital Association, whose mission is to transform health care through research and education.
- AHRQ is a federal agency whose mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.
The Patient Experience of Care is Fundamental to Clinical Improvement

- Understanding the patient experience of care is not an add-on activity: it should be used as a fundamental element in your other improvement efforts.
- For those working on the HRET Partnership for Patients Hospital Engagement Network (HEN) or another HEN, your work will benefit directly from your efforts to improve the patient experience of care (e.g., readmissions, ADEs).
- Lessons you learn in this HCAHPS Learning Network will help you succeed in the HEN project because—
  - Patient-centered care is a driver of clinical outcomes.
  - Employee and patient engagement are 2 sides of 1 coin.
  - HCAHPS assesses key factors in ADEs and readmissions.

Florida Hospitals’ HCAHPS Priorities

1. Nursing Communication*
2. Responsiveness*
3. Pain Management
4. Overall/Willingness to Recommend
5. Discharge Information

Source: Pre-Workshop Self-assessments
Biggest Gaps in Patient Ratings of Florida Hospitals vs U.S. Average

1. Responsiveness – 6% points below average patient rating of U.S. hospitals
2. Nursing Communication – 5% points
3. Medication Communication – 5% points
4. Cleanliness – 5% points
5. Physician Communication – 4% points

Source: Hospital Compare Data

Nurse Communication: Florida and U.S. Benchmark Hospitals
Source: WhyNotTheBest.org
Responsiveness: Florida and U.S. Benchmark Hospitals
Source: WhyNotTheBest.org

Medication Communication: Florida and U.S. Benchmark Hospitals
Source: WhyNotTheBest.org
Pain Management:
Florida and U.S. Benchmark Hospitals
Source: WhyNotTheBest.org

HCAHPS Technical Assistance Faculty

- Carrie Brady, MA, JD
  - HRET’s primary HCAHPS faculty
  - Former Connecticut Hospital Association vice president
  - Previously a vice president at Planetree
- Case study hospitals from Florida, identified using performance data
**Our Goal**

To support hospital teams in effectively using HCAHPS as a tool for improving quality, safety, and the patient experience.

**What We Will Do Today**

- Understanding HCAHPS
- Building a Strong Foundation
- Excellent Case Studies
- Improvement Strategies
- Your Brilliant Plans!

Remember:

“A person with a new idea is a crank until the idea succeeds.” Mark Twain
Pop Quiz!

- In the U.S., how many HCAHPS surveys:
  - Will be administered today?
  - Will be completed today?

A Fresh Perspective on HCAHPS

The Hospital Consumer Assessment of Healthcare Providers and Systems

How Can you Always Help Patients (and Providers) Succeed?
Understanding HCAHPS

Goals of HCAHPS

- CMS asked AHRQ to develop HCAHPS to:
  - Provide objective and meaningful comparisons of domains of hospital care that are important to patients
  - Create incentives for hospitals to improve
  - Enhance public accountability
HCAHPS In a Nutshell

- HCAHPS is a standardized national survey of recently hospitalized patients.

- Hospitals often add their own vendor’s questions to the standard 32 questions:
  - 21 substantive questions
  - 4 screening questions
  - 7 demographic questions

HCAHPS Topics (# of questions)
- Communication
  - Physician (3)
  - Nurse (3)
  - Medication (2)
- Pain Management (2)
- Responsiveness (2)
- Clean/Quiet (2)
- Discharge Information (2)
- Care Transitions (3)
- Overall Rating (1)
- Willingness to Recommend (1)

Misperception: Home Grown Tool

10. How would you rank your trip to California?
   1. Very Super Duper Good
   2. Super Duper Good
   3. Super Good
   4. Good
   5. Bad
   6. Super Bad
   7. Super Duper Bad
   8. Very Super Duper Bad
   9. Horrible
Survey Design Principles

- HCAHPS focuses on topics for which patients are the best or only source of information
- Most HCAHPS questions have a frequency answer scale (always, usually, sometimes, never) because reports of experiences are less subjective than “satisfaction”
- HCAHPS questions and survey protocols are based on rigorous scientific development and testing, as well as extensive stakeholder input
  - Patients were involved in creating the survey

Misperception: Only the Inpatient Experience Matters

- Patient experience is much broader than the topics covered by HCAHPS
- HCAHPS is part of a suite of surveys that focus on a variety of inpatient and outpatient healthcare settings
  - Communication and care transitions are key themes across settings
- Patients’ perceptions of their hospital experience are influenced by their outpatient experiences
  - Prior to admission
  - After discharge
“If we expect the healthcare workforce to care for patients, we need to care for the workforce.”

Can each person on your team reply “yes” to these questions every day?
1. “Am I treated with dignity and respect by everyone?”
2. “Do I have what I need so I can make a contribution that gives meaning to my life?”
3. “Am I recognized and thanked for what I do?”


Higher AHRQ patient safety culture survey scores are associated with better HCAHPS scores

Why HCAHPS Matters

Value-Based Purchasing (VBP) Overview

- DRG payments initially reduced by 1% in FY2013
  - Reduction rises by 0.25% each year, ending with 2% reduction in FY2017
- Payments are adjusted based on performance on HCAHPS (30%) and clinical process measures (70%)
- All questions other than willingness to recommend and the new care transitions questions are factored into VBP
- Clean/quiet are combined into one category
CMS Value-Based Purchasing

Discharge Info
Overall Rating 3%
Consistency (based on lowest HCAHPS score) 6%
Pain Management 3%
Clean/ Quiet 3%
Responsiveness 3%
Commun re: Meds 3%
RN Communication 3%
MD Communication 3%

HCAHPS 30%
Clinical Measures 70%

Increasing Relative Importance of HCAHPS for VBP

VBP FY 2014 (FINAL)
- Process, 45%
- Outcomes, 25%
- HCAHPS, 30%

VBP FY 2015
- Process, 30%
- Outcomes, 20%
- HCAHPS, 30%
- Efficiency, 20%
“Higher patient satisfaction with inpatient care and discharge planning is associated with lower 30-day readmission rates even after controlling for hospital adherence to evidence-based practice guidelines”

For some conditions, HCAHPS performance is more predictive of readmission rates than clinical performance measures

Summary of evidence from 55 studies

- Positive associations between patient experience and:
  - Health outcomes (objectively measured and self-rated)
  - Adherence to recommended medication and treatment
  - Preventative care
  - Health-care resource use
  - Quality and safety of care

_BMJ Open_ 2013;3:e001570 (available online at no charge at http://bmjopen.bmj.com/content/3/1/e001570.full)

The Latest Research

“[T]he percent of patients who reported [on HCAHPS] that they ‘sometimes’ or ‘never’ received help as soon as they wanted was significantly associated with an increased risk for CLABSIs.”

_PLOS One_, April 2013, Volume 8, Issue 4, e61097
How Are We Doing Nationally?

July 2013 Report: Average “Top Box” Scores
October 2011 – September 2012 Discharges

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Info</td>
<td>84%</td>
</tr>
<tr>
<td>Doctor Communication</td>
<td>81%</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td>78%</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>73%</td>
</tr>
<tr>
<td>Willingness to Recommend</td>
<td>71%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>71%</td>
</tr>
<tr>
<td>Overall Rating</td>
<td>70%</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>67%</td>
</tr>
<tr>
<td>Comm about Meds</td>
<td>63%</td>
</tr>
<tr>
<td>Quietness</td>
<td>60%</td>
</tr>
</tbody>
</table>


Ample Opportunities for Improvement Nationally

Even the best performing hospitals nationwide (95th percentile) receive 83% or less “top box” scores in the following 4 categories:

- Responsiveness – 83%
- Pain Management – 80%
- Quietness of Hospital Environment – 78%
- Communication about Medicines – 75%

Building a Strong Foundation

Essential Elements to Consider

- Leadership strategies
- Strategies for partnering with patients and families
- Workforce strategies
- Data use/performance improvement strategies
Leadership Strategies

- Align efforts
  - Discuss why, not just what and how
  - Connect the dots
  - Prioritize
- Inventory patient experience initiatives and meetings
  - Celebrate achievement and improvement (e.g., momentum award)
  - Eliminate/streamline what you can
- Acknowledge the patient is not always right

Capitalize on Opportunities to Partner with Patients/Families

- Patient/family advisory council or advisors integrated in hospital operations
- Patient/family as educators
- Rounding and shadowing
- Patient/family focus groups
- Active review and analysis of patient complaint and compliment data
- Post-discharge phone calls
New AHRQ Resource

- Guide to Patient and Family Engagement in Hospital Quality and Safety
- Provides detailed implementation guides and tools for four interventions:
  - Working with Patient and Family Advisors
  - Communicating to Improve Quality
  - Nurse Bedside Shift Report
  - IDEAL Discharge Planning


Workforce Engagement Strategies

- Restore a sense of purpose
  - Huddle devotions, patient compliment hotline
  - Recruit and retain the right team (e.g., “stay” interviews)
- Connect the workforce (e.g., face/name walls)
- Convert untapped resources
  - Expand the team (“collabetition”/team trades)
- Be creative
  - Respect multiple learning styles (e.g., experiential)
  - Play to learn (e.g., video contest) and share stories
Expand the Team: Ideas to Engage Non-Patient Care Staff

- “Helping others succeed” and “all hands on deck” initiatives
- Participation in and brainstorming with patient experience improvement teams
- Acting as patient ambassadors
- Staff only “patient/family” focus groups
- Patient experience idea hotline
- Use your volunteers

Collaborate, Don’t Dictate

- Engage frontline staff in all aspects of quality improvement
  - Ask staff for their ideas and what they need to accomplish them
  - Support staff initiative with guidance, tools, and resources

Seeds of great discoveries are constantly floating around us, but they only take root in minds well prepared to receive them.

—Joseph Henry
An Example of Collaboration: 
Back side of Data Collection Form

If you observe someone NOT doing the right thing, ask the following questions:

1. Is this a supply/logistic issue (can’t find forms, pens, etc.)
2. Is this a performance/knowledge/skill issue?
3. Is this a human factors (distraction, noise, fatigue) issue?
4. Other barriers to compliance?

Example courtesy of Northwestern Memorial Hospital, AHRQ Medication Reconciliation Toolkit Webinar

Improvement Techniques

“In the beginner’s mind there are many possibilities, but in the expert’s mind there are few.”

Shunryu Suzuki
Based on your own experiences as a hospital patient or on the experiences of your hospitalized loved ones, complete questions 1-25 on the HCAHPS survey.

Consider Your Improvement Model

Use a well-established process for quality improvement.

Don't take a scattershot approach.

Graphic Source: CAHPS Improvement Guide  www.cahps.ahrq.gov
Encourage Continuous Learning: Fail Fest

- Innovation requires a willingness to fail
- Acknowledge value of time spent on all initiatives, even the unsuccessful ones
  - Assess what contributed to the outcome
  - Learn from mistakes, but don’t keep repeating them
- A learning culture (as reflected on the AHRQ patient safety culture survey) is correlated with HCAHPS success
- Learn from mistakes by regularly convening staff to discuss what hasn’t worked and why

Take a Fresh Look: Shift to Always

Always Events® for the Optimal Patient Experience:

“those aspects of the patient and family experience that should always occur when patients interact with health care professionals and the delivery system.”

Criteria:
- Significant
- Evidence-based
- Measurable
- Affordable

The program was created by the Picker Institute, an independent nonprofit organization dedicated to advancing patient-centered care. More information and resources are available at http://alwaysevents.pickerinstitute.org/
Example: Improving Nurse Communication

A: Address and refer to patients by the name they choose, not their disease.

L: Let patient and families know who you are and your role in the patient’s care.

W: Welcome and respect those defined by the patient as “family.”

A: Advocate for patient and family involvement in decision making to the extent they choose.

Y: Your name badge: ensure patients can read it.

S: Show patients and families the same respect you would expect from them.

Dartmouth-Hitchcock Medical Center
http://alwaysevents pickerinstitute.org/?p=1166

Example: Improving Physician Communication

POTHOLEs
Columbia University Medical Center – New York Presbyterian

- Trains physicians in common “potholes” that can derail patient-centered care and Always Events strategies to address them

- Potholes identified through detailed analysis of patient perspectives

http://alwaysevents pickerinstitute.org/?p=1655
Example: Discharge

SMART Discharge
Anne Arundel Medical Center

- Standardized tools promote consistent communication of key elements throughout the hospital stay
  - Symptoms
  - Medications
  - Appointments
  - Results
  - Talk with me

http://alwaysevents.pickerinstitute.org/?p=1129

Example: Building Relationships

My Story
University of Minnesota Amplatz Children’s Hospital

- Helps providers connect with each child as a person
- Non-clinical information integrated into electronic medical record
  - e.g., hobbies, nicknames
- Expanded to adult hospital
- Similar Idea: Sacred Moment Upon Admission

http://alwaysevents.pickerinstitute.org/?p=1789
(Twin Rivers Regional Medical Center)
A Word of Caution

- CMS has imposed several prohibitions designed to prevent efforts to “game” the HCAHPS survey
  - Hospitals must not:
    - Attempt to influence patients to answer HCAHPS questions in a certain way
    - Tell patients the goal is to receive “always” responses
    - Ask patients why they chose a specific response
  - Use “always” language with staff, not patients

For more information, see CMS HCAHPS Quality Assurance Guidelines v. 7.0 (March 2012), p. 21–23 (available online at www.hcahpsonline.org/qaguidelines.aspx)

Domain Specific Strategies
Reconsider Communication from a Patient Perspective

- When asked what hospitals patients think their own roles are in patient safety, “follow instructions” is the most common answer

- Only 63% of patients report they are always getting basic information about the purpose and possible side effects of new medicine

We Are Not Good Proxies for Patients, We Need to Engage Them

Barriers and Facilitators to Patient Engagement

**Patient Barriers**
- Fear and uncertainty
- Low health literacy*
- Provider reactions

**Patient Facilitators**
- Self-efficacy
- Information
- Invitations to engage
- Provider support

*In a recent study, 53% of survey respondents agreed or strongly agreed that “most medical information is too hard for the average person to understand.”

Maurer M et al., Guide to Patient and Family Engagement: Environmental Scan Report, AHRQ Publication No. 12-0042-EF, May 2012 p.25

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Evaluating Your Communication Challenges

- Who has the information?
- Where is the communication breaking down? (among providers or with the patient and family)
- Who is responsible for communicating what information?
- Who else can you engage in the communication?
- What are you communicating? Are words, attitudes, and actions consistent?
- What tools and processes are in place to ensure that the communication is complete?
- What key information is not being consistently communicated?
- Where does the transfer of information occur? Are all important parties (staff, patient, family) included?
- Where is information maintained? Can the patient create and access information?
- When is the communication taking place? (Pre-hospitalization, admission, in-hospital, discharge, post-discharge)
- Does the communication occur on a predictable schedule?
Don’t Forget to Ask Why and Teach How

- What is the goal of the communication? Is it designed to achieve the goal?
  - Patients and families must be involved in this conversation
- Teach communication skills
  - Training
  - Observation
  - Videotaped skills labs
  - On the spot coaching

“Reflect and Connect”

- Put presence on the “to do” list
- Establish a relationship/encourage dialogue
- Recognize innovations in patient comments
- Identify and resolve common communication barriers:
  - Cultural
  - Language
  - Health Literacy
  - Physical/ Emotional State
  - Patient Priorities
Assess Understanding

Always Use Teach-Back!
Iowa Health System

- Facilitates communication through use of the teach-back method
- Extensive training toolkit developed, including:
  - Videos
  - Evaluation Tools
  - Coaching Tips

Training toolkit available at www.teachbacktraining.com

Remind Staff They Are Always Communicating

Words
Actions
Body Language
Attitude

Remember you also are always communicating.
Send the right message about patient experience.
Patient Perceptions of Attitude

- “What else are you besides a body and a diagnosis?”
- “I feel talked down to, like I can’t handle the answers. I feel like I don’t always get the full truth.”
- “The doctor was just in and out, and I didn’t have time to ask questions.”


Staff Perceptions

- “HCAHPS is a hospital reimbursement initiative, not a patient care improvement effort.”
- “I ask questions but can’t get answers. As an ED physician, I want to know my admitted patients’ HCAHPS scores. I’ve asked several times, but no one will give me that data.”
- “HCAHPS data tends to be interpreted as ‘don’t do this,’ rather than ‘let’s work together on this’ . . .”
Physician Communication from a Patient Perspective

Positive Behaviors:
- Treat patients as a partner
  - Participate in decision-making
  - Full explanations
  - Elicit and respond to patient concerns
  - Modify plan based on input
- Demonstrate care
  - Be available
  - Appear unhurried
  - Take time to answer questions
  - Provide emotional comfort
- Competence

Problematic Behaviors:
- Emergency physicians
  - Wait time/Responsiveness
- Hospitalists
  - Connection to PCP
- Specialists
  - Complexity of communication
- Disorganized care
- Lack of team communication


A Simple Solution: Sit Down

Photos courtesy of Community Hospital of the Monterey Peninsula
PSLN Physician Participant Suggestions for Engaging MDs

- Share the data, partner on analyses
- Present a problem to solve
- Work collaboratively
- Highlight best practices of peers
- Focus on patient care and connection to quality/safety

In a recent survey of hospitals and healthcare systems, 29% indicated that “lack of support from physicians” was a significant barrier to improving the patient experience.

Beryl Institute State of Patient Experience Findings 2013

Thinking About Responsiveness

- Proactive
- Pervasive
- Reactive
Reactive Responsiveness: Patient Perception

Time
- Elapsed Time
- Perceived Time

Response
- Initial Acknowledgment
- Resolution of Request

Waiting
- Informed
- Uninformed

Understand Staff Attitudes Toward Responsiveness

<table>
<thead>
<tr>
<th>Opinion on Call Lights</th>
<th>% positive responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the reasons for call lights are meaningful</td>
<td>77%</td>
</tr>
<tr>
<td>Most of the call lights require nursing staff's attention and care</td>
<td>52%</td>
</tr>
<tr>
<td>Most of the call lights pertain to patient safety</td>
<td>49%</td>
</tr>
<tr>
<td>Answering call lights prevents you from doing the critical aspects of your role</td>
<td>53%</td>
</tr>
</tbody>
</table>

Nearly half of the nurses in the study of four hospitals did not perceive answering call lights as a critical aspect of their role.

Source: Tzeng Huey-Ming. “Perspectives of staff nurses of the reasons for and the nature of patient-initiated call lights: an exploratory survey study in four USA hospitals” BMC Health Services Research 2010, 10:52.
Expanding the Team

- Collect data on reasons for call lights to identify unmet needs
- Engage the entire healthcare team in responding
- Provide multiple points of contact
- Take advantage of the “untapped healthcare workforce” — family and friends
  - Has the added benefit of helping prepare family for involvement in post-discharge care

Pervasive Responsiveness

- Being aware of and responding to patient/family needs is second nature
  - e.g., wayfinding
- The organization is responsive to staff
  - e.g., regular rounding on staff with follow-up, shadowing, trading places
  - Staff have their own “call buttons”
- Staff avoid “words that don’t work”
  - e.g., “short-staffed”
Pain Management Strategies

- Keep patient informed when next pain intervention is scheduled
  - e.g., place information on white board
- Offer complementary therapies and therapeutic diversions
- Anticipate and proactively plan for pain management, rather than reacting to it

Create Expectations

- Patient expectations
  - Be candid about the pain to be expected from scheduled procedures and develop shared goals and plan
- Staff education
  - Provide staff with training in pain management
  - Develop protocols for pain, including comprehensive order sets
  - Create a pain team with specialized expertise
    - Resource for patients and staff
Improving Pain Management with a Simple Communication Tool

Comfort and Pain Relief Menu

Exempla Saint Joseph Hospital

- Menu highlights variety of strategies available to manage pain, including:
  - Comfort items and actions
  - Personal care items
  - Relaxation aids
- Serves as communication resource for staff and ready reference for patients
- Empowers additional staff members to respond to pain

Available for free download as part of the Picker Institute Always Events® materials at http://alwayseventspickerinstituteorg/?p=1154

Don’t Overwhelm Patients

- 50+ pages of written materials provided at discharge
- Instructions to obtain appointments with five different providers
- No identified point of contact
- No one knowledgeable about the comprehensive care plan
- No follow-up or coordination

AHRQ Resource: Project RED

Key Components

- Discharge Advocate educates patient in hospital
- After Hospital Care Plan (AHCP) to patient, PCP
- Pharmacist calls patients 2–4 days post-discharge

Extensive AHRQ resources available at: www.ahrq.gov/qual/projectred

PSLN Participant
Discharge Innovations

- Red Envelope
- Three Most Important Things List
- Next Dose of Medications
- Discharge Plan “Award”
Medication Communication Strategies

- New Medication Information Sheet
- Patient-friendly Medication Administration Record
  - Generate a daily document that identifies the medication to be administered that day
  - Enables the patient (or family member) to learn and monitor the medication schedule
- Staff education (e.g., drug of the month)
- Pharmacist involvement

Think Broadly About Clean and Quiet

- HCAHPS questions:
  - Cleanliness “during this hospital stay”
  - Quiet “at night”
- Patient perceptions are influenced by:
  - Cleanliness in outpatient areas
  - Noise level at other times of day
- Innovative improvement strategies
  - Waiting area cleanliness rounding/concierge
  - Daytime quiet hours
Strategies to Improve Cleanliness

- Revise job descriptions and related materials
  - e.g., role is to prevent nosocomial infections
- Provide business cards/ability to directly contact
- Professionalize training
- Emphasize that cleanliness is the responsibility of all staff, not just Environmental Services

Make Environmental Services Visible

- Engage environmental services staff as a core part of department team
  - Encourage communication with patients
- Provide patients with ability to directly contact environmental services team
  - e.g., put name and number on the white board
- Leave a note/small gift so patients know service was provided, even if they aren't there
  - e.g., washcloth animals on admission, chocolate/mints, newspaper, quote of the day, sanitized strips/stickers
Make the Connection Between Quiet and Healing

A Single Night of Partial Sleep Deprivation Induces Insulin Resistance in Multiple Metabolic Pathways in Healthy Subjects

Effects of Sleep and Sleep Deprivation on Interleukin-6, Growth Hormone, Cortisol, and Melatonin Levels in Humans

Neurocognitive Consequences of Sleep Deprivation
Jeffrey S. Durmer, M.D., Ph.D., and David F. Dinges, Ph.D.

Hospital Noises Likely to Awaken Patients


Noises Likely to Arouse Patients (from most likely to least likely)
- Phone and alarms
- Conversations and overhead paging
- Snoring and electric towel dispenser
- Squeaky door, flushing toilet, ice machine
- Laundry cart, exterior noises (e.g. traffic)
Build a Culture of Quiet

- Eliminate or reduce:
  - Overhead paging, equipment “squeaks,” loud maintenance, unnecessary alarms
- Raise awareness of “noise”:
  - Have a staff member sleep on the unit to identify the culprits
  - Create quiet campaigns that support staff in reducing noise generated by guests
    - LOVE – lower our voices everywhere
    - SHHH – silent hospitals help healing

Partner with Patients

- Ask patients what noises kept them awake
- Offer to close the door if appropriate
- Ask about and preserve patient sleep rituals
  - e.g., a cup of tea, reading material, snack
  - Pair patients by sleep habits in non-private rooms
- Offer a sleep kit
  - e.g., ear plugs, sleep mask, aromatherapy
- Replace noise with soothing sounds/white noise
### Restore Quiet Time

- Implement quiet hours
- Give patients respite from non-urgent medical interventions
- Provide visual cues to staff, patients, and visitors
  - Signs
  - Dimmed lights
  - Electronic noise level monitoring game

### Make the Most of the Programs You Already Have

- Existing programs can provide essential information on the patient experience
  - Follow-up phone call process
  - Complaints/compliments
  - Patient/family advisory council
  - Focus groups
- Use the information gained to guide your improvement activities, not just to identify and address individual patient needs
Common Dissatisfiers

<table>
<thead>
<tr>
<th>Domains of Dissatisfaction</th>
<th>Implicit Expectations for Quality Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waits (15.8%)</td>
<td>Minimized Wait Times</td>
</tr>
<tr>
<td>Lack of Environmental Control (15.6%)</td>
<td>Control Over Physical Surroundings</td>
</tr>
<tr>
<td>Ineptitude (7.7%)</td>
<td>Safety</td>
</tr>
<tr>
<td>Ineffective Communication (7.4%) (*includes lack of communication between providers, as well as communication with patients)</td>
<td>Effective Communication</td>
</tr>
<tr>
<td>Substandard Amenities (6.9%)</td>
<td>High Quality Amenities</td>
</tr>
<tr>
<td>Disrespect (6.1%)</td>
<td>Treatment with Respect and Dignity</td>
</tr>
</tbody>
</table>


HCAHPS Curriculum 2012–13

All teleconferences are scheduled for 9–10 a.m., Pacific Time
Archives of all calls available: www.psl-network.org/

- December 7, 2012: Fundamentals of HCAHPS
- December 18/19, 2012: Using HCAHPS Data Effectively
- January 16, 2013: Nurse Communication
- February 13, 2013: Responsiveness
- March 13, 2013: Medication Communication
- April 24, 2013: Discharge Information
- June 5, 2013: Physician Communication and Engagement
- July 17, 2013: Pain Management
- August 14, 2013: Clean and Quiet